



Mental Health and Addiction in Prisons

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The Drugs in Prisons Programme of the Pompidou Group of the Council of Europe

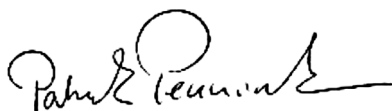
‘Show me your prisons and I shall say in which society you live’.

(Winston Churchill)

Improving health in penitentiaries, with respect for human rights, is the main objective of the Drugs in Prisons Programme of the Pompidou Group of the Council of Europe. International experts stressed the need to tackle substance abuse and HIV infections in European prisons at the International Conference on Mental Health and Addictions in Prisons, which was organised by the Pompidou Group of the Council of Europe together with the Romanian Anti-Drug Agency and the National Prison Administration in Bucharest on 27 and 28 February 2013. The articles in this publication reflect the main conclusions and arguments of the experts attending the conference.¹

Prison is a risky environment for both the prisoners and the staff. In particular, injecting drug users are exposed to various health risks, i.e. overdosing, abscessed infections of injection sites, and the transmission of blood-borne diseases such as Hepatitis C or HIV. Limiting the spread of communicable diseases in prisons therefore benefits both prisoners and society as a whole, and reduces the burdens on a country's health system.

This is why we collaborate intensively with national governments, to develop strategies of drug treatment and social re-insertion of drug-using detainees. Promoting through-care, sustaining drug treatment efforts and guaranteeing continuing care for people entering and leaving prison will reduce relapse and recidivism. With a strong element of cooperation between the countries involved, we are confident of extending best practice in the fields of penitentiary reform and drug policies throughout Europe as a whole.



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¹ The opinions expressed in this work are the responsibility of the authors and do not necessarily reflect the official policy of the Council of Europe.

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Introduction: Blind Spots and Hot Spots

Drug use in Prisons - Risks, Public Health and Human Rights

Robert Teltzrow, Project Manager, Pompidou Group

Two major inventions, Jeremy Bentham's Panopticon – a prison with a circular structure and an inspection house in the middle – and the CCTV camera, have increased the level of supervision and reduced the number of blind spots in prisons. Nevertheless, security measures alone cannot prevent illicit and licit drugs from entering prisons, nor prevent prisoners from using them. Prisons are not only hot spots for high-risk behaviours such as injecting drug use, which can lead to infections from blood-borne diseases, but also blind spots in our societies when it comes to treating drug-using prisoners with the dignity they deserve. This is why prison policies need to address drug addiction as one of the major human rights and public health issues that prison systems encounter today.

Raising awareness about human rights and public health issues was also the goal of the International Conference on Mental Health and Addictions in Prisons, which took place in Bucharest on 27 and 28 February 2013. More than 100 participants from 15 different countries attended the conference, which was organised by the Pompidou Group and the Romanian Anti-Drug Agency in conjunction with the National Prison Administration. Experts, decision-makers and frontline workers expressed the pressing need for immediate and far-reaching actions to achieve effective drug treatment and HIV prevention in European prisons. The experts attending the conference assessed that many eastern and south-eastern European countries are still struggling to modernise their prison systems. The high incidence rates of HIV and Hepatitis infections in prisons due to the sharing of injection equipment, in particular in Ukraine and Russia, show that immediate and effective actions are needed for healthier prisons. Moreover, many western European prisons also show a high prevalence of drug use and HIV / Hepatitis, and need to take concerted steps to further improve their health systems too. In addition to these public health issues, there are a number of human rights violations reported in European prisons, as documented by the European Court of Human Rights (ECHR) and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). At the conference there was a broad consensus that national governments and the international community need to address these violations by improving drug treatment systems and preventing prisons from becoming blind spots in society. Increased supervision in closed prison settings could offer an opportunity to

provide integrated services 24 hours a day, without loss of follow-up, and a greater chance to encourage treatment adherence, in contrast to less controlled community settings where the mobility of drug users and other environmental factors make studying the effects of such interventions more difficult.

The articles in this publication touch on a broad array of medical, psychological and social services for drug-using inmates, both before and after release. Although different drug treatment approaches, such as opiate substitution treatment and drug-free therapy, follow different philosophies (based on the acceptance or inevitability of drug use versus abstinence-oriented drug treatment), the participants at the conference agreed that diverse drug services are necessary and complement each other in practice.

Prof. Heino Stöver gives a comprehensive overview of drug use, mental health problems, and blood-borne virus infections (BBVs) in European prisons and presents different drug services and their goals in his article. Taking into account the lack of funds suffered by many prison systems, he stresses that interventions must be evidence-based and interlinked in order to reduce drug use and drug-related risks effectively. He describes the most promising drug services from the initial assessment of incoming prisoners to aftercare and through-care programmes. The strength of *Stöver's* contribution is his ability to analyse and discuss different interventions critically, with a human focus on the individual and specific situation of drug users as patients.

Implementing the professional independence of health care workers in the penitentiary system and sound standards of medical ethics are of particular importance for health services in prisons, as shown in *Dr Jörg Pont's* contribution. *Pont* reflects on the principle of professional independence as a prerequisite for six other ethical principles promoted by the CPT, i.e. free access to health care, equivalence of care, patient's consent and medical confidentiality, preventive health care, humanitarian assistance and professional competence. He argues that it is crucial when vulnerable populations such as drug users and inmates with mental illness are treated. In this concise case for abolishing dual loyalty conflicts by uncompromising separation of medical roles in prisons, the reader quickly understands why 'a doctor caring for prisoners should not be the prison's doctor, but the prisoners' doctor'.

Dr Hans Wolff's contribution about the Geneva model of Opiate Substitution Treatment and Harm Reduction in prisons starts by describing the European situation, which shows a much higher prevalence of drug use and HIV and Hepatitis in prisons when compared to the general population. In his opinion, the existing disparity between the care services for drug users inside prisons and those for drug users outside prisons violate the principle of equivalence of care under international recommendations. The second part of his article presents good practices of harm reduction and substitution services provided in correctional settings in Geneva. Concluding that these services proved to be effective, feasible and in accordance with human rights principles, *Wolff* argues that harm reduction should be implemented universally in all correctional institutions.

Based on prison statistics, *Dr Sven Todts* describes the situation of mentally disordered offenders (MDOs) in the Belgian prison system. He contends that many of the MDOs do not receive the treatment they need because there are not enough treatment facilities for them. As a result, many of them remain in prisons where teams of health care and social workers are unable to offer care of the quality provided outside prison. The reasons for this are understaffing and, according to *Todts*, the regrettable decision in 2007 to split the psychosocial department in such a way that the medical staff (e.g. psychiatrists) and professionals dealing with the psychosocial dimension (e.g. psychologists, social workers) are structurally separated. *Todts* hopes that the quality of care will improve for MDOs and drug-dependent inmates after the completion of forensic hospitals and the upgrading of drug services.

Dr Mihai Corciova outlines the general drug situation in Romania in the first part of his article. He claims that the 'openness' that followed the break-up of the Soviet Union allowed the illegal drug market to flourish and more youth to experiment with illicit drugs without being informed about the risks of these substances. Romanian drug services were unprepared to deal with increasing numbers of drug users, especially in urban areas. Drug use has also increased in recent years in conjunction with the emergence of 'new psychoactive substances', which are very popular among drug users in Romania. *Corciova* argues that, since these substances are normally injected with greater frequency, they might also be responsible for the reported increase in the prevalence of blood-borne diseases in Romania, alongside the closure of needle syringe exchange sites due to lack of funds. Among the good practices in Romania, *Corciova* mentions the Therapeutic Communities, which are run jointly by the Romanian Anti-Drug Agency and the National Prison Administration.

Dr Sanja Stojadinovic's contribution introduces the reader to the general drug situation and drug treatment services in Serbia. She goes on to present in detail the unique work of the Special Prison Hospital in Belgrade, which is specialised for legally enforced treatment of offenders with drug, alcohol and mental health problems. The work of this specialised clinic covers psychosocial interventions, structured group work, counselling and psychotherapy and drug-free units. *Stojadinovic* expresses the hope that the prison reforms currently underway in Serbia will further extend the scope of psychosocial interventions such as counselling and psychotherapy, residential programmes, drug-free units and aftercare programmes.

According to *Ms Elisaveta Sekulovska*, drug use is increasing in the Former Yugoslav Republic of Macedonia, and as a consequence, health services in prisons need to build capacity to respond to the needs of drug-dependent prisoners and prisoners living with blood-borne diseases and mental illness. National reform activities to this end are currently being implemented by the Directorate for Execution of Sanctions in conjunction with a number of national and international partners. *Sekulovska* lists further types of psychosocial services for drug-using prisoners which are, or should be, of particular importance for adequately serving vulnerable groups of prisoners, i.e. risk assessment,

counselling, sentence planning, motivational interviewing, HIV prevention, Methadone treatment and other more specific programmes.

Dr Svetlana Doltu and Iuliana Adam show in their article that the establishment of needle and syringe exchange programmes and the use of opiate substitution treatment are key ways to help curb addiction and HIV infections in Moldova. Moreover, they stress the important work of prison psychologists in the Department for Penitentiary Institutions of the Ministry of Justice. According to *Doltu* and *Adam*, it is crucial that psychologists support the medical treatment of drug-using prisoners with psychological assessments, counselling and rehabilitation courses.

Prof Peter Sinapius looks at the issue of drug use in prisons from a very different, but no less critical perspective. Starting from the observation that prisons are places that restrict freedom and autonomy, he is able to relate to prisoners' drug use as an attempt to 'escape reality, a way of seeking a world without borders and boundaries'. However, instead of creating autonomy, this attempt normally leads to addiction and disease. *Sinapius* then compares drug use to the effects of art in prison. Through examples of art therapy projects he organised in prisons, he concludes that art may help prisoners to transcend the boundaries of prisons by stimulating communication and opening imaginary spaces of freedom.

Mr Stefan Enggist presents the history, achievements and current plans of the World Health Organisation (WHO) Health in Prison Project (HIPP) in his article. HIPP was launched by the WHO in 1995 amid the global HIV epidemic and the revision of the judicial systems of the Eastern Bloc after the breakup of the Soviet Union. A network of European countries and international organisations such as the Council of Europe Pompidou Group, the United Nations Office on Drugs and Crime, the International Red Cross (ICRC), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and others joined forces with the WHO in order to exchange experiences and improve prison health throughout Europe. *Enggist* also describes the content and context of the most important publications and reference documents published by HIPP. Currently the HIPP is working on two new publications. *Good governance of prison health in the 21st century* discusses the question of which of a country's ministries should be responsible for prison health. The second publication will be a revised version of the guidance paper *Health in prison: A WHO guide to the essentials of prison health*.

Drug use, mental health and drugs in prisons

Prof Heino Stöver, Fachhochschule Frankfurt University of Applied Sciences

Introduction

Drug use, mental health problems and blood-borne virus infections (BBVs) (including HIV/AIDS and viral Hepatitis) are serious health problems in prison populations and in the wider criminal justice systems. This makes these places important settings for the provision of effective drug-related and BBV services to help reduce the damage that drug use does to health, prison safety and security, and the community at large (through increased re-offending and infections on release).

Large proportions of people who enter the criminal justice system and prison have a history of drug use and injecting. Many of these people continue to use drugs while in prison. The prison environment may impact positively on some drug users, helping them to stop or reduce drug use, but for others prison will be an environment where they switch to more harmful patterns of drug use.

Prisons are risk environments because they are often overcrowded, stressful, hostile and sometimes violent places in which individuals from poor communities and from ethnic and social minorities are overrepresented, including people who use drugs, and migrants.

A European study on health problems arising in prison highlighted three main issues: substance abuse, mental health problems and communicable diseases (Tomasevski, 1992). These three problem areas are closely interrelated. Some of the harms associated with drug users in the criminal justice system include:

- high rates of HIV and viral Hepatitis infection (imprisonment is associated with higher rates of blood-borne virus infection among injecting drug users);
- high rates of tuberculosis in some countries;
- restricted access to harm reduction services and treatment for drug dependence and BBVs;
- increased risk of death by overdose on release;
- increased risk of passing on infections acquired in prison;
- increased risk of re-offending on release.

Although alternatives to imprisonment have been developed and introduced in many countries, more and more people who have used or still use drugs enter prison settings. Only some are in prison as a result of a conviction for a drug offence. Most are imprisoned for other drug-related offences. Generally, in many countries the number of drug users with problematic consumption patterns in prison has dramatically increased over the last two decades. Problematic drug use is defined as 'injecting drug use or long duration/regular use of heroin/cocaine and/or amphetamines' (EMCDDA, 2011). This definition can also include other opioids such as methadone. Furthermore, drug consumption is deemed to be problematic if this behaviour is joined with other risk behaviour, causes damage to other persons or produces negative social consequences. Every sixth prisoner is thought to be a problem drug user (Hedrich and Farrell, 2012). Thus, people who use drugs are over-represented in prisons throughout Europe. Several factors have contributed to this, including poverty, migration, violence and the fact that increased incarceration is often politically expedient. Ultimately, however, repressive legislation against drugs in the context of increasing drug consumption in the community has often played an important role.

This fact inevitably affects life in penal institutions. Drugs have become a central theme: a dominating factor in the relationships between prisoners and between prisoners and staff. Many security measures are aimed at controlling drug use and drug trafficking within the prison system. Daily prison routines are in many respects dictated by drug-dependent inmates and drug-related problems: drug-related deaths, drug-induced cases of emergency, increase in the number of people who use drugs, dealer hierarchies, debts, mixed drugs, drugs of poor quality, incalculable purity of drugs and risks of infection (particularly HIV and Hepatitis) resulting from the fact that syringes and drugs are contaminated and shared. Drugs become the central medium and currency in prison subcultures. Many routine activities for inmates focus on the acquisition, smuggling, consumption, sale and financing of drugs.

Prison management is faced with increased public pressure to keep prisons drug-free. Few prison managers talk frankly and in public about drug use in prisons, establish adequate drug services and develop new drug strategies. People who confess that drug use is prevalent in prisons and that prison is a risk environment are frequently blamed for failing to maintain prison security. The number of prison managers who deny or ignore drug use in prison therefore remains great. Furthermore, many prison physicians believe they can cure inmates' drug problems by temporarily forcing them to stop using drugs. It therefore becomes obvious why dealing with people who are dependent on drugs in detention is difficult. The goal of rehabilitating prisoners must be pursued, but prison managers in many countries face rising drug consumption among inmates and political and economic circumstances that make solving the drug problem even more difficult. The current situation of judicial authorities is paradoxical. They have to find a solution to a problem that is not supposed to exist: drugs in prisons.

Nature and prevalence of drug use and related risks in prisons and on release

Many drug users in prison come from the more disadvantaged groups in society, with a high prevalence of low educational attainment, unemployment, physical or sexual abuse, relationship breakdown or mental disorder. Many drug users lead chaotic lives and experience a range of issues with housing, employment, education and health that need to be addressed. Many of these prisoners never had access to health care and health promotion services before imprisonment. The health care services therefore offer an opportunity to improve their health and personal well-being (The Patel Report, 2010).

Drug use in prison takes place in extreme secrecy, and drug seizure statistics, the confiscation of needles/syringes and positive urine test rates only indicate some of the full story of drug use behind bars. The patterns of drug use vary considerably between different groups in the prison population. For instance, drug use among women differs significantly from that among men, with different levels and types of misuse and different motivations and behavioural consequences. Studies show that substances available outside prison can also be found inside prison, with the same regional variation in patterns of use. The quality of these drugs is often poor compared with that of drugs in the community.

Some prisoners use drugs in prison to fight boredom and to help them deal with the hardships of prison life or to overcome a crisis situation, such as bad news, conviction and sentencing or violence. Imprisonment thus sometimes seems to provide reasons for taking drugs or continuing the habit, or causes relapse after a period of withdrawal.

Many countries report changes in the patterns of drug use (volume and type of drug) when the preferred drugs are scarce. Studies and observations of prison officers indicate that switching to alternative drugs (such as from opiates to cannabis) or to any substitute drugs with psychotropic effects, regardless of their potential damage, (illegal drugs and/or medicine) is widespread. Due to a lack of access to the preferred drug or because of controls (such as mandatory drug testing), some prisoners seem to switch from cannabis to heroin, even if on an experimental basis, because cannabis may be detected in urine up to 30 days after use.

In many prisons, the most commonly used drug besides tobacco is cannabis, which is used for relaxation purposes. Some studies have shown that more than 50% of the prisoners use cannabis while in prison: prevalence at entry varies between 38% in France and 81% in Scotland (Stöver *et al.*, 2008). Studies indicate that both prison staff and inmates believe that cannabis gives psychological relief and has a positive impact on the social ambiance in the particular setting of prison.

Therefore, tackling cannabis use in prison needs to take into account those effects, and include harm reduction measures tailored to individual users and their therapeutic needs.

Generally, this means that alternatives to substance use have to be developed in order to favour a calm and safe environment in prison.

A much smaller percentage reports injecting drugs in prison. The extent and pattern of injecting and needle sharing vary significantly among prisons. Prisoners who use drugs on the outside usually will reduce their levels of use in prison and only a minority of prisoners use drugs daily. This may be due to the reduced supply of drugs or it may reflect the ability of drug-using inmates to reduce or stop drug use while in prison. However, according to various studies undertaken in Europe, between 16% and 60% of people who injected on the outside continue to inject in prison (Stöver *et al.*, 2008). Although injecting less frequently than outside, prisoners are much more likely to share injecting equipment than drug injectors in the community and with a greater number of people (Jürgens *et al.*, 2009). Many were accustomed to easy and anonymous access to sterile injecting equipment outside prison and start sharing injecting equipment in prison because they lack access to it.

Although injecting drug use in prison seems to be less frequent than in the community, each episode of injecting is far more dangerous than outside due to the lack of sterile injecting equipment, the high prevalence of sharing and already widespread infectious diseases. Prisons are high-risk environments for the transmission of HIV and other blood-borne virus (BBV) infections for several reasons, including:

- a disproportionate number of inmates coming from and returning to backgrounds where the prevalence of HIV and BBV infection is high;
- authorities not officially acknowledging HIV and BBV, thus hindering education efforts;
- activities such as injecting drug use and unsafe sexual practices (consensual or otherwise) continuing to occur in prison, with clean injecting equipment and condoms rarely being provided to prisoners;
- tattooing and piercing using non-sterile equipment being prevalent in many prisons;
- epidemics of other sexually transmitted infections such as syphilis, coupled with their inadequate treatment, leading to a higher risk of transmitting HIV through sexual activity.

In the first documented outbreak of HIV within a prison population in 1993, 43% of inmates reported injecting within the prison – and all but one of these individuals had shared injecting equipment within the prison (Taylor and Goldberg, 1996). The high rates of injecting drug use, if coupled with lack of access to evidence-based prevention measures, can result in a frighteningly rapid spread of HIV and Hepatitis B and C. There were early indications that HIV could be transmitted extensively in prisons. HIV outbreaks in prison have been documented in a number of countries, demonstrating how rapidly HIV can spread in prison unless effective action is taken to prevent transmission.

Studies also show the following:

- Although smoking heroin ('chasing the dragon') plays an increasing and significant role all over Europe, this route of administration is not widespread in prisons because drugs are so expensive in prisons and injecting maximises the effect of a minimal amount of drugs, and is not as easily detectable as smoking (both for prison staff and other prisoners).
- A substantial number of drug users report having first started to inject while in prison. Studies of drug users in prison suggest that between 3% and 26% first used drugs while they were incarcerated and up to 21% of injectors initiated injecting while in prison (Stöver *et al.*, 2008).
- In addition to illegal drugs, legal drugs, alcohol and prescribed pharmaceuticals often contribute to the substance dependence and related health problems of prisoners. Many prisoners have a long history of regular use of legal drugs. Polydrug use is common among offenders entering custody, co-dependent on any combination of alcohol, opiates, stimulants and benzodiazepines. Dual diagnosis or the co-existence of mental health and substance use problems has also increased in recent years.
- Some prisoners may also discover new substances while in prison (medicines or tablets) or develop habits of mixing certain drugs they did not mix outside.

The vulnerability of drug-using prisoners to suicide and self-harm in prison is followed for many prisoners upon release from prison, which is a very critical time. In the week following release, prisoners are 37 times more likely to die of a drug overdose than other members of the public due to diminished opioid tolerance (women are 69 times more likely to do so) (Farrell and Marsden, 2005). Prisoners who have not taken drugs frequently during detention often have difficulty in adapting to the new situation after release. They return to old habits and consume drugs in the same quantity and quality as before prison. After release, many injecting drug users continue with their habit. A study indicates that 63% of those who injected before prison inject again in the first three months after release (Stöver *et al.*, 2008). Prison, therefore, cannot be seen as providing a short- or longer-term solution to individuals' problems with drugs. The transition from life inside prison to the situation in the community is an extremely sensitive period. The longer a drug user stays in prison, the more difficult adapting to life outside prison will be. Even a prison sentence of just a few weeks, during which no drugs are consumed, poses a considerable risk to released drug users; because of a reduced tolerance for opiates, even small quantities can be life-threatening.

Prevention, treatment, harm reduction and aftercare – guiding principles

In general, drug services in prisons can be divided into: assessment, prevention, counselling, abstinence-oriented and medication-assisted treatment, self-help groups and peer-driven interventions, harm reduction measures and pre-release and aftercare programmes.

Guiding principles and goals of drug services in prisons

It is essential to recognise that drug dependence (whether opiates, cocaine, tobacco, alcohol or other drugs) is a chronic disease (not a criminal or hedonistic behaviour), characterised by a long process of relapses and attempts at stabilisation. It is a disorder that consequently requires a continuing care and support approach. It should be treated in the same manner as other chronic illnesses (including diagnosis, treatment plan, control of progress, monitoring, etc.).

Guiding principles of drug services in prisons:

- It is vital that any drug treatment and intervention strategies in the community and in prison are not developed in isolation, but linked to other relevant initiatives and strategies. Prison drug strategy should be part of, and in line with, the national drug strategy.
- All drug services available in the community should also be available in prisons, in the same quality, size and accessibility. Guidelines developed by the World Health Organization's (WHO) Health in Prisons Project and the Council of Europe's Pompidou Group and its principles for the provision of healthcare services in prisons (2001) state that: 'There should be health services in prisons which are broadly equivalent to health services in the wider community' (WHO, 2001).
- Drug strategies and interventions in prisons require actions to be taken both on the level of individual behavioural change and on the structural level. Although targeting programmes at individual prisoners or groups of prisoners is important, there is also a need for more structurally oriented measures to run concurrently, to comprehensively address necessary improvements in the living conditions of the prisoners and the working conditions of prison staff.
- Drug dependent prisoners should be given a choice, an appropriate 'menu of services', including medical treatment, psychosocial interventions, harm reduction and broader social care that promotes resettlement and recovery.
- Interdisciplinary, multi-professional drug services should combine psycho-social and pharmacological approaches on the basis of stimulation of self-help potentials. Only a comprehensive approach is promising for tackling the complex phenomenon of drug dependence.
- The different services should be interconnected with each other and should offer

the possibility of a transition by the choice of the patient from one module to the other (e.g. from medication assisted treatment to abstinence oriented). A balanced treatment system is vital to ensure that drug-dependent prisoners get access to the types of treatment that are appropriate to their changing needs and circumstances.

- It is vital that drug treatment and interventions are matched to individual need and appropriate to individuals at the time that they are within the criminal justice system i.e. making sure that the right people get the right intervention, at the right time.
- With regard to prevalent somatic or psychiatric co-morbidity among drug users, drug services should be linked to respective services in prisons (psychiatric services and general health service).
- In order to prevent treatment gaps on the edge of community prison and prison community, drug services should be organised in close relationship with community services (continuity of care of drug treatment within and between prisons and community services after release). Local partnerships should be established in order to develop routines and integrated care pathways (between prisons and community services that support the treatment and interventions that are most effective, targeted at the right users with abstinence-based treatment for some, medically assisted treatment for others).
- Apart from the specific drug treatment, lasting changes can only be achieved with help and support from outside the treatment system (family and friends, peer support/mutual aid networks, access to housing, and education and employment opportunities). Emphasis is also needed on developing life skills to help prevent relapse into drug use and offending, and a lot of importance placed on crisis support, peer support and daytime activities to help make the transition to a normal life.
- The needs of particular groups (women, minority ethnic groups, people with dual diagnosis (mental health and substance use problems) must be considered.
- It is vital that the service user's 'voice' is heard and their experiences are taken into account. According to health promoting strategies, active involvement of drug users, their families and local communities is pivotal. The involvement of service users should be encouraged and facilitated through regular consultation and service user satisfaction surveys. Service users should be involved in making decisions on how services are developed, designed and delivered.
- Clear and consistent standards for monitoring and evaluating drug-related and BBV services should be established to improve the quality of health care that is available. This should include standardised data collection (including gender disaggregated data) so that the measurement and quality of data within a country and between different countries is harmonised, information dissemination is improved, and quality criteria are implemented.
- The allocation of sufficient and sustained funding (in the form of both financial and human resources) is of critical importance and continued lobbying and advocacy work is crucial in helping to secure the provision of high quality drug-related and BBV services in prisons and criminal justice systems.

The goals of drug services in prisons must be, as a minimum, protecting prisoners to leave prison in a healthier state than upon arrival and, as a maximum, psycho-socially stabilising prisoners and encouraging them to continue treatment after release. Thus, the ultimate goal of all treatment of drug dependency on an individual level is to achieve abstinence from their drug – or drugs – of dependency either with or without medically assisted treatment. On a systemic or institutional level, reducing re-offending and improving health and rehabilitation are the overarching twin aims (the outcome could be measured with four topics, which need to take into account the situation after release):

- reduced drug use;
 - reduced re-offending;
 - improved health and social functioning;
 - increased employment and enhanced workforce skills
- (The Patel Report, 2010, p. 13ff).

What works?

Given the enormous investment in criminal justice system interventions for drug dependent prisoners, we know remarkably little about what works, for whom, in which period of his/her sentence and drug career. It is difficult to transfer results of evidence-based interventions into the custodial setting. However, taking into account the lack of funds for many prison administrations, only those interventions should be supported which have proven evidence, are effective and efficient. Furthermore, it can be stated that 'positive experience from in-prison treatment helps inmates to continue treatment after release, reduce relapse rates and related health risks, and also reduce delinquency recidivism' (Uchtenhagen, 2006).

Apart from the necessary continuity of care, research evidence shows that treatment success largely depends on the duration of the intervention (the longer the intervention, the better the outcome) and its connection with additional services: e.g. the provision of help and support on and after release, with aftercare being increasingly seen as an important component of an integrated treatment programme offered to drug-using prisoners.

It is well established that good drug treatment for prisoners can reduce both drug use and rates of re-offending. Therapeutic communities, opioid substitution treatment, intensive psychosocial support/supervision on release and 12-step abstinence-based programme have particularly strong evidential support. That means that pharmacological and psychosocial as well as other supportive 'wraparound' interventions are promising strategies to stabilise prisoners. Especially the importance of having integrated medical and psychosocial services within a comprehensive package, including a range of offers that meet the needs of drug-dependent prisoners is critical for effective drug services.

The Patel Report (2010) puts it this way: 'One of the overall themes to emerge is that people need to feel they have choices. This is as important when deciding about treatment and interventions options and in choosing their own route to recovery i.e. working toward abstinence. The reality of supported self-change is vital in a recovery-focused treatment system in order to raise aspirations and create opportunities for further self-change and personal development.'

Isolated interventions, not linked with offers of psychosocial or pharmacological treatment, are not promising ways to reduce drug use or drug-related risks e.g. there is not a great deal of evidence, either within or outside prisons, on the effectiveness of substance misuse-related advice and information.

Psychosocial drug treatment and pharmacological approaches as complementary orientations in a comprehensive package of drug services

An integrated drug treatment system, as developed in England (Marteau *et al.*, 2010), is needed in order to comprehensively respond to the complex phenomenon of drug dependence. Drug-free as well as pharmacological interventions together with self-help stimulation are the key for successful drug services: psychosocial drug treatment and clinical substance dependence management have to be integrated and harmonised. Thus, drug-free orientation and pharmacological treatment are no longer contradictory strategies, but on the contrary can complement each other ideally.

Assessment of drug problems and related infectious diseases

In almost all prisons, the prison doctor sees every incoming prisoner within 24 hours of admission for a medical check. Nearly all prisons have a health unit comprising doctors, nurses and psychologists. Smaller prisons often rely on private contract doctors. The size of the team varies according to the prisons and their capacities. Cases with special health needs are referred to the prison hospital.

Nearly every European prison prepares treatment plans tailored to the specific needs of every prisoner for the duration of the prison sentence. This plan should also cover the drug treatment and psychosocial support measures to be taken after release. Treatment plans include steps towards social rehabilitation and health promotion to strengthen personal competencies and skills. If necessary, treatment measures are included and staff or special treatment boards will review progress. Although through-care planning is perceived as inevitable to deliver adequate services to drug users, this is harder to achieve but nevertheless necessary for those with a short-term sentence.

Psychosocial drug treatment and rehabilitation

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

Prisons run a variety of rehabilitation programmes for drug users based on different therapeutic approaches and assumptions. The programmes are designed to reduce the risk of re-offending through alleviating prisoners' substance use problems. Three main approaches and types of programmes can be distinguished.

1. **Cognitive behavioural therapy (CBT)** with different levels of intensity (low/medium intensity programme; gender specific and short duration). The aim is to gain social learning experiences, and to understand and treat drug-related problem behaviour associated with substance-related offending.
2. **12-step programme:** The 12-step approach is based on social learning within a peer approach, with new group members given instructions on the means to a drug-free life by more established prisoners. It works on the assumption that addiction is a lifelong illness that can be controlled but not necessarily completely cured. The programmes are high-intensity for highly dependent prisoners, no matter which specific drug they are dependent on (programmes may last for 15–18 weeks).
3. **Structured therapeutic community:** Therapeutic communities are based on hierarchical treatment and aim to teach new behaviours, attitudes and values, reinforced through peer and therapeutic community support. It is available for adult prisoners with a medium or high risk of reconviction and level of dependence on drugs (The Patel Report, 2010).

The referral to these programmes is based on individual risks and needs. The different approaches allow the individual to be directed towards the treatment that is most suited to the severity of their problem and fits with their personal characteristics and circumstances. Some of the CBT programmes are suitable for people who are stabilised on opioid substitution programmes either as part of the process of working towards abstinence or towards a better stabilisation, while the 12-step and therapeutic community models require participants to be entirely drug-free before commencing the programme. 'The factors which are rated as being good include the quality of relationships, ease of access and experiencing a transformation in which drug users describe their life as having being "turned around"' (The Patel Report, 2010, p. 29).

These approaches can additionally be matched with, on the one hand, voluntary drug testing which intends to provide an incentive for prisoners to stay drug free – either

because they are recovering from drug dependence or because they wish to continue receiving particular privileges, such as a release on temporary licence or a more desirable job within the prison. On the other hand, having something meaningful to do, including employment, education and structured programmes seem to be a key determinant in remaining drug-free.

Abstinence-oriented treatment and therapeutic communities in prisons

Abstinence-oriented treatment for prisoners is provided predominantly in special facilities (therapeutic communities). Most of the Council of Europe countries have abstinence-based programmes. Therapeutic communities are intensive treatment programmes for prisoners with histories of severe drug dependence and related offending, who have a minimum of 12-15 months of their sentence left to serve. Therapeutic communities are drug-free environments that implement an intensive treatment approach that requires 24-hour residential care and comprehensive rehabilitation services. Residents are expected to take between three and 12 months to complete the programme.

In general, therapeutic community treatment models are designed as total-milieu therapy, which promotes the development of pro-social values, attitudes and behaviour through positive peer pressure. Although each therapeutic community differs in terms of services provided, most programmes are based on a combination of behavioural models with traditional group-based, confrontational techniques. As a high-intensity, often multi-stage programme, therapeutic communities are provided in a separate unit of the prison. Many in-prison therapeutic communities ensure a continuum of care by providing community-based aftercare, which is closely connected to the specific therapeutic community and part of the correctional system.

Little research has been done on the effectiveness of therapeutic communities and the sustainability of abstinence. The unsolved problem is that therapeutic communities are often not linked with interventions of 'safer-drug use' and prophylaxis of mortality after relapse on release. It is suggested that the treatment experiences should be followed up after release.

Contract treatment units and drug-free units

Drug-free units (or wings or contract treatment units) aim to allow the prisoner to keep their distance from the prison drug scene and market and to provide a space to work on dependence-related problems. The focus in these units is on drug-free living. Prisoners stay in these units voluntarily. They commit themselves (sometimes with a contract) to abstinence from drugs and to not bringing in any drugs and agree to regular medical check-ups often associated with drug testing. Prisoners staying in these units sometimes enjoy a regime with more favours and privileges, such as additional leave, education or work outside, excursions and more frequent contact with their families. Drug-free units

(often called drug-free zones) do not necessarily include a treatment element. They aim to offer a drug-free environment for everyone who wants to keep their distance from drug-using inmates.

The purpose of staying in a contract treatment unit is that the inmate will remain drug-free or at least become motivated for continued treatment after imprisonment. Attempts will be made to motivate the inmate to strengthen his or her health and personality, to participate in work routines and to maintain and strengthen his or her social network.

Before being placed in the unit, inmates have to declare (by signing a contract) that they are willing to remain drug-free during their stay, to submit to regular urine sampling to check for the absence of drugs and to participate actively and positively in the life of the unit.

The unit offers support in the form of close staff contact and possibly relaxed prison conditions for treatment reasons, as long as the inmate refrains from taking drugs during the prison term. The contract treatment units work with group therapy and behavioural consciousness. The treatment principles for the contract treatment units reflect a fundamental concept that the inmates can be supported in their decision to stop drug use by offering close personal contact and talks with drug dependence experts. Thus, a person is attached to each inmate in a contact person scheme in the units. The contact person is responsible for the inmate's treatment plan and for handling general casework concerning the inmate. Moreover, treatment includes sessions with supervisors: external people with a theoretical and practical background as therapists. The contact person, the supervisor and the inmate hold regular sessions – tripartite talks – to investigate the inmate's development and consider the course of future treatment. Another part of the treatment is the group dynamics. This consists of motivating the inmates to support each other in the everyday life in the unit. Group dynamics are developed by creating good physical surroundings and an open environment in the units and by both staff and inmates participating in a series of activities inside and outside the unit. Finally, the units work with the concept of the consequential teaching procedure, which means that an inmate caught using drugs or counteracting the principles of the unit is expelled from the unit. The treatment plans take into account the treatment needs of the individual. They set out targets for the inmates' stay in the unit, and decisions are made on any further treatment outside.

Counselling, peer support and peer-driven interventions

Peer education and peer support can be defined as the process by which trained people carry out informal and organised educational activities with individuals or small groups in their peer group (people belonging to the same societal group, such as of the same age or prisoners). Peer education has the overall aim of facilitating improvement in health and reduction in the risk of transmitting HIV or other blood-borne diseases, targeting individuals and groups that cannot effectively be reached by existing services. Peer-driven interventions make systematic use of the high and authentic value of peers.

Based on the data available and extrapolating from the literature on community-based programmes, education programmes in prisons – as in community settings – are more likely to be effective if peers develop and deliver them. As Grinstead and colleagues (1999) stated:

‘When the target audience is culturally, geographically, or linguistically distinct, peer education may be an effective intervention approach. Inmate peer educators are more likely to have specific knowledge about risk behaviour occurring both inside and outside the prison. Peer educators who are living with HIV may also be ideal to increase the perception of personal risk and to reinforce community norms for safer sexual and injection practices. Peer education has the additional advantage of being cost-effective and, consequently, sustainable. Inmate peer educators are always available to provide services as they live alongside the other inmates who are their educational target.’

Peer educators can play a vital role in educating other prisoners, since most of the behaviour that puts prisoners at risk of HIV, Hepatitis and overdose in prisons involves illegal (injecting drug use) or forbidden (same-sex sexual activity (in some countries) and tattooing) and stigmatised (same-sex sexual activity) practices. Peers may therefore be the only people who can speak candidly to other prisoners about ways to reduce the risk of contracting infections. Peer educators’ input is also not likely to be viewed with the same suspicion as the information provided by the prison hierarchy. Peer educators are more likely to be able to realistically discuss the alternatives to risk behaviour that are available to prisoners and can better judge which educational strategies will work within their prison and the informal power structure among prisoners. Finally, peer-led education has been shown to be beneficial for the peer educators themselves: individuals who participate as peer educators report significant improvements in their self-esteem.

However, as with other education programmes, preventive education among peers is difficult when prisoners have no means to adopt the changes that would lead to healthier choices. Peer support groups need to be adequately funded and supported by staff and prison authorities, and need to have the trust of their peers, which can be difficult when the prison system appoints prisoners as peer educators because it trusts them, rather than because the prisoners trust them.

Involvement of community services

In the past decade, approaches have developed and grown substantially to divert individuals away from prison and into treatment alternatives as well as a range of services within prisons. Specific legislation in several countries has attempted to enhance links between the criminal justice system and health services to reduce the number of

drug users entering prison. Despite this development, the number of prisoners with drug dependence has continued to grow. As drug users often serve short sentences, they return into their communities and many return to their old drug-using habits. Support services need to be continued in order to sustain successes that may be achieved while in custody. This indicates that criminal justice agencies need to link better with drug services.

Pre-release units

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

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

The challenge for prison services in facilitating a successful return to the community is not only to treat a drug problem but also to address other issues, including employability, educational deficits and maintaining family ties.

Harm reduction information needs to be provided to reduce the risk of a relapse to heroin or multiple drug use after leaving the prison. Few prisons speak frankly and proactively about relapse. A prison in Antwerp has a brochure available for those who leave the prison. It specifically focuses on practical information, health and risk problems (such as overdose) at the time of release.

Many prisons undertake efforts to reduce relapse and to provide social reintegration. Protocols are therefore sometimes set up with drug treatment centres from the national and community health networks. In Portugal, for instance, some projects focus on preparing for freedom and that getting a life means getting a job. Moreover, peer groups are developed to support treated drug addicts to prevent relapse.

Aftercare

Several studies show that effective aftercare for drug-using prisoners is essential to maintain gains made in prison-based treatment. Nevertheless, prisoners often have difficulty in accessing assessments and payment for treatment on release under

community care arrangements. The following conclusions are drawn from a multi-country survey on aftercare programmes for drug-using prisoners in several European countries (Fox, 2000).

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

Working with families and maintaining family ties

The European Health Committee (established in 1954 by the Committee of Ministers of the Council of Europe) stated in 1998:

'One of the inevitable consequences of imprisonment is the temporary weakening of social contacts. It is true that family ties are not broken off completely, in the sense that in most cases a visit of at least one hour per week is permitted; nevertheless the prisoners' relationships suffer enormously from the confinement. A large number of wives, husbands and children of detainees feel punished themselves to a similar extent as their convicted spouses and fathers. Besides, and worse still, in many cases the marriage is bound to fail or be ruined.'

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

Through-care

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

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

The Scottish Prison Service has general considerations required for through-care:

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

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

Therapy instead of punishment

Several countries have legal provisions for suspending the sentence of drug users. In Sweden, Section 34 of the Prison Treatment Act (from 1 April 1999) states that a prisoner may be permitted – while still serving the prison sentence – to be placed in a treatment facility outside prison. This is not by definition a suspended sentence – it is an alternative to staying in prison until release. Another possibility is that the court sentences a person to probation with contract treatment. This is possible when there is a clear connection between

drug abuse and crime. The person has to accept and give consent to treatment instead of prison. If the person interrupts or neglects the treatment, the contract treatment will be interrupted and converted into a prison sentence.

Counselling and the involvement of community health structures

Counselling is a direct, personalised and client-centred intervention designed to help initiate behaviour change – keeping off drugs, avoiding infection or, if already infected, preventing transmission to other inmates or partners – and to obtain referral to additional health care, disease prevention, psychosocial and other needed services in order to remain healthy.

Health care employees require different information than guards or surveillance staff; inmates have their own specific background, subculture and language. Disease prevention material from the outside cannot simply be transferred to the prison setting; the relevant target groups require prison-adapted versions. This requires input from different groups based on interviews and focus-group discussions. Initial drafts and design need to be tested and approved. Both prison staff and prisoners greatly influence any prison environment. Both groups should therefore participate actively in developing and applying effective preventive measures and in disseminating relevant information.

Involvement and support from municipal health structures should have priority; non-governmental drug service, HIV and Aids organisations have especially valuable expertise and networks that can contribute to enhancing the quality of material development and sustaining this as an ongoing activity. Some prisons even have their own advisory bureau on drug issues, and the social workers in some prisons take care of these problems. In contrast to internal workers, prisoners more widely accept and trust external workers because the outsiders have a duty to maintain confidentiality and have the right to refuse to give evidence. Moreover, the external workers are more experienced and know about the content of, and requirements for, the various support services offered. Counsellors on drug issues in prison should primarily provide information about the various support services and programmes available inside and outside prisons. In a second step, their efforts should focus on motivating prisoners to overcome their drug use. A major advantage of external drug counselling is that it links life inside and outside the prison and thus is very helpful for continuing treatment that was started in prison.

Vocational training

Both doctors and prison staff confront multiple drug use in their everyday work. Use of tobacco, cannabis, alcohol, benzodiazepines and opioids is widespread, and withdrawal and craving are relatively frequent. Nevertheless, physicians and prison personnel know too little about the issues and problems related to drug use. It is vital, therefore, that staff receive adequate training to tackle the problems connected with drug use in prisons and

to move towards a more treatment-focused approach. Prison staff needs training and regular updating on all aspects concerning HIV, Hepatitis and drug abuse, especially on medical, psychological and social aspects, in order to feel secure themselves and be able to give prisoners appropriate guidance and support.

Also, human rights and medical ethics in prisons are important issues. An e-learning course by the World Medical Association is taking up these issues.

Specific groups

The diverse needs of drug users and those at risk of infection in police custody and prison should be recognised and the type of services offered to them should be responsive to their particular needs and delivered without discrimination. These groups include: women, members of ethnic and cultural minorities, foreign language speaking offenders, older prisoners, juveniles/young offenders and those with psychiatric co-morbidities and cognitive impairments.

1. Services that are responsive to and meet the specific needs of female drug users and women at risk of infection are required because in some countries women still face barriers to treatment. These should include more services and treatment opportunities, and services that have been designed specifically to meet their needs.
2. Services that meet the specific needs of juveniles/young offenders who are drug users or may be at risk of infection are required.
3. Foreign nationals who use drugs or are at risk of infection should be given equal access to treatment, care and support when entering police custody or prison to ensure that their health needs are addressed while they are detained. They should also be provided with information (in an accessible format and a language that they understand) about what is available to them on their release (including what is available if they are deported on release) or on transfer to another jurisdiction.

References

Connections Project (2011). *Good Practice in Preventing Drug Misuse and Related Infections in Criminal Justice Systems in Europe*. University of Kent.

EMCDDA (2011). Estimates of prevalence of problem drug use at national and subnational level: bibliographic references. Table PDU-0. Publications Office of the European Union, Luxembourg,

European Health Committee (1998). The organisation of health care services in prisons in European Member States. Strasbourg, Council of Europe

Farrell M, Marsden J (2005). *Drug-related mortality among newly-released offenders 1998 to 2000*. London, Home Office (Home Office Online Report 40/05; <http://www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=27ECC17D-CEF3-451E-8DBB-4336FA695ECB&mode=link&guid=c460f97af5e449f189088a5545d9175c>, accessed 22 June 2012)

Fox A (2000). *Prisoners' Aftercare in Europe: A four-country study*. London: ENDHASP.

Grinstead O. *et al.* (1999). Reducing post-release HIV risk among male prison inmates: a peer-led intervention. *Criminal Justice and Behaviour*, 26:453–465.

Hedrich, D and Farrell M (2012). Opioid maintenance in European prisons: is the treatment gap closing? *Addiction* **107** 461–463.

Jürgens R, Ball A and Verster A (2009). *Lancet Infect Disease* **9** (1) 57–66

Marteau D, Palmer J and Stöver H (2010). Introduction of the Integrated Drug Treatment System (IDTS) in English prisons. *International Journal of Prisoner Health* **6** (3) 117–124

Stöver, H., Weilandt, C.; Zurhold, H.; Hartwig, C.; Thane, K. (2008). Final Report on Prevention, Treatment, and Harm Reduction Services in Prison, on Reintegration Services on Release from Prison and Methods to Monitor/Analyse Drug use among Prisoners. European Commission, Directorate-General for Health and Consumers. Drug policy and harm reduction. SANCO/2006/C4/02, page 58 http://ec.europa.eu/health/ph_determinants/life_style/drug/documents/drug_frep1.pdf

Taylor, A. and D. Goldberg (1996). Outbreak of HIV infection in a Scottish prison: why did it happen? *Canadian HIV/AIDS Policy and Law Newsletter* 2(3): 13-14

The Patel Report (2010). *Prison Drug Treatment Strategy Review Group. Reducing Drug-Related Crime and Rehabilitating Offenders. Recovery and rehabilitation for drug users in prison and on release: recommendations for action*. Publisher: Location.

Tomasevski K (1992). *Prison Health: International standards and national practices in Europe*. Helsinki: Helsinki Institute for Crime Prevention and Control.

Uchtenhagen A (2006). *The Lisbon Agenda for Prisons. All on drugs and public health in prisons*. Publisher: Lisbon.

United Kingdom Parliament (1999). *Memorandum by HM Prison Service*. London: United Kingdom Parliament. Available at: <http://www.publications.parliament.uk/pa/cm199899/cmselect/cmhaff/363/363ap02.htm> (accessed 29 June 2012).

WHO and Council of Europe (2001). *Prison, Drugs and Society*. Berne/Switzerland

Further reading

Greifinger R (2007). *Public health behind bars*. In: Greifinger, R. (ed.): *From Prisons to Communities XVI*, 576 p. 56 illus.

World Medical Association (2012). *E-learning Ethics Course* [online]. Available at: <http://www.wma.net/en/70education/10onlinecourses/30ethics/index.html> (accessed June 2012).

Professional independence of health care workers in the penitentiary system

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At first glance, *Professional independence of health care workers in the penitentiary system* might appear to deal with administration rather than mental health. However, I am grateful for the chance to share with you some thoughts about professional independence as part of this meeting on Mental Health and Addiction for two reasons:

First, because it is the core ethical principle for health care in prison and the prerequisite for the six other ethical principles of health care in prison, as stated by the CPT, i.e. free access to health care, equivalence of care, patient's consent and medical confidentiality, preventive health care, humanitarian assistance, and professional competence.[1]

Second, because professional independence and sound standards of medical ethics are of particular importance in the care of the most vulnerable prisoners, such as those with mental disorders.

Professional independence and the aforementioned ethical principles as a basis of health care in prison have been amply and clearly laid down in internationally agreed rules, resolutions, declarations and recommendations by the United Nations [2], the Council of Europe [3,4], the World Medical Association [5], the International Council of Nurses [6], Physicians for Human Rights [7] and Penal Reform International.[8]

On the subject of professional independence, the above documents define the role of health care professionals such that they are to act as the prisoners' personal caregivers: 'A prison doctor acts as a patient's personal doctor' (CPT Standards 73).[1] Penal Reform International states in its publication *Making Standards Work*: 'Confidence of prisoners in the health care of a prison can only be obtained if it is known to everyone in the prison that for a prison physician, nurse or health care worker the patient has to have and indeed has priority over order, discipline or any other interests of the prison.' [8] In terms of semantics, a doctor caring for prisoners should not be the prison's doctor, but the prisoners' doctor, and should fulfil this task in complete loyalty to the patients.

This implies that health professionals caring for prisoners should refuse to become involved in any medical activities that are not in the interest of the prisoners' health. This is very clearly expressed in the 1982 UN Resolution *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. Principle 3 states: 'It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.' [2]

Respecting these principles results in a professional profile of health care professionals working in prison, the sole task of which is the physical and mental health of the prisoners:

- Individual medical care of prisoners;
- Inspection of food, hygiene, living conditions and physical/mental exercise of prisoners;
- Advice to prison management and training on healthcare matters to everybody in prison

This profile shows also that professional independence is in no way a contradiction to inter-professional co-operation. It includes supervision of, advice to, co-operation with and training for the prison management and security staff in health care matters, all of which clearly are in the interest of the prisoners' health. However, this co-operation has to respect the different tasks and accountabilities of health professionals and security staff/prison management: The exclusive task of the health care professionals is the health of the prisoners to whom they are primarily accountable. The task of security staff and prison government is safety and security and they are primarily accountable to the state administration and to the public. Both jobs are difficult and challenging and need mutual respect.

For the many patients with mental disorders in prison, medical professional independence is of utmost importance: According to the CPT standards [1] and the European Prison Rules [4], 'persons who are suffering from mental illness and whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for the purpose'.

The question of whether the mental state of a mentally ill prisoner is incompatible with detention in prison and hospital treatment is needed is to be decided only by the physician (psychiatrist) and solely on medical grounds, in complete independence of any custodial considerations.

Another example is the difficult assessment of whether a patient is mentally not competent for giving consent, e.g. when a medical intervention needs to be considered without the patient's consent in the case of acute psychosis. Again, the decision is up to the physician only and has to be made without the undue influence of anybody else.

Professional independence is also needed for keeping strict medical confidentiality, i.e. the non-disclosure of patient-related medical data to the prison administration, or the refusal of issuing forensic certificates without the explicit consent of the patient.

Regarding particularly drug-addicted offenders, professional independence requires that the health care team not participate in obtaining blood/urine samples for security reasons or in body searches.[1,3,5]. If medical expertise is needed for such security matters, public health officers or other medical personnel not involved in the care of prisoners should be called in.

In addition, professional independence does not comply with participation in disciplinary measures such as certifying prisoners fit for solitary confinement or allowing non-medical considerations to modify diagnostic or treatment decisions.

Complying with professional independence yields not only good ethical conduct but also results in tangible professional advantages: it promotes the confidence of inmates in the medical care; it leaves no doubt as to medical professionalism; it prevents misunderstandings; it provides guidance in situations of conflict; it supports quality assurance; it protects against legal appeals; and it gives international support.

The professional independence of health care staff and other principles in medical ethics were agreed and laid down in the aforementioned international documents decades ago. However, in many European penitentiary systems professional independence is still regarded as limited, both by health professionals as well as by prison administrations. Wherever the professional independence of health care workers in prison is not respected or not fully guaranteed, their challenging work is made even more difficult because of dual loyalty. This is the ethical dilemma most often encountered by health care professionals working in prison; the clinical role conflict between professional duties to the patient and obligations, express or implied, to the interests of a third party such as the prison government, the prosecutor or the court.[7]

How can we improve this situation and close the gap between written ethical standards and prevailing prison realities? Or, to use the title of the excellent document by Penal Reform International, how can we make standards work? [8] The following recommendations should improve the current situation:

1. Raising awareness and training in medical ethics in prison for health care professionals because they must stick to solid medical ethics in order to cope with the aforementioned conflicts and identify and meet the many ethical dilemmas they encounter in their work. In addition, it is at least as important to make medical ethics known to, understood by and accepted by the whole prison community, i.e. prisoners and the non-medical staff. Furthermore, the involvement of national health authorities, professional boards and societies should be strengthened for support, supervision and oversight of health care professionals working in prison.
2. Reducing or abolishing dual loyalty conflicts by uncompromising separation of medical roles in prison: Professionals caring for prisoners should adhere exclusively to care giving in complete professional independence. Medical

functions in the interest of the state, prosecution, court or the security system should be performed by professionals who are not involved in the care of prisoners. This can be managed best if prison health care is organised in complete independence of prison authorities and placed under the responsibility of the public health authorities.[9] Several countries have successfully completed the process of organising health care in prison independently from the prison administration and integrating it into the public health structures: the Swiss cantons Geneva, Wallis and Waadt; Norway; France; New South Wales in Australia; England, Wales and Scotland. Several other countries are in a state of planning or of transition regarding the change of management of prison health care from the penitentiary system towards the health authorities (Spain, Italy, Slovenia, Turkey, Georgia, Moldova, and Russian Federation). Those countries that have completed this transition report, in addition to the reduction of dual loyalty conflicts, improved quality of health care, increased professional independence, improved continuity of care, the use of common resources and expertise for health care in the community and in the penitentiary system, completion of public health initiatives and epidemiological surveillance as well as better recruitment and less isolation of prison health care staff.

3. We should strive for the incorporation of medical ethics standards into penitentiary laws in order to achieve full compliance of penitentiary law with standards of medical ethics. Given the present economic crisis and populist legislative initiatives that favour security measures rather than health care matters in prison, we must strengthen our advocacy of the importance of prison health for public health in order to achieve the acceptance by the public and politicians required.

All these are the intentions of the recent *Geneva Declaration 2012 on Health Care in Prison* drawn up at the European Conference on Health Promotion in Prison, which is online at <http://ump.hug-ge.ch/> and can be signed by sending an email to Geneva.Declaration@hcuge.ch.

References

1. CPT Standards 2002, rev. 2011 www.cpt.coe.int/en/documents/eng-standards.pdf
2. UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians for the Protection of Detained Persons and Prisoners Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1982 www.un.org/documents/ga/res/37/a37r194.htm
3. Council of Europe: Ethical and Organisational Aspects of Health Care in Prison. Recommendation R (98) 7 [https://wcd.coe.int/ViewDoc.jsp?Ref=Rec\(98\)7&Language=lanEnglish&Ver=original&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383](https://wcd.coe.int/ViewDoc.jsp?Ref=Rec(98)7&Language=lanEnglish&Ver=original&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383)
4. Council of Europe: Recommendation Rec (2006)2 on the European Prison Rules. <https://wcd.coe.int/ViewDoc.jsp?id=955747>
5. World Medical Association Policies www.wma.net/en/30publications/10policies/
6. International Council of Nurses. Nurses' role in the care of detainees and prisoners. Adopted 1998, revised 2011 www.icn.ch/images/stories/documents/publications/position_statements/A13_Nurses_Role_Detainees_Prisoners.pdf
7. Physicians for Human Rights: Dual Loyalty and Human Rights in Health Professionals Practice. <http://physiciansforhumanrights.org/library/report-dualloyalty-2006.html>
8. Penal Reform International: Making Standards Work. An international handbook on good prison practice. 2nd edition, 2001. www.penalreform.org/publications/making-standards-work-international-handbook-good-prison-practice
9. Pont J, Stöver H, Wolff H: Dual loyalty in prison health care. *American Journal of Public Health* 102 (3):475-480, 2012

Opiate Substitution Treatment and Harm Reduction in prisons: the Geneva model

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Abstract

The prevalence of drug use and high burden of infectious diseases among detainees make addiction an important medical issue to address in prison. To the detriment of these patients, effective drug policy programmes and therapies such as Opioid Substitution Treatment (OST) or Needle and Syringe Exchange Programs (NSP) are not available in every prison, a contradiction against international recommendations. However, in the prison of Champ-Dollon in Geneva, Switzerland, OST and NSP have been provided for more than 15 years. The experiences of Geneva show that effective harm reduction and therapeutic measures can be implemented in correctional settings. Our NSP is safe and acceptable to health care personnel and prison officers as well to inmates using intravenous drugs. Also, prescription of OST for opioid-dependent detainees by trained physicians is feasible and safe in a pre-trial setting. Our treatment audit demonstrates that it was in accordance with international guidelines. However, the methadone dose was lower when compared to general OST recommended treatment guidelines. Our NSP can be improved to increase access to syringes and improve their rate of return. Access to harm reduction methods should be universal, in accordance with human rights principles, and should for this reason be implemented in all detention facilities.

Introduction

Detainees are a vulnerable population with high morbidity [1,2]. They frequently have poor medical follow-up given their limited previous access to healthcare due to educational, social and economic disadvantages [1,3]. Prison is a significant opportunity to address the health needs of vulnerable groups. In particular, prison health services aim to reduce inequalities by providing primary care services that are similar in range and quality to those available in the community [4].

The prevalence of drug use is particularly high among detainees: in the European Community, lifetime prevalence of drug use in this group ranges from 29% to 86% [5]. As many as 69% of detainees regularly use illicit drugs, and about 60% of drug users continue to use drugs in prison [5,6]. In the US, 50% to 80% of detainees have a history of substance abuse, actively abusing in the previous year, and about 20% of them have used IV drugs [7,8]. A quarter to a third of US heroin users go through the US justice system at some point

during their lifetime [9]. In Switzerland, 20-50% of detainees have a history of substance use, with up to 60% of them reporting having also used drugs during incarceration [10,11].

Infectious diseases are a problem in prison, with prevalence of Hepatitis C infection rates at 12-31%; two to six-fold higher than in the general population [12]. HIV prevalence among prisoners is reported to be below 5% in most European countries and the US. But in some places, such as Spain, it is as high as 15% [13]. In Swiss prisons, HIV prevalence is estimated at 1% [11].

For opioid dependence, opiate substitution treatment (OST) has proven to be the most useful treatment, offering a risk reduction in overdose mortality [14,15] (around 14 times lower) after release from prison. The post-release period is a particularly vulnerable transition time for prisoners – it carries a mortality rate that is 20 times higher than the general population [16,17]. Furthermore, OST decreases IV use in jail and consequently lowers the risk of infectious disease transmission [18], and the propensity towards criminal behaviour after release [19].

Given its proven use and validity, OST treatment access in detention is necessary and required to abide by the principles of fundamental rights [20]. However, OST is only available in prisons among 41 countries, even as the treatment is available in 77 countries on a community basis (outside prison). This disparity violates the principle of equivalence of care under international recommendations, which means that medical care in prison should be equivalent to the care provided to the general population in the same region [21,22]. Considering the risk of opioid overdose and death at the time of prisoner release (especially in cases where prisoners have undergone forced detoxification during their prison stay) [16,17], official guidelines recommend that all opioid-dependent persons should have access to OST and that complete tapering should be avoided during imprisonment. Follow-up after prison release should be scheduled; if OST is no longer indicated or logistically impossible, tapering of OST should be initiated in preparation for release.

OST has been available since 1970 in Switzerland's largest remand prison, located in Geneva. Before that time, methadone was available, but only for those who were already in substitution treatment or who were in acute withdrawal.

Setting and description of the prison study population

In 2007, Switzerland housed 115 institutions for 5,715 prisoners, where 29% of the individuals were in pre-trial detention, yielding an average of 76 prisoners per 100,000 residents – one of the lowest rates in the world [5]. Geneva however topped the national statistics with an average of 200 inmates per 100,000 residents. According to EMCCDA 2010, the majority of detainees in Swiss jails of this type are male (93.6%) and of foreign

origin (81.4%) [5]. Of note, the canton of Geneva has the highest proportion of foreigners (38.3%) among its general resident population [23].

The prison of Champ-Dollon is Switzerland's largest remand prison, situated in Geneva and built in 1977. Initially built for 270 prisoners, the prison is now overcrowded, with an occupancy rate of 209% in 2013.

The medical prison unit

The medical prison unit connected to the Geneva University Hospitals functions independently of the prison administration. It offers low-threshold primary care and employs 37 health professionals, including general practitioners, nurses, psychiatrists, psychologists and dentists. The facility operates 24 hours a day with a nurse present at all times. All detainees admitted to the facility have a health assessment by primary health care nurses within the first eight hours of their admission. This screening serves as a triage mechanism to identify health problems and medical needs that need more urgent attention, or allegations of violence during arrest. The nurse evaluation is also an introduction to the facility's health service and explanation of access to drug treatment (detoxification, OST) and specific harm reduction measures such as condom distribution and needle and syringe exchange. When necessary, nurses refer detainees immediately to a primary care physician. Inmates can ask for a medical consultation at any time and be transferred to a primary care physician. Referrals to the psychiatrist occur via the primary care physician.

Socio-demographic profile

Among the 1,500 to 2,500 detainees entering the prison every year, 233 (9.1%) were opioid users. Primary regions of origin were Western Europe (28.9%), North Africa and the Middle East (27.5%) and Sub-Saharan Africa (20.1%). Some lengths of stay were as short as one week (27%), and 78% of prisoners were in prison for less than three months. Among the opioid users, 95.3% were male with a mean age of 29.7 years (SD 7.1, range 18-57), and 74.7% had a previous incarceration.

Drug use and opiate substitution treatment

Forty percent (39.9%) of participants of the OST programme in prison were IV drug users and 63.1% used opioids through another route of administration (such as sniffing or smoking). Nearly all of the opioid users (94.8%) used another substance: 70.8% cocaine, 63.5% tranquillisers, 55.4% alcohol, and 44.2% cannabis. Four users (1.7%) had a skin abscess on arrest.

Detainees only received OST with indication confirmed by a trained physician. There were no refusals of OST when treatment was indicated and proposed by the physician.

Methadone was the prescribed substitution medication of choice in the majority of patients (n=159 patients, 95.8%). The average dose of methadone was 41.7 mg (SD 29.1). Other prescribed therapies included buprenorphine (4.2%), and tramadol or codeine (5.4%). Tramadol and codeine therapies were generally used for a shorter period of time, and for patients refusing methadone or buprenorphine. Among those individuals who received OST, 48.8% maintained their treatment until leaving the prison.

Complications due to OST (including overdose) – defined as requiring a transfer to a hospital – did not occur. No deaths occurred in the institution in 2007.

Among all opioid users who received OST, half of them could be reached for follow-up after their release into community services. Opioid users who did not receive OST (because lack of medical indication) had lower rates of follow-up (28.4%) after transition into the community (missing data for 9 cases).

Prison needle and syringe exchange program (NSP)

Harm reduction is intended to reduce the negative effects of drug use on addicts and on society. Since the 1980s, NSP has been in existence in community settings, starting in Amsterdam in 1981 in response to an HBV outbreak among injection drug users and has been implemented in more than 80 countries since then [22]. Unfortunately, only 7 countries have implemented NSP in prison settings. This is striking, because NSP has also been shown to be effective in reducing HIV infections in prison among 10 systematic HIV evaluations [13,22].

In Switzerland, we use the **Flash box** which is an actual prevention kit used in community as well in correctional settings in Geneva. It contains the following (see Figure 1a): two 1 ml sterile syringes with filter, two sterile needles (available in two different sizes, 'orange Flash' and 'brown Flash'), two alcohol swabs for disinfection, two dry swabs, two 1.5 ml phials of 0.9% NaCl and two 0.5 g sachets of ascorbic acid.

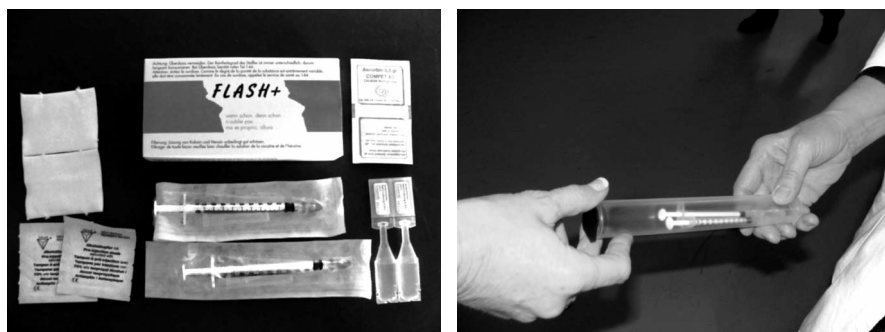


Figure 1: Orange Flash box: (a) contents; (b) syringe exchange container

There are several possible methods of delivery for these injection kits, from the hand-to-hand system of transfer by a health professional, either independent or from the institution, and interveners and non-governmental organisations, or distribution by peers (other inmates) as well as an automatic dispenser.

In the Champ-Dollon prison system, every detainee can request a box from the medical service. The requesting prisoner is seen the same day by a nurse so that the product he uses is known and he can receive preventive information (hand-washing, risk of overdose, discretionary use, the need to return his used material for the protection of the wardens and fellow prisoners). Later, a Flash box is handed in a confidential way to him at his cell door, along with a container for returning his used material (figure 1b). In the event of subsequent requests from the same person, the 'one for one' exchange principle is applied but with a certain degree of flexibility. All the prison staff have received special training in the application of the protocol, and general guidance on addictive behaviour, and the risks of HIV and hepatitis transmission.

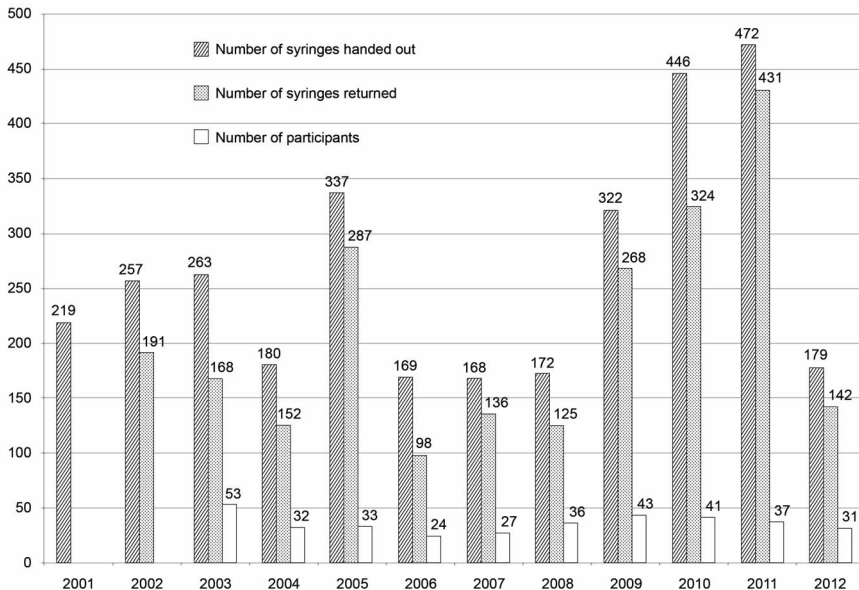


Figure 2: Annual distribution of given (blue) and returned (red) syringes as well as participating inmates (green)

Each year from 2001 to 2012, between 168 and 472 syringes were handed out to between 24 and 53 prisoners. The syringe return rate, measured from 2002 to 2012, varied from 58% to 91%. Figure 2 represents the annual distribution results for kits or

individual syringes and, from 2002, the number and rate of return of syringes and the number of persons requesting these.

All requests, with one exception, came from users who were already injecting themselves before they were imprisoned. The only detainee for whom this was not the case was in the habit of smoking base cocaine and was not aware that sodium bicarbonate could be obtained by the same means as the Flash boxes. After receiving this information, he no longer used drugs intravenously during his prison stay, but only by smoking.

No acts of aggression or other incidents involving the contents of prevention kits (for example, threats, injury from a syringe left in a dustbin, etc.) were reported, either by the prison administration or by health care staff.

Conclusions

The experiences of Geneva show that effective harm reduction and therapeutic measures can be implemented in correctional settings. Our syringe exchange programme is safe and acceptable to health care personnel and prison officers as well to inmates using intravenous drugs. Also, prescription of OST for opioid dependent detainees by trained physicians is feasible and safe in a pre-trial setting. Our treatment audit demonstrates that it was in accordance with international guidelines. However, the methadone dose was lower when compared to general OST recommended treatment guidelines. Our syringe exchange programme can be improved to increase access to syringes and improve their rate of return. Access to harm reduction methods should be universal, in accordance with human rights principles, and should for this reason be implemented in all detention facilities.

Bibliography

1. Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *J Epidemiol Community Health*. 2009; 63(11): 912-919.
2. Fazel S, Baillargeon J. The health of prisoners. *Lancet* 2011; 377: 956-965.
3. Watson R, Stimpson A, Hostick T. Prison health care: a review of the literature. *Int J Nurs Stud* 2004; 41: 119-128.
4. Council of Europe. Recommendation R (98) 6. 1998.
<https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=530653&SecMode=1&DocId=459562&Usage=2>
5. EMCDDA 2010 Annual report on the state of the drugs problem in Europe. 2010 – 102 pp.
http://www.emcdda.europa.eu/attachements.cfm/att_120104_EN EMCDDA_AR2010_EN.pdf
6. Bird SM, Rotily M. Les usagers de drogue dans le système judiciaire: les détenus. 2003.
<http://ar2003.emcdda.europa.eu/fr/page038-fr.html>.
7. Greifinger R. Public health behind bars: from prisons to communities. Dobbs Ferry N.Y.: Springer; 2007.
8. Mumola C.J., Karberg J.C. Drug Use and Dependence, State and Federal Prisoners, 2004. October 2006, NCJ 213530.
<http://bjs.ojp.usdoj.gov/content/pub/pdf/dudsfp04.pdf>.
9. Rich JD, McKenzie M, Shield DC, et al. Linkage with methadone treatment upon release from incarceration: a promising opportunity. *J Addict Dis*. 2005; 24(3): 49-59.
10. Hausser D. PREVENTION DE LA TRANSMISSION DU VIH DANS LES PRISONS SUISSES. Analyse secondaire sur la base de la littérature disponible. *Raisons de santé*. 1999; (40).
<http://www.iumsp.ch/Publications/pdf/RdS40.pdf>.
11. Wolff H, Sebo P, Haller D, et al. Health problems among detainees in Switzerland: a study using the ICPC-2 classification. *BMC Public Health*. 2011; 11: 245-278.
12. Tan JA, Joseph TA, Saab S. Treating hepatitis C in the prison population is cost-saving. *Hepatology* 2008; 48(5): 1387-1395.
13. Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. *Lancet Infect Dis*. 2009; 9(1): 57-66.
14. Huang YF, Kuo HS, Lew-Ting CY et al. Mortality among a cohort of drug users after their release from prison: an evaluation of the effectiveness of a harm reduction program in Taiwan. *Addiction* 2011 ; 106 : 1437–1445.

15. Brugal MT, Domingo-Salvany A, Puig R, Barrio G, García de Olalla P, de la Fuente L. Evaluating the impact of methadone maintenance programmes on mortality due to overdose and aids in cohort of heroine users in Spain. *Addiction* 2005; 100(7): 981-9
16. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison— a high risk of death for former inmates. *N Engl J Med* 2007; 356: 157-65.
17. Seaman SR et al. Mortality from overdose among injecting drug users recently released from prison: database linkage study. *BMJ* 1998; 316; 426-428
18. Larney S, Toson B, Burns L, Dolan K. Effect of prison-based opioid substitution treatment, and post-release retention in treatment, on risk of re-incarceration. *Addiction* 2011; 107: 372–380.
<http://www.ncbi.nlm.nih.gov/pubmed/21851442>
19. Teesson M, Ross J, Darke S, et al. One year outcomes for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS). *Drug Alcohol Depend.* 2006; 83(2): 174-180.
20. Bruce RD, Schleifer RA. Ethical and Human Rights Imperatives to Ensure Medication-Assisted Treatment for Opioid Dependence in Prisons and Pre-trial Detention. *Int J Drug Policy* 2008; 19(1): 17-23.
21. Kastelic A, Jörg P, Stöver H. Opioid Substitution Treatment in Custodial Settings A Practical Guide. WHO Europe, United Nations Office on Drugs and Crime. 2008.
http://www.unodc.org/documents/balticstates/Library/PrisonSettings/OST_in_Custodial_Settings.pdf
22. Harm Reduction International. The Global State of Harm Reduction 2012.
http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf . 2012
23. Office cantonal de la statistique de la République et Canton de Genève. Population résidante genevoise : + 2 278 personnes en 2007. Janvier 2008.
<http://www.bfs.admin.ch/bfs/portal/fr/index/themen/01/22/press.Document.105197.pdf>

Mental Health Services in the Belgian prison system

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The Belgian Prison system

In February 2013, Belgium had a total of 11,760 inmates, an incarceration rate of 107 per 100,000 inhabitants. A further 1,028 sentenced prisoners were detained at home under electronic surveillance. The prisoners are housed across 33 prisons, which have a total capacity of 8,950. This means that there is considerable overcrowding, a problem that is mainly concentrated in the remand prisons of the larger cities.

The prison system also manages three closed detention facilities for minors (< 18 years old), but technically speaking, these are not prisons: although the prison system manages security aspects, the follow-up of these minors is the responsibility of the different regional governments.

The lack of capacity is tackled in different ways: the system of electronic surveillance is being expanded, one prison is rented from the Dutch government, and finally four new prisons are planned or under construction.

The composition of the Belgian prison population is particular. Almost one third of all inmates are remand prisoners. This high percentage is a reflection of management problems and arrears in the judicial system. Almost 60% of inmates are sentenced prisoners. Finally, a staggering 10.7% are mentally disordered offenders (MDOs). The fact that MDOs do not find their way to psychiatric treatment facilities, and sometimes stay without treatment for years, has been criticised by many authorities such as the European Court of Human Rights. In the following paragraphs, we will look at this problem in more detail.

Mentally disordered offenders

Under Belgian law, an offender is called mentally disordered when three conditions are met:

1. a mental disorder must be present: 'a state of insanity' or 'a state of severe mental disorder';

2. as a result of the mental disorder, the offender was unable to control his behaviour at the moment of the act and at the moment of the court decision;
3. the offender must represent a danger to himself or to third parties.

If the three conditions are met, any court (including a popular jury) can 'intern' the said offender. Since he is no longer considered responsible for the offences, there will be no sentence. The MDO is detained first and foremost to protect society and secondly to allow the provision of treatment necessary for reintegration into society. Once a decision of 'internment' has been reached, the responsibility for the offender shifts to a so-called 'commission for the protection of society', consisting of one judge (president of the commission), one lawyer and one medical doctor (usually but not necessarily a psychiatrist). The commission has extensive powers, including the possibility of unlimited detention on the one hand and immediate placement in psychiatric care or even at home under family care on the other.

If an MDO stays in prison, he is referred to one of ten psychiatric wards or to a so-called 'social defence unit'. The psychiatric wards were originally meant to house MDOs for a short period before they were transferred to a treatment facility, either in the outside world or in a social defence unit (part of the prison system).

The problem of the commissions is that there are not enough treatment facilities for MDOs. As a result, large numbers remain in prison, as is shown in the following table:

Number of MDOs per prison:

	North		South	
Psychiatric ward	Antwerp	61	Mons	38
	Louvain	51	Jamioulx	31
	Bruges	61	Lantin	43
	Ghent	120	Namur	31
			Forest (Bxl)	107
			Berkendael	11
SDU	Turnhout	120	Paifve	199
	Merksplas	333		

From the above table, it is easy to deduce that the problem is much more pressing in the north (Dutch-speaking) part of the country. The reason is that in the (French-speaking)

south, the Walloon regional government runs two psychiatric hospitals that are dedicated to the care of forensic patients: Les Marronniers in Tournai for male MDOs and La Chêne aux Haiesin Mons for female MDOs. Furthermore, the social defence unit of Paifve consists of a dedicated prison that only houses MDOs.

As a result, the situation in the south is much more favourable than in the north, with the exception of the situation in Forest prison (the Brussels remand prison). As the psychiatric wards in the north are too small to care for all the MDOs, many mentally disordered offenders have to live among the other prisoners, putting them at risk of bullying, etc.

The care for mentally disordered offenders has since 2007 been taken up by care teams, which are part of the prison health care service. They consist of psychiatrists, psychologists, social workers, psychiatric nurses and therapists. Although the teams consist of dedicated professionals, they are much too small to offer a quality of care that is comparable to the quality of care in the outside world. Moreover, the care teams are also supposed to take care of the psychiatric cases among the general prison population, since there is no other help available for these inmates.

Until a few years ago, the psychological care and social support for MDOs was provided by the psychosocial department of every prison. The psychosocial services consisted of psychiatrists, psychologists and social workers. They operated separately from the health care service and were managed by the prison governors. The psychosocial department offered assistance and help to prisoners, but acted at the same time as an expert service, offering advice on the danger of recidivism, etc. In 2007, the psychosocial department was finally split: psychiatrists had to choose between a care function (and were then added to the health care service) or an expert function. Regrettably, those with other professions (psychologists, social workers) did not have this choice: they all stayed part of the psychosocial department, which was now reduced to an expert department. The net result of the splitting of the psychosocial department was that hardly any psychological or social support for prisoners (MDOs or others) remained, and hence the construction of the care teams in order to alleviate at least some of the problems of the MDOs.

Solutions

The problem of the lack of care for MDOs has been recognised and in the past few years solutions have been proposed. Which type of care should be proposed depends largely on the necessary intensity of care on the one hand and the degree of danger (the need for the protection of society) on the other hand. For the northern part of the country, where the problem is the most acute, the situation can be broken down as follows:

Levels of care intensity versus levels of security in the Flanders region (%):

Care intensity ► Security ▼	Low	Medium	High	Total
Low	7	8	4	19
Medium	5	17	28	46
High	11	9	15	35
Total	23	34	53	100 (n=599)

Solutions should be the easiest for the one in five MDOs (19%) with a low risk profile: they should be helped in the community, either on an ambulatory basis, in psychiatric care centres, or in regional general psychiatric hospitals. This level of care, however, depends largely on the regional governments. In other words, the minister of justice (or of public health) cannot influence the development of this sector. As the need for all types of care for the general population in the Flanders region is important (care for the elderly, the handicapped, child day care facilities...), money for forensic initiatives only becomes available in a piecemeal fashion.

Mid-security patients (46%) are treated in dedicated forensic psychiatric units of regional psychiatric hospitals. Again, there is a significant lack of treatment slots available. As hospitals in Belgium are private institutions, the government cannot force hospitals to build forensic units. Even so, a modest expansion is planned for the coming years.

The most difficult group to offer treatment to is the high security group. They should be taken into treatment in dedicated forensic psychiatric hospitals. Up till now, these facilities have been non-existent in the Flanders region. However, major developments are underway: two facilities are currently under construction. The hospital in Ghent will be able to treat 272 male MDOs; the hospital in Antwerp 180 male MDOs. Furthermore there have been propositions – but not yet firm plans – to open a small psychiatric forensic hospital (unit) for 20 to 30 female MDOs.

Psychiatric problems in remand and sentenced prisoners

As elsewhere in Europe, there is a feeling that psychiatric illness in remand prisoners and in sentenced prisoners is increasing, but so far we do not have any hard scientific data to confirm this. Anyway, indirect markers show that the need for psychosocial and even psychiatric support and treatment is important: two thirds of all prisoners in Belgium have used illegal drugs at least once in their life, and one in three prisoners use illegal substances while in detention. Meanwhile, more than one in three prisoners use at least one form of psychotropic medication (versus more than 10% in the general population).

So far and with the exception of the prescription of medication by psychiatrists and GPs, hardly any professional help is available. The ten psychiatric wards which were described earlier are filled with MDOs and the few staff available (the care teams) have a lot of work. For the moment, there are no concrete plans to alleviate this situation. It is more or less hoped that treatment staff and treatment options will become available after 2014, when a large number of MDOs will have left the prison system for the forensic hospitals which are now under construction. The psychiatric wards could then be reconstructed as regional psychiatric treatment facilities.

Finally, a national specialised ('third-line') psychiatric ward is planned within the new Brussels prison, which should be ready in 2016.

In the meantime, efforts are being made to get more heroin users into substitution treatment and to expand drug help in prisons: a new therapeutic community is planned, as well as the expansion of drug-free prison wings.

Romania and illegal drugs at a glance – Trends and services

Dr Mihai Corciova, Psychtherapist

'Modern' drug history started in Romania after December 1989. Before then, it was alcohol, tobacco and, if you were lucky, some coffee. Of course, there was some use of psychoactive drugs, both from the medical system, despite strict controls, and from combinations of different drugs that were possible to buy without prescription (such as codeine tablets). Alcoholism and smoking were the main problems in the area of substance abuse.

The 'openness' that followed after 1989 has seen a new market for illegal drugs flourish, causing Romania to become not only a transit hub for illegal drugs but also a consumer country.

There were even existing networks of people able to re-orient their business towards illegal drugs, and in this respect the country was ready for the new trade. The same cannot be said when it comes to drug services (and I will refer only to socio-medical services), and much less the consumer.

Conversations with people who started using illegal drugs (heroin) in the 1990s reveal a common thread: at first, they did not know what to expect. There were teenagers wishing to outdo previous generations, for whom substance abuse meant tobacco and alcohol, and do 'what they saw in the movies'. The first time they had a withdrawal, they did not understand what was happening to them.

From another perspective, with little more than 20 years of illegal drugs use history, we can say that ex-users have gradually started to get involved in activities aimed at active users only in the last few years. Even from the start, external organisations, which financed a lot of programmes in Romania, were seeking the involvement of the drug users in programming and implementation. This had little success, probably due to the fact that at the time, Romania did not have enough experience in the drug field and, due to the communist background, the communities were not exactly aware of their identity. However these efforts contributed a lot to opening the way for when the users grew older. Even so, we can say that communities and peer organisations are still in their youth.

The medical system was lacking trained resources and functional working mechanisms. It took time for the system to become organised and for new services to be developed and become functional, and the process that was started is still continuing today. The first services confronted with the new problem were the psychiatric ones, and these were the first to face the new challenge.

Another reality was the fact that the drug users were condensed in specific areas, mainly big towns, and Bucharest and the surrounding area had and still has the largest number of drug users. The spread of drug use increased greatly as soon as new psychoactive substances came on the market (synthetic cannabinoids, cathinones, piperazines) and due to their initial legality, the phenomenon became more visible at national level.

For Bucharest the ratio of drug users increased every year, starting with 2007 (17.4 per 1,000, age 18 – 49) till 2011 (20.1 per 1,000, age 18 – 49). The figures by now are probably much higher. Even for the past few years, since there are still problems in collecting the data, all the figures are probably higher. ²

The services for drug users in Romania are organised based on existing legislation and are systematised on three levels:

The first level aims to provide basic medico-psychosocial care with the purpose of reducing the harm/risks of drug use. In this category the services listed include information sharing, needle and syringe exchange programmes, condom distribution, counselling, voluntary testing for HIV and Hepatitis B and C, medical care, and campaigns to raise awareness.

The second level is represented by the out-patient services which, besides voluntary counselling and testing for blood-borne disease, offer substitution treatment (methadone, buprenorphine), abstinence maintenance treatment, out-patient detoxification, medium medical care services, occupational therapy, medical and psychiatric services, group, family and individual counselling and psychotherapy.

The third level is related to the therapeutic communities. This service aims to facilitate rehabilitation and social reinsertion of ex-drug users and includes campaigns to raise awareness and the training of human resources.

This structure can be reflected by the number of units reporting data showing the services used at national level: 27 medical units of the Ministry of Health (in-patient and out-patient services); 32 centres of the National Anti-Drug Agency (out-patient integrated care services); 5 private centres.

In 2011 the services were accessed by 3,587 beneficiaries, of which 2,355 were concerned with illicit drugs and new psychoactive drugs. The main drugs for which services were provided were the new psychoactive substances (42.5%) and heroin (31.3%).

Since 2010 there has been a sharp increase in the use of the new psychoactive substances, which typically represent the main injected drug. As the new psychoactive

² All data/statistics in this document have been extracted from the National Anti-Drug Agency Report 2012. For more information please visit <http://www.ana.gov.ro/rapoarte%20nationale/en/National%20Report%20on%20Drugs%202012.pdf>

substances have short-term effects, their use is associated with a higher injecting frequency and, due to the urge of the user for a new dose, there is an increased number of those who share the injecting equipment.

Due to these and, maybe also due to better reporting, the prevalence of blood-borne diseases increased slightly in 2011 for Hepatitis B (15.0%) and accentuated increasing for HIV (6.12%) – above the European average. For Hepatitis C there seems to be a slight decrease (68.5%) in the context of rates that are higher than other European countries. Another probable explanation of the increase is the closure of a number of needle and syringe exchange programmes that were financed through international funds, and when the projects finished no governmental structure could provide a continuation of the funding. In 2012/2013 the only governmental structure that mobilised resources for these programmes was the National Anti-Drug Agency.

The third level of services includes the therapeutic communities. There are not many of these, and some of them were initiated and are run by Christian associations. These communities have a lot of experience and are providing complex programmes but their number and capacity is limited (five organisations which are part of the Romanian Substance Abuse and Addiction Coalition (ROSAAC)). For all of them, support comes from different sources: national, international and individuals. However, the Romanian Insurance System does not cover these services and therefore there is a barrier in accessibility. These expensive services can be accessed only by a limited number and category of beneficiaries.

The National Anti-Drug Agency is also in the latest stage of implementation of three other therapeutic communities in three areas of the country and, in partnership with the National Administration of Penitentiaries, with financial support through EEA Grants, developed and implemented three other therapeutic communities in three Penitentiaries. These are fully functional and are continuing to provide services even today. Due to the specific conditions provided by the Penitentiary System, staff and locations, the investment is much lower and the sustainability is higher for the specific group of inmates.

The three-level approach for the drug challenge offers a good theoretical basis for development and budgetary allocation, but in terms of existing services and functionality, there is still much to be done. The priority was and still is to have accessible and low-cost services, and therefore the greatest investments were made in levels one and two. Even so, there is still need for more services. For level three, the developments belong mainly to the civil society; there are even efforts being made to make operational public units in this direction. Other problems are related to the communication and co-operation between different providers. The co-operation between the National Antidrug Agency and the National Administration of Penitentiaries, in the area of providing services and ensuring the treatment continuity from community to prison, and vice versa, or the co-operation with the service providers from the civil society, is an example of good practice but there is still a great deal to be done to improve the co-operation with the Health System.

Drug treatment and risk assessment of drug-using inmates in Serbia: Treating drug users in prison

Dr Sanja Stojadinovic, Psychologist, Special Prison Hospital Belgrade

Introduction

According to the Serbian Ministry of Health, in 2011 there were approximately 150,000 drug-dependent persons in Serbia, 24,000 of whom were opiate dependent. More than 1,700 drug users were in treatment in 25 institutions. Most of them began their treatment more than 10 years after they had first used drugs. The City Institute for Public Health reports that in Belgrade there are five drug-dependent persons for every 1,000 inhabitants, or 7,805 dependent persons in total. The prevalence of drug dependence is 495.2 per 100,000 inhabitants and has increased over recent years.

Official records show that a large majority of patients in state or private medical facilities request an opiate dependency treatment. There are many more requests than there are available medical capacities and trained professionals for different treatment programmes (Kovacevic & Raketic, 2009).

In 2010, the second round of integrated bio-behavioural surveillance survey was carried out among 571 injecting drug users (IDUs) aged 18 and over who injected drugs in the last month in Belgrade (300 persons) and Nis (200 persons) using respondent-driven sampling methodology (Ministry of Health of the Republic of Serbia, 2010). The results show that HIV prevalence in the sample was as low as 2.4% in Belgrade and 4.5% in Nis. Prevalence of Hepatitis C infection was 77.4% in Belgrade and 60.5% in Nis. The median age of first injecting a drug was 21 years in Belgrade and 22 years in Nis. The practice of sharing needles and syringes with other users in the previous month was reported by 23% of sampled IDUs in Belgrade and by 15% in Nis.

Drug use in Serbian prisons

Official records of the Serbian Ministry of Justice's Prison Administration show that the number of drug using inmates is around 1/3 of the whole prison population (see table below). According to the estimation made by the Prison Administration, 60% of them used heroin before detention, 40% of them were injecting drugs.

year	Number of inmates entering prison	Number of drug users	%
2012	8132	2472	30.39
2011	7925	2811	35.47
2010	7660	2528	33.00
2009	9023	3286	36.42

Number and percentage of inmates entering Serbian prisons from 2009 to 2012

In 2009, voluntary and confidential counselling and testing for HIV and Hepatitis C of all newly admitted patients, individual and group counselling on risk behaviours, HIV, HCV and overdosing were implemented in healthcare services in penal institutions. Methadone substitution therapy in penal institutions is available to all who were on methadone treatment before admission to any of the institutions. In the past three years, options for introduction of methadone treatment have been expanded in the institutions upon recommendation of an attending psychiatrist.

With the support of the Mission of the OSCE, in 2007 drug-free units were opened at two Penal Correctional institutions: in Nis and the Special Prison Hospital in Belgrade. The prerequisite for prisoners to be at these units is their absolute abstinence from all psychoactive substances.

Pharmacological interventions and psychosocial treatment are more efficient when delivered in an integrated manner. Nevertheless, psychosocial support for drug users in Serbian prisons is lacking, as well as aftercare programmes.

Special Prison Hospital in Belgrade

The Special Prison Hospital is a unique institution in the Serbian justice system, specialised for legally enforced treatment of offenders with drug, alcohol and mental health problems. It was founded in 1969 and, at that time, offered specialised treatment for offenders from the whole territory of former Yugoslavia. Offenders are, at the time of committing the crime, assessed as unaccountable due to mental disorder or partially unaccountable due to consumption of drugs or alcohol. Court sentences for drug users include prison sentences as well as closed treatment measures.

Now the Special Prison Hospital implements closed treatment measures for offenders from the territory of the Republic of Serbia and, after the treatment are over, most offenders with prison sentences are transferred to prisons. There are a total of 600 patients, of which 160-200 are at the Drug Addiction Department. The majority of patients at the Drug Addiction Department are heroin users, most of whom were injecting drugs.

The Special Prison Hospital offers healthcare and treatment services to the patients. There are 22 psychiatrists, 8 psychologists, 12 educators and 4 social workers. The hospital has security staff, so it resembles a prison in that it has a high level of security.

Psychosocial interventions in drug dependency treatment in the Special Prison Hospital

'Psychosocial interventions are any formal, structured psychological or social intervention with assessment, clearly defined treatment plans and treatment goals, and regular reviews as opposed to advice and information, drop-in support or informal keyworking' (National Collaborating Centre for Mental Health, 2007).

Psychosocial treatment of drug users in the Special Prison Hospital involves different psychosocial interventions:

- structured group work
- counselling and psychotherapy (cognitive-behavioural, gestalt, client-oriented)
- Drug-free unit.

Structured group work in the Special Prison Hospital

Structured group work usually focuses on 'pre-' and 'post-' treatment issues. Interventions include:

- **Motivational enhancement:** delivered via motivational interviewing (MI). MI focuses on enhancing motivation to change problematic behaviour and uses methods such as developing a feeling for discrepancies, expressing empathy, and supporting self-efficacy. Pre-treatment, it can enhance clients' readiness for change; post-treatment, it can reinforce treatment gains and build motivation for sustaining changes on release.
- **Relapse prevention:** 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 include managing cravings, preventing a 'lapse' from 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.
- **Pre-release:** planning and preparation for release are particularly important for prisoners with drug dependencies given the high risk of relapse and overdose. Pre-release work includes 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 in the Special Prison Hospital

To alter attitudes, beliefs, and behaviour that support drug use, the drug abuser must engage in a therapeutic change process. Since 2010, psychotherapy in the Special Prison Hospital has applied principles of effective drug dependence treatment according to the recommendations of the United Nations Office on Drugs and Crime. Psychotherapy based on a cognitive-behavioural approach (CBT) aims at modifying cognition, behaviour and beliefs. CBT includes relapse prevention strategies such as training the drug users to develop skills to identify triggers, avoid high-risk situations and to cope with such situations. Components include managing cravings, preventing a 'lapse' from 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.

Besides this, one of the major goals of psychotherapy is connecting to the external world by developing adequate relationships with therapists, family and social network outside the closed universe of addiction. In order to maintain abstinence and accomplish a better therapy outcome, client and therapist need to establish a meaningful relationship or *positive therapeutic alliance*. Since drug users usually leave treatment prematurely, psychotherapy proves to be effective in keeping them in treatment.

Applying a *relational approach* in individual and group psychotherapy based on attachment theory leads to the establishment of an effective therapeutic alliance. *Relational approach* in psychotherapy puts an emphasis on creating a deep, independent attachment to a new lifestyle and to people sharing that new lifestyle. Careful monitoring of the patient experience is necessary in order to follow up the therapeutic process of change. One of the patients in the Special Prison Hospital described his psychotherapeutic experience: 'I came from the dark side, tied up by the barriers put up by others and myself, bound by fear. My life was just a simulation, filled with substitutions of life. Now, I am the person striving to conquer my fears, anger and guilt by positive thinking. I am learning to deal with everyday problems and frustrations; I am learning to communicate freely and to exchange my emotions with others. *I am learning to be free, in order to learn who I am.*'

Drug-free unit in the Special Prison Hospital

The drug-free unit is an area set aside for prisoners with drug use problems who commit to remaining drug-free while living there. This is normally supported by drug testing. The Special Prison Hospital Unit has been open since May 2007, as a result of co-operation with the OSCE Mission to Serbia. The Mission sponsored the construction, set-up and staff training for the unit.

The drug-free unit supports the inmates' fight against drug use by providing a drug-free environment and professional medical, psychological, educational and social services.

It provides enhanced conditions and a set of activities including more intense psychosocial treatment through structured group work and counselling and psychotherapy. Participation in the drug-free programme is voluntary and requires a high degree of commitment from its participants.

From 2007 until now, a total of 139 inmates were involved in intense psychosocial treatment provided in the drug-free unit. Three inmates tested positive for drugs in 2007, six in 2008 and three in 2009. Since 2010 there have been no relapses, so the concept of the drug-free unit has proved its efficacy in treating drug users.

Serbian Prison Reform

'What works?' with offenders: tailoring treatment to match needs

Reform of the Treatment service in Serbian prisons started in 2010 with the adaptation of the rulebook of treatment, treatment programme, classification and re-classification of offenders (Sl. Glasnik RS, 2010). Reform is implemented by the Serbian Prison Administration and supported by the OSCE Mission to Serbia. The Council of Europe is not currently involved, but has supported necessary legislation, the development of human rights protection of prisoners, the treatment of juveniles and the implementation of alternative sanctions.

The main goal of Serbian prison reform is to implement an evidence-based approach to offenders and to introduce 'what works' principles in offender programmes.

'What works' offender programmes, based on Canadian meta-analytic studies, are focused on targeting offender behaviour by tackling criminogenic needs, rather than more generic welfare needs, tend to involve planned interventions over a specified period of time, and are characterised by a sequence of activities designed to achieve clearly defined objectives (Raynor, 2004). Influenced by cognitive-behavioural approaches, 'what works' programmes are aimed at securing behavioural change by exploring the links between cognition and behaviour and by enabling offenders to develop and build their thinking skills and behavioural repertoire.

Implementation of these principles in Serbian prison reform was divided into two phases:

1. Introducing **risk assessment tools**
2. Treating **criminogenic needs** of offenders in order to decrease the rates of re-offending.

In the first phase of reform, the Offenders Assessment System (OASys) has been applied in risk assessment for offenders with prison sentences over three years.

The Offenders Assessment System is designed to make it possible to:

- assess how likely an offender is to be re-convicted;
- identify and classify offending-related needs, including basic personality characteristics and cognitive behavioural problems;
- assess risk of serious harm, risks to the individual and other risks;
- assist with management of risk of harm;
- link the assessment to the supervision or sentence plan;
- indicate the need for further specialist assessments;
- measure change during the period of supervision/sentence.

The second phase of Serbian prison reform is directed to introducing specialised programs targeting criminogenic needs (risk factors in which it is possible to intervene) of offenders in order to decrease the rates of re-offending. One of them will offer psychosocial treatment for drug users. For all specialised programmes, the prisoner's consent will be required.

Substance dependence is a high-risk factor for re-offending. Untreated substance-using offenders are more likely than treated offenders to relapse into drug use and return to criminal behaviour. Findings show unequivocally that providing comprehensive drug abuse treatment to criminal offenders works, reducing both drug abuse and criminal recidivism (Pearson and Lipton, 1999).



Planning of treatment and assessing of inmates' needs

The specialised programme for drug-using inmates in all Serbian prisons will be based on United Nations Office on Drugs and Crime recommendations for the effective treatment of drug users. It will be modelled according to the programme in the Special Prison Hospital, mainly delivered via structured group work, but it could be implemented individually. Interventions will include:

- **Motivational enhancement:** delivered via motivational interviewing in order to build motivation for change, compliance for treatment and provide remaining in treatment for sufficient time;
- **Relapse prevention** (training drug users to develop a range of skills to identify, anticipate, avoid and/or cope with high-risk situations and triggers for relapse);
- **Pre-release:** planning and preparation for release.

Outlook / the way ahead

The new strategy of the Serbian Prison Administration for the period 2013-2020 is currently being developed and will further improve the treatment of drug users in prisons. It will include harm reduction interventions (needle exchange, condom distribution, and methadone maintenance in all prisons) and psychosocial interventions in drug users' treatment.

The Programme for psychosocial treatment will be developed and all employees of the Treatment Service in Serbian prisons (approximately 200 psychologists, educators and social workers) will be trained to implement the programme by the Training Centre of the Serbian Prison Administration.

Co-operation with institutions in the community for the treatment of drug users and implementation of models of good practice from other European countries are promising approaches in creating an integrated treatment for drug users. Also, in future, a wider range of psychosocial interventions should be provided in Serbian prisons such as counselling and psychotherapy, residential programs, drug-free units and aftercare programs for prisoners re-entering the community in order to help drug users to maintain changes and to successfully reintegrate into the community after release from prison.

References

- Andrews, D. A. and Bonta, J. (1998). *The Psychology of Criminal Conduct* (Second edition). Cincinnati, OH: Anderson Publishing.
- Kovacevic, M. & Raketic, D. (2009). Drug situation in Serbia. *European Psychiatry*, 24 (1), S435.
- Ministry of Health of the Republic of Serbia, IPH of Serbia (2010). Survey among populations most at risk on HIV and among PLHIV.
- Ministry of Justice Prison Administration (2011). Annual report on prison administration operations.
- National Collaborating Centre for Mental Health (2007). National Clinical Practice Guideline Number 51: Drug Misuse Psychosocial Interventions.
- Pearson, F.S. and Lipton, DS (1999). A Meta-Analytic Review of the Effectiveness of Corrections-Based Treatment for Drug Abuse. *The Prison Journal*, 79(4):384-410.
- Pravilnik o tretmanu, programu postupanja, razvrstavanju i naknadnom rayvrstavanju osudjenih lica (2010). *Sl. glasnik RS*, 72.
- Raynor, P. (2004). The probation service 'pathfinders': Finding the path and losing the way? *Criminology and Criminal Justice*, 4(3): 309-325.

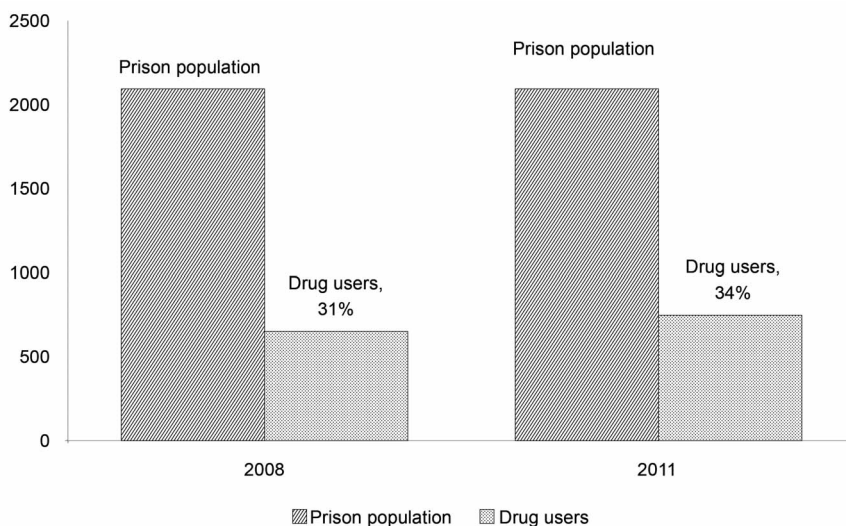
Prison reforms in the Republic of Macedonia - Drug treatment in Macedonian prisons

Ms Elisaveta Sekulovska, Psychologist, Ministry of Justice, Directorate for Execution of Sanctions of The Former Yugoslav Republic of Macedonia

Introduction/Challenges

An increasing number of drug-dependent prisoners in the Republic of Macedonia has increased the need for health care and treatment services in prisons. This is because of intensive changes of consciousness, psychological and physical dependence of the prisoners serving their sentences, the emergence of violent behaviour by prisoners towards other prisoners, themselves or prison staff, and co-morbidity with personality disorders, psychosis, depression and other disorders/diseases.

Annual data from all penitentiary institutions reported an increasing number of drug users. In 2008, approximately 649 out of 2101 prisoners, or 31%, were drug users. The total of the prison population on 31 December 2011 was 2,212, out of which 746 were drug users, or 34%.

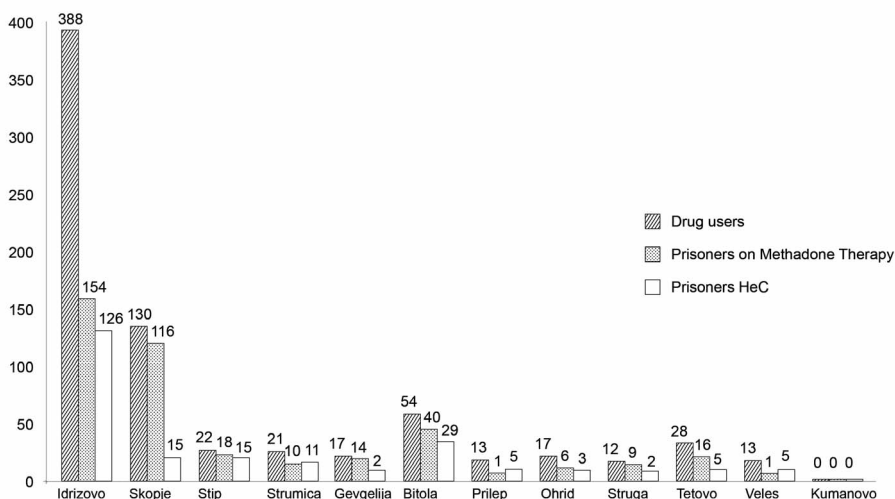


Picture 1: Prison population and drug users in 2008 and 2011

The results in Picture 1 indicate a need for action in building capacities to respond to health care and treatment needs of prisoners, drug prevention activities, availability of methadone therapy, psychosocial support and harm reduction measures.

The greatest need for medical and psychological treatment is at the Idrizovo Penitentiary Institution, because of its prison population, its number of drug users, the prevalence of Hepatitis C and co-morbidity with personality disorders, psychosis, depression and other disorders/diseases. If the drug-using prisoner has previously been identified as having a psychopathic personality disorder or severe mental illness, the medical treatment and medications have priority in the drug treatment with a specialist assessment by a qualified medical practitioner.

The Government of the Republic of Macedonia in December 2012 adopted the Health Care Strategy for prisoners 2012-2014 with Action plan 2012-2014.



Picture 2: Prevalence by Institution in 2011

HIV/AIDS were not registered during 2011. There are assumptions that it is possible that the 0 figure does not correspond to the actual number because of the right of personal choice for testing of each person (The Health Care Strategy for prisoners 2012-2014). There were two prisoners in 2010 identified with HIV/AIDS who received medical treatment outside prison.

Background

The Republic of Macedonia is a country located in the central Balkan Peninsula in Southeast Europe. It declared its independence from Yugoslavia in 1991. Its population in 2011 numbered 2,058,539. The country's capital city is Skopje, with about half a million inhabitants.

The Directorate for Execution of Sanctions is a body within the Ministry of Justice of the Republic of Macedonia. One of its responsibilities is to organise, implement and supervise the execution of sanctions: imprisonment, juvenile imprisonment, alternative measures – community service and home detention, protective supervision imposed by decision on probation and correctional measure – referral to educational and correctional institutions. Another responsibility of the Directorate is to provide in-house training and development. The Directorate co-operates with institutions, associations and organisations dealing with the problems of enforcement of sanctions.

The country penitentiary system is composed of thirteen institutions of which two are correctional-educational institutions (one in Veles for male juveniles and one in Idrizovo for female juveniles), two are closed penitentiary institutions (in Idrizovo and Stip), one is an open penitentiary institution in Struga, and eight are semi-open institutions: Bitola Prison, Prilep Prison, Ohrid Prison, Tetovo Prison, Skopje Prison, Kumanovo Prison, Strumica Prison and Gevgelija Prison.

Correctional-educational institutions are for female and male juveniles who are serving educational-correctional sentences.

Closed institutions are for first-time offenders sentenced to over three years' imprisonment and repeat offenders sentenced to over six months' imprisonment.

Semi-open institutions are for first-time offenders sentenced to less than three years' imprisonment and repeat offenders sentenced to less than six months' imprisonment.

Open institutions are for first-time offenders sentenced to less than five years' imprisonment.

Interventions and Partners

The Directorate for Execution of Sanctions continues to undertake a number of reform activities with specific legislative interventions in the field of resocialisation, security and health care of the prisoners, activities to improve living conditions in prisons, as well as more staff capacity building activities in penal and correctional institutions in the Republic of Macedonia.

The Directorate's partners include:

- Council of Europe
- European Commission
- European Agency for Reconstruction
- Global Fund

- Country Coordinating Mechanism
- Ministry of Health of the Republic of Macedonia
- Ministry for Education and Science of the Republic of Macedonia
- Ministry of Labour and Social Affairs of the Republic of Macedonia
- Ministry of Interior of the Republic of Macedonia
- Clinic for Infective Diseases and Febrile Conditions, Skopje
- Clinic for Toxicology, Skopje
- Bureau for Drugs of the Republic of Macedonia
- Centre for Prevention and Treatment of Drug Addiction, Psychiatry Hospital Skopje
- WHO
- UN
- UNODC
- OSCE
- NGOs: HOPS, Doverba, Via Vita, Hepta

The role of the Ministry of Health and Country Co-ordinating Mechanism of the Republic of Macedonia (CCM) in drug treatment in prisons

The Republic of Macedonia has an established partnership with the Global Fund to fight against AIDS, tuberculosis and malaria and has implemented grants since 2004. Until now, five grants have been or are being implemented, two for tuberculosis and three for AIDS. The primary recipient is the Ministry of Health. With the co-operation of the CCM and the Ministry of Health, educators have been running educational sessions for prisoners and prison staff since 2004.

In December 2012, the CCM adopted the Policy on linking sexual and reproductive health and HIV/AIDS in order to improve the co-operation of all the relevant partners in health promotion and HIV/AIDS protection at national level. This policy also targets drug users in prisons with a view to achieving integration of services for HIV and SRH of drug users, especially the vulnerable group of women in prisons.

Another important component, which is a part of the HIV Programme in our country, is treatment for Hepatitis C. This activity is implemented in the Clinic for Infective Diseases and Febrile Conditions in Skopje. It is planned to provide 235 people with treatment for Hepatitis C over five years through this programme, which will be implemented in co-operation with two NGOs. Out of the 235, a certain proportion of prisoners will be included.

One of the newest activities of the CCM is promoting the idea of social entrepreneurship of vulnerable groups in society and prisons, such as a new sustainable model of funding for drug users and other vulnerable targeted groups. Two cycles of training were held in 2012, attended by participants from NGOs and CCM representatives.

Psychosocial service

The contact and trust that is built in the relationship between prisoners and prison staff can contribute to achieving the defined treatment goals. Conversation and advice that prison professionals give to drug-dependent prisoners can make a contribution to their well-being and stable psychological condition. Counselling, where available, is a wonderful opportunity for drug-dependent prisoners to improve their condition and life. In addition, each social and occupational activity gives the prisoner a sense of respect and positive self-actualisation.

The psychosocial and counselling interventions undertaken must be for the benefit of each prisoner. This means that effective interventions must be planned individually and must tackle the inner part of the prisoner.

Psychological treatment

According to the Guidelines for types and methods of treatment, adopted and implemented in 2011, the following types of treatment for prisoners can be applied: interview, individual conversation, individual motivational work, individual counselling or psychotherapy, group motivational work and group counselling or psychotherapy.

Is psychosocial support and counselling an important part of drug dependence treatment?

- Assessment of suitability of the prisoner is necessary.
- The right drug dependence treatment is tailored to a person's dependence and individual needs.
- Co-morbidity with personal disorders, psychosis, depression and other conditions can have priority in the treatment of drug-dependent prisoners. Psychotherapy can also treat the other mental health conditions that often contribute to prescription drug abuse.
- Counselling is an essential part of drug dependence treatment. Cognitive-behaviour approach, family counselling and other therapy modalities can help people recovering from opioid dependence.

The number of drug-dependent prisoners who are on methadone therapy is much higher than the number of prisoners suitable only for psychological and psychosocial interventions without methadone therapy.

Risk assessment as part of a general admission procedure of the prisoner

The Instrument for risk assessment and needs of the prisoner and Self-Assessment Questionnaire were established and implemented in 2011. After assessment, the

professional team working in the admission department, which is multi-professional and consists of a psychologist, physician, head of security and social worker, sets three goals/specific needs to be accomplished during the prisoner's sentence. The first goal/need has priority in the treatment during the sentence. Psychologists in all penitentiaries work in the admission department of the prison and in treatment with prisoners, except in the Idrizovo Penitentiary Institution where one psychologist works in the admission department of the Institution.

Risk assessment as part of the Macedonian Prison Substance Programme

The assessment manual for the Macedonian Prison Substance Programme regulates the assessment and criteria for entering the programme.

The Sentence Plan

Setting the goals to be achieved by every prisoner during his/her sentence is the most important activity in the admission period.

The sentence plan should consist of specific treatment and other activities, such as vocational training, working arrangements, training for life skills, and learning skills that will help the drug-dependent prisoner to integrate into society after release.

Motivational interview as part of the professional work with the prisoner

It is said that what our mind can conceive, our body will achieve. Motivating prisoners to change in a positive way is a skill in which prison staff should be trained.

Prison staff from the admission professional teams was trained in motivational interview skills during 2011 and 2012.

Specific Treatment Programmes

In the Strategy for Re-socialisation and Social Adaptation 2010-2012, nine specific vulnerable treatment groups of prisoners needing specific treatment measures during their sentences are targeted.

We agree that prison is an environment in which one can find many more vulnerabilities or vulnerable groups. In The Health Care Strategy for Prisoners 2012-2014, priority is given to women in prisons, juveniles, violent offenders, drug- and alcohol-dependent prisoners, sex offenders and long-term prisoners. Extending activities in these programmes in the future and training prison staff are two of our strategic goals and activities defined in the Health Care Strategy.

Reducing of violence

The Directorate for Execution of Sanctions established and implemented new procedural guidelines on violence in prisons in February 2013.

Training for prison staff in anger management is another activity that should be undertaken in 2013, with the aim of reducing and coping with the emergence of violence in prisons.

Macedonian Prison Substance Programme: In what way will the Macedonian Prison Substance Programme contribute to drug users in prisons?

Drug-dependent prisoners need medical and psychological care. This programme enables the staff to work with drug-dependent prisoners through a set of techniques with a cognitive-behavioural approach. Cognitive behaviour psychotherapy teaches a person how to recognise moods, thoughts and situations that cause addiction cravings. A therapist helps the person to avoid these triggers and replace negative thoughts and feelings with ones that are healthier and more functional. The skills learned in cognitive behaviour psychotherapy can last a lifetime, making it a potentially powerful method of treatment for drug abuse, anxiety and other conditions.

The content of the programme works on the various issues of the affected drug-dependent prisoners. For the prisoners who after a two-week period are assessed as suitable for the programme, the programme team will work using an ABC model, cognitive distortions and changing thinking patterns of the prisoner over 12 weeks through 36 group sessions. Also individual sessions can be offered to the prisoners and they can cease the use of methadone on the advice of medical staff. It is therefore important for the programme team to be multi-professional and consist of a psychologist, a medical doctor, a security officer, a social worker and education providers.

Benefits of the Programme are:

- Self-awareness of the drug-dependent prisoners;
- Techniques for changing thinking patterns through ABC model and working with cognitive distortions;
- Techniques for coping with cravings;
- Guidance through process of changes;
- Setting achievable personal goals for the prisoners during their sentence;
- Ceasing the use of methadone with the advice of medical staff whenever possible.

Outlook

What is planned in the field of drug treatment in Macedonia in 2013/2014?

- Activities for prevention of infection and diseases;
- Implementation of Protocol for distribution of condoms, Protocol for methadone therapy and Protocol for medical care of prisoners with HIV/Hepatitis C/other infections and diseases;
- Anger management as part of prison staff education;
- Educational programme for prison staff for drug – basic and advanced level;
- Educational programme for prison staff for infections and diseases in prisons;
- Psychological and medical treatment of drug-dependent prisoners;
- Improvement of the medical prison facilities;
- Sustainability of the three existing Methadone centres and a possibility for developing new ones in other prisons;
- Drug-free unit in the Idrizovo Penitentiary Institution.

What is needed in the field of drug treatment in Macedonia?

- Continuing prison staff training for the re-socialisation, security and medical care sectors;
- Improvement of prison and medical facilities.

About me: It was my pleasure to write about drug treatment in prisons in the Republic of Macedonia. I have more than 10 years' experience working as a psychologist in Bitola Prison and two years' as an advisor-inspector for the treatment of prisoners in the Ministry of Justice – Directorate for Execution of Sanctions. I have had an active role in many working groups for prison reforms since 2006. I was the team leader in the working group for Guidelines for types and methods of treatment for the prisoners (Official Gazette of the Republic of Macedonia No. 173/2011). I was a team leader in the working group for The Health Care Strategy 2012-2014, Guidelines and Programmes. I have conducted many workshops and training sessions for prison staff on prison reforms, specific treatment measures, bylaw regulations, risk assessment as part of the treatment of the prisoners, motivational interview skills etc. Also, I am an active member of the Country Co-ordinating Mechanism of the Republic of Macedonia. My education in the last eight years in two psychotherapy backgrounds – transactional analysis and cognitive behaviour psychotherapy – gives me the adventure of initiating activities for establishing and implementing prison reforms in the framework of the set strategic goals of the Directorate of Execution of Sanctions and the Republic of Macedonia.

Psychological and medical care for drug users in prison establishments in the Republic of Moldova

Svetlana Doltu, Head of Medical Service of the Department of Penitentiary Institutions (DPI) of the Republic of Moldova

and **Iuliana Adam**, Head of Psychological Service of the DPI, Republic of Moldova

Prison systems worldwide seek to improve the human condition of prisoners by offering knowledge, treating various physical and mental disorders, and helping inmates develop useful skills to earn an honest living after release. This is why prison psychologists have such an important role in humanising the institution and re-socialising the inmates.

Achieving re-socialisation in prisons depends on the personnel involved in this process and, to a great extent, on the social and psychological service that has been established in prisons in order to facilitate psychosocial rehabilitation and the social reintegration of prisoners. The activities carried out by this service are geared towards mitigating the negative influence of imprisonment on the personality and behaviour of prisoners as well as the identification and development of skills and abilities that enable them to integrate into a normal social life after release from prison.

Created in 1994, in accordance with the Prison System Reform Concept and following the adherence to the international agreement on the Standard Minimum rules for the treatment of prisoners, the psychological service currently carries out a series of tasks that are fundamental in the process of re-socialisation of prisoners.

In conformity with these normative acts, the Department for Penitentiary Institutions of the Ministry of Justice has appointed 35 units of employed psychologists to work with prison establishments to facilitate the psychosocial rehabilitation and social reintegration of prisoners.

One of the basic functions of psychologists in the prison system is assisting convicted drug users with HIV/TB. Currently, working together with medical services, they have registered considerable progress in this area and have managed to develop best practices for working with this vulnerable category of prisoners.

Therefore, there is a series of activities that can be conducted by psychologists to provide psychological assistance to imprisoned drug users as well as behaviour change programmes for inmates.

One of the educational approaches implemented in prisons is a rehabilitation programme for drug users (developed according to cognitive-behavioural theory). The programme consists of two stages: the informative phase includes 10 psycho-pedagogical lessons with the purpose of informing inmates about the damaging effects that drugs have on personality development; the second phase is rehabilitation, which involves psychological support and relapse prevention training.

Implementation of measures to reduce the risk of transmission of HIV and HCV make prisons safer not only for prisoners, but also for prison staff.

Prevention of these diseases in prisons in Moldova includes:

- Prevention and control programs for HIV, TB, HCV and STIs;
- Methadone substitution therapy;
- Syringe exchange programs;
- Distribution of condoms;
- 'Peer to peer' health training programmes;
- Effective collaboration with the National HIV/AIDS Programme, etc.

From 2005 to date the following achievements have been recorded:

- in 2013, the DPI expanded the package provided by the government sector by taking over the needle exchange programme;
- having a smaller number of ORT sites in the civilian sector helps gradual 'forced' exclusion from ORT after release;
- issues caused by the influence of criminal subculture and polinarcomania;
- medical and non-medical staff turnover.

Following a series of training sessions conducted for doctors and psychologists, organised in collaboration with the Pompidou Group CE, specialists have concluded that the combination of substitution therapy and psychosocial rehabilitation is a guarantee for successful treatment. A very important factor in the process of drug rehabilitation is psychological support, whose absence can lead to the failure of medical treatment and can be a negative reinforcement factor in subsequent attempts to implement change.

In late 2011, the Department for Penitentiary Institutions, in collaboration with the Pompidou Group (Council of Europe), initiated a project that aims to familiarise Moldovan prison staff with the motivational interviewing technique – internationally acclaimed method.

For a period of one year, three training workshops and two supervision workshops were held, the purpose of which was to train psychologists in providing psychological assistance to convicted drug users and motivating them to enter treatment; achieving a motivational process as prescribed by the most advanced studies in psychology; the techniques used by specialists in the field of psychosocial assistance for drug users, etc.

The project aims to train a group of specialised psychologists, selected from various penitentiary subdivisions, in motivational interview techniques. In the future these will become trainers and instruct other psychologists, who work in the Moldovan prison system.

The group of trainers that has been educated in this field will not only put into practice their knowledge of motivational interviewing, but also prepare other professionals working in prisons to offer psychological assistance to prisoners who use drugs and motivate them to enter treatment in 2013.

The implementation of the abovementioned measures ensure further professional training of prison staff in the field of psychosocial assistance for prisoners, and also improve the image of the prison system both nationally and internationally.

Art Therapy in Prisons

Prof Peter Sinapius, International Institute for Subjective Experience and Research (ISER)/ MSH Medical School Hamburg (University of Applied Sciences)

'The jail is looking at me like from a mirror; my mouth is closed like the door that keeps me from hate in the morning, from my own and from the hate of those who have imprisoned me. I wish I could lose my mind so as not to understand the senselessness of my punishment.'

These are the words of an inmate from a prison in Germany. They were recently published in a book of stories and poems by prisoners ³.

In prison there is no freedom. The inmates are controlled by clear rules. Contact with friends and relatives is interrupted and the space for privacy and retreat is reduced to a minimum. Independence is lost and prisoners have no autonomy. They are excluded from the social community.

As a result, fundamental conditions of life are affected. The withdrawal of liberty is an existential incident. This pressure leads to a high suicide rate, especially in the first weeks of imprisonment. Between 2000 and 2004, 442 prisoners in Germany committed suicide, 279 of whom did so within the first 6 months of imprisonment and seven within 24 hours of arrest.

German penal law states that:

- Life in prison should be as similar to the general conditions of life as possible.
- Harmful effects of imprisonment should be prevented.
- Imprisonment should be executed in a way that helps to reintegrate the prisoners into life outside prison.

The reality is far removed from these principles. Imprisonment is neither similar to the living conditions outside the prisons nor does it teach the prisoners to lead a life of independence. Life inside and outside prison is clearly distinguished. Prison is a foreign place for those who are outside.

*Prisons are always the others*⁴ was the title of an art exhibition that took place in Berlin four years ago. One part of the exhibition consisted of collaborations between artists and prisoners. One work showed a video documentation of a project in the USA entitled 'Question Marks' from the year 1996.

³ William V.: Ich suche meine Augen. In: In jeder Nacht lacht der Teufel leise – Literatur aus dem Strafvollzug 2011. Assoverlag.

⁴ 'Knast sind immer die Anderen'

'Question Marks' was developed as an exchange project between two groups of prisoners who had never met before: ten long-term inmates from the U.S. Federal Penitentiary, one of the largest high-security prisons in the United States, and thirty young people from the Juvenile Court / Fulton County Child Treatment Center in Atlanta. Over three months a video exchange between these two groups was organised. The background to the videos was a series of art-workshops that dealt with questions of perception, space and relationships. The inmates created their images in visual art and performances, which became a starting point for discussions about themes of intimacy, family, crime and punishment. Each group documented its own work process, which it then made available to the other as material for the exchange between the long-term inmates and the group of young inmates.

In a further development, questions were formulated that addressed society as a whole; these were printed on car number plates, which were then driven in public. On the plates people could read: Are you scared of the lifestyle that you must now live as a young man? Who should I fear? Are you who you say you are? What do you want to know about me? Can you get away?

The project shows possible effects of art in prison. It opened boundaries to facilitate development and to stimulate communication. This seems paradoxical, because the purpose of prison is the opposite: it is isolation, restriction of personal scope, exclusion from the community, limitation of freedom and communication. The reason that art makes something possible that is not part of real life in prison is that it opens imaginary spaces and follows its own rules. In these spaces of freedom the possibilities become almost limitless. Dramas can take place about murder and killing without any blood actually flowing. The prisoners can travel to foreign countries, without the prison walls being torn down. They can create visions and hopes for the future.

The desire to open up boundaries beyond everyday life in prison leads to an above-average drug use inside. The use of drugs is an attempt to escape reality, a way of seeking a world without borders and boundaries.

Through the influence of drugs as well that of art, inmates have access to an alternative world experience, a reality the prison system does not have access to. But there is a crucial difference between these two options of going into an alternative world. Unlike artistic imagination, the use of drugs reduces a person's autonomy or even destroys it. It is replaced by addiction and disease. Artistic work however opens spaces of freedom that allow individual development and change processes even within the context of imprisonment.

I'll show you some examples of artistic work in prison that I supervised:

Three students worked in a women's prison for 8 weeks with 6 inmates. The penitentiary had 22 imprisonment places. 90% of women who are imprisoned have committed crimes

related to drug abuse and drug trafficking. In the beginning they were very shy and unsure, lacking confidence. That changed significantly during the work. The group worked with various artistic media: masks were built, pictures were painted, plays were performed, the participants danced and made music. The women themselves were amazed at their own capacity. One woman said, while cutting eyeholes into her mask: 'Until now I've known how to stab someone violently with a knife, but to handle a knife in such a fine and sensitive way is new for me'.

The women increasingly developed confidence and discovered the art work as a way to communicate and to act responsibly beyond hierarchy and subordination. The space in which the artwork took place was clearly distinct from the context of the prison's everyday life. It was not about adaptation and subordination. The inmates and the students related to and cooperated with each other.

The dancing showed what effect art can have in prison. It opens up a possibility which is usually denied: free movement. Dance influences the perception of space, time, one's body, others, and relationships that become visible through the movement. While moving you are moved. In this way art creates space for processes of change.

Another art project in the penitentiary in Bremen is a workshop called Open Walls, in which the prisoners produce sculptures. The sculpture studio was founded in 1978 on the occasion of a competition. At that time there were many changes in a variety of social fields, including prisons. This brought art rehabilitation projects into institutions. The purpose was to address the core of the human being and to give space for individual expression.

The prisoners work in the art studio as part of their obligation to work and are paid for it. The sculptures, which emerge from the hands of the inmates, are placed in public spaces such as squares, schools or playgrounds.

One prisoner, who has been in jail since 2010 said, 'I took drugs; I am here because of drug-related crime. I had nothing to do with art before, but in the sculpture workshop of the prison, I realised how much fun it is. Here I am finally doing something useful.'

The way to relate to any artistic material is a kind of creative dialogue, which differs considerably from the interactions that are determined by the rules of the prison. When you work on a thick piece of wood to make a sculpture you go into a dialogue with the material. While you impress the material, the material will make an impression on you: It is hard or soft, its fibres stand up against the blows or receive and absorb them, its internal structure and texture challenges you to work in a certain direction. You cannot do whatever you want; you are forced to respond to the piece. If a prisoner works in this way, he has new experiences: his actions are not determined by extrinsic rules as they result from an active dialogue and the intrinsic properties of the material.

Another prisoner who has been involved in the sculpture workshop reports of his experiences:

'While working on my sculptures I can solve problems and reduce complexes, which even by psychiatrists and psychologists are deemed unsolvable. My confidence has increased by working in the group and I don't want to miss this atmosphere. In a sense you can say this is like therapy...it's the best thing I've seen in 16 years of being in prison.

The production of sculptures is like childbirth, the sculpture is born, sometimes it's even painful... To carve a stone is like merging with the material that is carved, you develop a sense of the stone from which the sculpture is created, you get to know the mass of a stone to its very inner core...

It is very important that everybody can express himself, so that we can present our true thoughts to the outside world, and not what society says about us...' ⁵

⁵ Paul Bichler in: In jeder Nacht lacht der Teufel leise – Literatur aus dem Strafvollzug 2011. Assoverlag.

Drugs and mental health in prisons: constant concerns of the Health in Prisons Programme (HIPP) of WHO/Europeⁱ

Mr Stefan Enggist, Technical Officer, Prisons and Health, World Health Organisation

For most of the 20th century, prison health received little public health attention. In the 1980s this changed. First, this was due to the breakup of the Eastern Bloc and the revision of the judicial system in the countries concerned. Second, this was caused by the emergence and rapid spread of HIV/AIDS, especially throughout the prison systems of many countries worldwide.

It was the Council of Europe, together with Finland, that organised the first-ever seminar on prison health in Tampere, Finland, in 1991. In 1992 England and Wales made a proposal to the WHO to establish a network of countries to exchange experiences on prison health, which, as had been established at the seminar in Tampere, shared similar problems, but had up to then found no common response.

In 1995, the WHO launched its Health in Prisons Project (HIPP), which by now has developed into a regular programme of WHO/Europe. Its main aim was the improvement of health in prisons through policy changes initiated by consensus recommendations based on good practices derived from experiences and initiatives from all over Europe.

Countries' participation in the project was official, with a representative of the governmental body in charge of prison health being the national focal point for HIPP. The focal points' remit included participation at annual network meetings, production of consensus recommendations, and regularly reporting on issues regarding prison health. The United Kingdom established a WHO/HIPP Collaborating Centre within the Department of Health.

From the start, there were also other key organisations that partnered HIPP, such as the Pompidou Group of the Council of Europe, the International Council of the Red Cross (ICRC) and others.

The first network meeting on prison and health was organised by HIPP in 1996. A first strategic plan for HIPP addressed three core areas:

1. Communicable diseases
2. Mental health
3. Drugs.

In 1997 a first consensus statement by UNAIDS and WHO/Europe HIPP concerned HIV/AIDS, STIs and Tuberculosis in prisonsⁱⁱ. Among others, it called for measures against overcrowding, which was seen as major factor for raised risks of infection. One of the measures proposed was avoiding the criminalisation of illicit drug use.

From 1999, HIPP devoted a lot of its attention and resources to the difficult problem of illicit drugs in prisons, which had become a major issue for many prisons, and a concern for public health. The Pompidou Group of the Council of Europe and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), established by the European Commission, had up to then already done remarkable work on drugs in European societies. These bodies, as well as some NGOs dealing with the issues above, have worked together and greatly influenced WHO/Europe HIPP.

In 2001, the Pompidou Group, together with HIPP, organised a common network meeting on prisons and health in Bern, Switzerland. Following this, the consensus paper *Prisons, Drugs and Societies: Principles, Policies and Practices*ⁱⁱⁱ was published jointly by the WHO and the Pompidou Group in September 2001. The document drew on the experience of HIPP and the Pompidou Group according to which any national strategy for reducing the harm from illicit drugs must include the tackling of drug issues in prisons. The document based its argumentation on the right to health of prisoners, and was addressed to actors of influence on prison health policy at governmental and non-governmental level. It was also widely distributed to prison staff and prisoners. It was ambitious in that its aim was for Europe to be the first WHO Region to have tackled the problems of drugs in prisons comprehensively and successfully and in so doing to have contributed considerably to harm reduction in society at large. Regarding its implementation, the document included guidelines and checklists for key staff and prison managers, in order to guarantee minimum standards of services for people who consume drugs in prisons. The paper also addressed issues including the existence, possibility and evidence of prison needle and syringe programmes (PNSPs).

Drug problems have continued to be one of HIPP's major concerns over the years. This has led to the publication of a series of drug-related documents, such as:

- *Status paper on prisons, drugs and harm reduction (2005)*^{iv}
- *Prevention of acute drug-related mortality in prison populations during the immediate post-release period (2010)*^v
- *Prison health – HIV, drugs and tuberculosis (2013)*^{vi}.

Mental Health has also always been a major concern of HIPP.

In 1998, as a result of a network meeting in the Netherlands, the consensus statement *Mental Health Promotion in Prisons*^{vii} was published. It started with the assumption that all imprisonment is detrimental to mental health, and that prison is not a good place to care for people with mental health problems who should instead be transferred to appropriate health facilities.

Seven years later, in 2005, there was a network meeting in Trencin, Slovakia, that was dedicated to mental health issues in prisons. The report became the so-called *Trencin Statement on prisons and mental health*^{viii}. Some of the points raised were, that urgent action is needed in order for prisons not to become the twenty-first century asylums for people with poor mental health, and that mental health problems of prisoners are often related to drug problems, bad prison conditions and a poor development of diversion schemes for mentally ill prisoners. The *Trencin Statement* named some key criteria for success in this field:

- Acceptance that prisons are not good places to treat those with serious mental health problems
- Importance of assessing the vulnerability of newly admitted prisoners through reception policies
- Staff training
- Promoting mental health and wellbeing as a central prison policy.

To date, HIPP has addressed further important prison health issues such as, among others, the special health needs of female prisoners^{ix} and, once again, the control of communicable diseases in prisons (see: the *Madrid Recommendation*^x).

Over the last two years, HIPP has been driving forward two major projects.

The first project deals with the governance of prison health. In most countries of the WHO/Europe either the Ministry of Justice or the Ministry of Interior is responsible for prison health. Because health services in prisons did not meet the health needs of prisoners adequately, over the last few years some countries have transferred the responsibility for prison health to the Ministry of Health. Subsequently the members of the WHO/Europe Network on Prison and Health have asked the WHO for guidance on the governance of prison health. A special Expert Group on the Stewardship of Prison Health as well as Network members have contributed to the draft document *Good governance of prison health in the 21st century*, which is currently in consultation among members of the network of prison and health. The document starts with the evidence that prison health impacts on general public health. In the second part it sets out the basic institutional principles of prison health in accordance with international law. On the basis of the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), and the case law of the European Court of Human Rights (ECHR), in the third part the document reveals serious persistent shortcomings of prison health in the Member States of WHO/Europe. The comparison between a state of prison health that is desirable from a legal and public health perspective, and the actual state of prison health in the WHO/Europe Region, leads WHO/Europe to postulate that:

- the steering and coordination of all relevant actors and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility, whereby

- it is incumbent on Ministries of Health or any other competent health authorities to provide health care services in prisons and to advocate for prison conditions favourable to health.

WHO/Europe is convinced that such governance of prison health would be in accordance with and supportive of the new European policy for health, *Health 2020*^{xi}, the *WHO Roadmap to Prevent and Combat Drug-Resistant Tuberculosis 2011-2015*^{xii}, the *European Action Plan for HIV/AIDS 2012-2015*^{xiii}, and the *Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012-2016*^{xiv}, as well as in line with and supportive of the recommendations and standards of the Council of Europe relating to prison health. The publication and launch of the document in 2013 should be extremely supportive of a further integration of prison health into general public health, both on a policy level and administratively. Such a development should eventually have a positive impact on the health of prisoners, communities and societies alike.

A second project to be accomplished in 2013 is the publication and launch of a revised edition of *Health in prisons: A WHO guide to the essentials in prison health*^{xv}, which was first published in 2007.

In addition to the first edition, the new guide will include chapters on pre-trial detention, non-communicable diseases, alcohol and prisoners, tobacco use in prisons, older prisoners, violence and sexual abuse in prisons, and solitary confinement.

Last but not least, in light of Health 2020 and the reform of the WHO, HIPP is currently carrying out a strategy check. In this context HIPP will not only review its mission, vision and goals, it will also try to renew and strengthen existing, and set up new strategic relationships with partner organisations such as the Pompidou Group or the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). WHO/Europe is convinced that it must keep its unique leadership role in prison health by networking with other institutions, bodies and instruments whose missions cover the protection of prisoners' health, for their sake and for the sake of better public health.

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- i This article is based on: Gatherer, A, Møller, L, Hayton, P (October 2005): The World Health Organization European Health in Prisons Project After 10 years: Persistent Barriers and Achievements. In: American Journal of Public Health, Vol. 95, No 10: 1696-1700 (<http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2003.057323>, accessed 4 April 2013).
 - ii WHO (1998): HIV/AIDS, Sexually Transmitted Diseases and Tuberculosis in Prisons. Joint Consensus Statement, WHO/UNAIDS.
 - iii WHO/Europe, Pompidou Group of the Council of Europe (2001): Prisons, Drugs and Society. A consensus Statement on Principles, Policies and practices (http://www.euro.who.int/__data/assets/pdf_file/0003/99012/E81559.pdf, accessed 4 April 2013).
 - iv WHO/Europe (2005): Status Paper on Prisons, Drugs and Harm Reduction (<http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health/publications/pre-2005/status-paper-on-prisons,-drugs-and-harm-reduction2>, accessed 4 April 2013).
 - v WHO/Europe (2010): Prevention of acute drug-related mortality in prison populations during the immediate post-release period (http://www.euro.who.int/__data/assets/pdf_file/0020/114914/E93993.pdf, accessed 4 April 2013).
 - vi WHO/Europe (2009): Prison health – HIV, drugs and tuberculosis (http://www.euro.who.int/__data/assets/pdf_file/0009/98973/92295E_FS_Prison.pdf, accessed 4 April 2013).
 - vii WHO/Europe (1998): Consensus statement on mental health promotion in prisons. (http://www.euro.who.int/__data/assets/pdf_file/0007/99016/E64328.pdf, accessed 4 April 2013).
 - viii WHO/Europe (2007): Trencin statement on prisons and mental health (http://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf, accessed 4 April 2013).
 - ix WHO, UNODC (2009): Women's health in prison. Correcting gender inequity in prison health (http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf, accessed 4 April 2013); WHO, UNODC (2011): Women's health in prison. Action guidance and checklists to review current policies and practices (http://www.euro.who.int/__data/assets/pdf_file/0015/151053/e95760.pdf, accessed 4 April 2013).
 - x The Madrid Recommendation: Health protection in prisons as an essential part of public health (http://www.euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf, accessed 4 April 2013).
 - xi WHO Regional Office for Europe (2012). Health 2020 policy framework and strategy. (http://www.euro.who.int/__data/assets/pdf_file/0020/170093/RC62wd08-Eng.pdf, accessed 22 December 2012).
 - xii WHO/Europe (2011). Roadmap to Prevent and Combat Drug-Resistant Tuberculosis. The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011-2015 (http://www.euro.who.int/__data/assets/pdf_file/0014/152015/e95786.pdf, accessed 22 December 2012).
 - xiii WHO/ Europe (2011). European Action Plan for HIV/AIDS 2012-2015 (http://www.euro.who.int/__data/assets/pdf_file/0011/153875/e95953.pdf).
 - xiv WHO (2012). Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012-2016. (http://www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf, accessed 2 December 2012).
 - xv WHO (2007): Health in prisons. A WHO guide to the essentials in prison health (http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf, accessed 4 April 2013).

