

Akzeptanzorientierte Drogenarbeit/ Acceptance-Oriented Drug Work

ISSN 1861-0110

INDRO e.V.

Forschungsbericht / Research report

Health needs of drug dependent prisoners in four countries (Estonia, Hungary, Lithuania, Poland)

[Die gesundheitlichen Bedürfnisse drogenabhängiger Inhaftierter in vier Ländern (Estland, Ungarn, Litauen, Polen)]

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Abstract

The majority of people held in European prisons have severe problems associated with drug use, together with related health and social disadvantages. Those categorised as problematic drug users (PDUs) constitute a substantial proportion of prison populations in Europe. Recent figures indicate that a third to a half of prisoners having illicit drug use experience before imprisonment. Acknowledging the existence of a drug problem within prison walls often remains a taboo for prisoners, staff, management and politicians. Moreover, lack of continuity of care and support throughout the criminal justice system (CJS), from the moment of arrest to release from prison into the community, contributes to failures in reintegration, drives the “revolving door effect”, with drug users routinely caught in the criminal justice system and does not allow for the full implementation of the principle of equivalence of health services in prison comparable to those available in the community.

Most of the countries, who joined the European Union (EU) most recently have, to varying degrees, implemented effective treatment programmes and harm reduction projects outside of the prison system. However, effective drug treatment and blood-borne virus (BBV) prevention programmes within the prison walls and follow up services for released inmates with problematic drug use still have, in most New Member States, to be developed. Overall, prison policies and practices, in particular in dealing with drug users and related (infectious) diseases, remain an important EU concern. In few of the New Member States the public health imperative of a healthy prison system receives the political attention it deserves.

This research is bringing together countries that reflect (some of the) different legal and penitentiary systems, varying “drug cultures” and levels of HIV/HCV problems among the New Member States. The study aims to find the commonalities and differences that influence the implementation of continuum of

care approaches towards a healthy prison system. From that policy perspective four countries were chosen to provide an interesting mix (Estonia, Hungary, Lithuania, and Poland).

As risks related around drug use is a sensitive topic, we chose methods that reflect the need for anonymity and confidentiality. Focus groups with independent translators, anonymous quantitative methods as well as the views of NGOs might contribute to a complete picture, which will be amended by the perceptions and experiences of prison staff of all levels, representatives of the Prison Administration and the Ministry of Justice.

The research project is using a triangulation methodology consisting of quantitative and qualitative instruments plus an extensive literature review. Altogether 593 people were interviewed: 490 prisoners in the quantitative survey, 66 participants in prisoner focus groups, 27 experts working in prison and in NGOs (e.g. prison directors, doctors, nurses, social worker) and 10 experts from the Ministries of Justice and/or Prison Administration. All data are taken together in order to better understand health care structures in the specific countries and prisons, to be able to assess gaps and needs, with the final goal to develop baselines for further health care development.

Measures to control drug use are mainly oriented towards supply reduction (controlling drug smuggling, drug testing) and to a lesser extent towards demand reduction. However, the acquisition of drugs in prison is perceived mainly as easy or very easy by 39.5% of the respondents and 60.5% said it's either very or rather difficult.

The health status of prisoners is very heterogeneous throughout the four countries studied. The spread of blood-borne virus (BBV) infections varies greatly between countries: 18.7% of the whole sample of 490 inmates in the four countries report a HIV infection and 32.2% a HCV infection.

The study shows that drug use takes place inside prisons although to a lesser degree than outside. The drug use experiences both inside and outside prison vary between the four countries substantially. Opiate use in prison is reported by 25% in Lithuania, 15% in Estonia and to a lesser degree in Hungary and Poland.

The high prevalence of BBV infections in most of the prisons compared to community levels is in itself a massive threat for prison health care. On top of that risk behaviour, especially needle sharing, has been reported in many interviews. If heroin or home-made opioids etc. are used, the drugs are mainly taken intravenously.

In several countries visited a discrepancy could be observed in the perceptions of prison health care by prisoners and officials. Whereas 20.6% of prisoners are rating the quality of health care services as rather good or very good, 79.3% as rather bad or very bad, the professionals (doctors, nurses) often are assessing the quality of prison health care as partly higher than in the community, or as sufficient to meet the health care needs of prisoners.

The treatment quality stated by the inmates does not differ that much between countries. In Hungary almost one third of inmates stated the treatment quality to be very good or rather good, while in the other countries it is less than a fifth.

Apart from abstinence-oriented approaches it is important for the countries to develop and/or adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services. Furthermore programmes against physical, sexual, and psychological violence have to be developed in order to reduce health risks for all prisoners. Other future challenges are treatment forms for the increasing number of poly-drug users and sufficient prison-community linkages to establish sustainable pathways of throughcare.

Research is lacking, especially on risk behaviour and longitudinal studies, which bring about more insight into the transition period from prisoner's return into the community. The long-term effects of interventions regarding sustainability are mostly unknown.

Introduction

The majority of people held in European prisons have severe problems associated with drug use, together with related health and social disadvantages. Those categorised as problematic drug users (PDUs) con-

stitute a substantial proportion of prison populations in Europe. Taken only the number of sentenced prisoners with drug offences as main offence in penal institutions in the European Union, Croatia, Turkey and Norway (on 1 September 2008) “fifteen of the 26 countries for which information is available report proportions over 15%, indicating that drug-related crime is an important category of custodial offence in many European countries” (Carpentier et al. 2011). The number of drug users in prisons is even higher. With great variations between countries and prisons, studies from western European countries indicate a third to a half of prisoners having drug use experience before imprisonment (EMCDDA, 2009). Acknowledging the existence of a drug problem within prison walls often remains a taboo for prisoners, staff, management and politicians. Moreover, lack of continuity of care and support throughout the criminal justice system (CJS), from the moment of arrest to release from prison into the community, contributes to failures in reintegration, drives the “revolving door effect”, with drug users routinely caught in the criminal justice system and does not allow for the full implementation of the principle of equivalence of health services in prison comparable to those available in the community. This is mentioned in many instruments and guidelines from international bodies such as the WHO, Council of Europe and European Union – e.g. in its Action Plans on Drugs and in the Council Recommendation on the prevention and reduction of health-related harm associated with drug dependence (Council of Europe, 2003).

Prison administrations have traditionally responded to drug use through an abstinence-based approach within their establishments, which sits comfortably with institutions whose primary aim is preventing prisoners from committing further offences. In many European countries, the implementation of treatment (including substitution treatment) and harm reduction measures in the CJS is still insufficient, in spite of the widespread recognition of its value (Hedrich et al. 2011; EMCDDA, 2008). However, in the light of evidence showing the existence and extent of drug use within prisons (EMCDDA, 2008; EMCDDA, 2009), some European prison administrations have included harm reduction as one of the central goals of prison drug related interventions (Stöver et al. 2009). Nonetheless gaps in treatment delivery, discontinuity of care, treatment interruption are common phenomena throughout Europe when it comes to transfer from the community to prison services and vice versa. Public health of the whole community is also challenged, when prisoners are not provided with protective tools to prevent the spread of infectious diseases which can affect the prison environment, but also the community where prisoners will revert to.

Successful cooperation between prisons, other criminal justice institutions, health services, civil society and private sector organisations are quintessential for the success and outcome of the services. For instance some European studies of correctional treatment concluded that residential prison treatment was cost effective only if aftercare services were completed (Patel The Patel Report 2010, Griffith et al., 1999; McCollister et al., 2003). Continuity of care and links between prison, police detention and community care for drug users are also scarcely established, thus putting newly released prisoners at risk of relapse into drug misuse, overdose and even death (Farrell and Marsden, 2008) and reducing the chances for successful reintegration.

Most of the countries, who joined the European Union (EU) most recently have, to varying degrees, implemented effective treatment programmes and harm reduction projects outside of the prison system. However, effective drug treatment and blood-borne virus (BBV) prevention programmes within the prison walls and follow up services for released inmates with problematic drug use still have, in most New Member States, to be developed. Overall, prison policies and practices, in particular in dealing with drug users and related (infectious) diseases, remain an important EU concern. In few of the New Member States the public health imperative of a healthy prison system receives the political attention it deserves.

This research study is bringing together countries that reflect (some of the) different legal and penitentiary systems, varying “drug cultures” and levels of HIV/HCV problems among the New Member States. The study aims to find the commonalities and differences that influence the implementation of continuum of care approaches towards a healthy prison system. From that (policy) perspective the four countries chosen provide an interesting mix: Estonia, Hungary, Lithuania, and Poland (see **table 1**). Within the four countries visited there are a total of 269 prisons/penal institutions with a total of 108,473 prisoners in these

four countries.

Table 1: Country information

	Estonia	Hungary	Lithuania	Poland
Imprisonment rate (per 100,000 population) 2010	254	165	276	218
Occupancy level	97.2% (1.1.2010)	134.1% (31.12.2010)	100% (1.1. 2011)	97.1% (31.5.2011)
More than 3 years' sentence (2006)	62.8%	48.1%	56.3%	28.8%
Lifetime illicit drug use before imprisonment	no data	44% / 58% lifetime prevalence (2008/2009)	49% lifetime prevalence (2003)	49% lifetime prevalence adult men (2007)
Lifetime injecting drug use before imprisonment	no data	10% (2008)	no data	6% (2001)
Prison drug use last year	no data	8% (2008)	13% (2003)	20% (lifetime in prison, 2007)
Prison injecting drug use, lifetime	no data	0.2% / 0.7% (2008)	no data	3% (2001)

(Council of Europe, 2007; EMCDDA, 2009; EMCDDA, 2011: different numbers show different study results; International Centre for Prison Studies (ICPS), 2011)

The four countries of this study joined the European Union in 2004. All four countries have an above-average imprisonment rate (prisoners per 100,000 of population) compared to EU average at around 120 prisoners per 100,000 inhabitants (EMCDDA, 2009: 34). In Estonia, the prison population decreased overall since 1992, in Hungary and Lithuania there is no clear trend, in Poland there is an increase over the years. The latter might be connected to a policy change in Poland in 2000, which abolished the depenalization of drug possession installed by law in 1997, resulting in increasing numbers of drug offences (Krajewski, 2004). All countries experienced essential law changes since the end of the communist regime, e.g. the transferral of prison administration from the Ministry of Interior to the Ministry of Justice.

Infection rates (HIV and hepatitis) are very high in Estonia and Lithuania among drug users, and therefore in the custodial setting as well. Segregation of HIV-positive prisoners was practiced in Estonia and Lithuania, resulting in stigmatisation. In Estonia HIV-testing was compulsory until 2002.

Illicit drug use has increased during the 1990ies in all four countries considerably, and therefore also in prison. For example in Estonia recent data provided by the Prison Department show that 28% among the male and more than 50% of the female prison population are considered as drug addicts. In Lithuania the number of drug users in prison tripled in the last ten years from 6.6% in 1999 to 20.1% in 2009. Facing these increasing numbers of drug users, drug treatment has been developed in all four countries since the 1990ies both inside and outside prison walls. Prison-based opioid substitution treatment (OST) is scarcely offered in all four countries, if at all. In Estonia: no legal obstacles but practically non-existent, mainly due to discontinuation in arrest houses and negative attitude towards OST by both staff and inmates (Subata and Rotberga, 2009). Since the study was conducted OST has been implemented on low scale (Stöver and Thane, 2011).

The objectives of the study are operationalised into concrete questions on (i) prevalence, (ii) nature and severity, (iii) characteristics and correlates of problematic drug use, including risk behaviours for HIV and other infectious diseases, (iv) need for care and treatment services and available support systems. The

study also assesses differences in prevalence, nature, characteristics and need for services associated with gender. For a detailed report on this study see Stöver and Thane (2011).

Methods

The focus of this study was to collect data on and therefore increase knowledge and understanding of the spread of drug related health risks, and the health care services in prisons. This is being done by analysing the views of all actors concerned in order to come to proposals for improvement in the end. Only a comprehensive view on health care reality in prisons is providing the basis for future developments in this area. Health care can be viewed completely different by the different actors involved. Representatives of the prison administration for example might point to certain offers, which are not perceived by the target group of drug using inmates at all. On the other hand both views might go together quite congruently. As risks related around drug use is a sensitive topic, we chose methods that reflect the need for anonymity and confidentiality. Focus groups with independent translators, anonymous quantitative methods as well as the views of NGOs might contribute to a complete picture, which will be amended by the perceptions and experiences of prison staff of all levels, representatives of the Prison Administration and the Ministry of Justice.

The research project is using a triangulation methodology consisting of quantitative and qualitative instruments plus an extensive literature review. All data are taken together in order to better understand health care structures in the specific countries and prisons, to be able to assess gaps and needs, with the final goal to develop baselines for further health care development.

The quantitative survey was conducted by partners in the respective countries (independent NGO or university/researchers) who also translated the questionnaire into the respective languages as well as into Russian language. The questionnaire was developed on the basis of international instruments and was self-completed by the inmates. The survey took place in eight prisons in Estonia, Hungary, Poland, Lithuania (two prisons each), and in one prison hospital (Poland). Inmates focus group interviews were conducted in two prisons in each country with independent translators. Interviews with representatives of Ministry/prison administration, prison staff, and NGOs took place in each country. The prisons visited varied in the type of prisoners accommodated, i.e. males and females, adults and juveniles and pre-trial and sentenced prisoners substantially (see table 2). Altogether 593 people were interviewed: 490 prisoners in the quantitative survey, 66 participants in prisoner focus groups, 27 experts working in prison and in NGOs (e.g. prison directors, doctors, nurses, social worker) and 10 experts from the Ministries of Justice and/or Prison Administration. The survey was conducted between October 2008 and April 2009. Data analysis was done with SPSS 17.0 and comprises descriptive analysis.

However, the results of this research can not be taken as representative. The prisoners involved mostly were chosen because of a drug use history, and this group is therefore over-represented in order to allow a deep insight into drug-related issues in general in these countries.

Results

This paper gives a detailed picture of health status, drug use, health care and drug services in prison in Estonia, Hungary, Lithuania and Poland. 490 prisoners were interviewed by self-administered questionnaire. Of these 35.9% are women (for sample characteristics see **table 2**).

Physical, sexual, and psychological violence are important issues in the prisons visited. 22.9% of the sample confirms the existence of sexual violence in prison, physical and psychological violence is reported by 50.0% and 66.7% respectively.

Estonian Ministry of Justice representatives emphasize that self harm and suicide (attempts) are more or

less frequent in pre-trial and the first stage of imprisonment.

Table 2: Sample characteristics

	Estonia (n=167)	Hungary (n=102)	Lithuania (n=107)	Poland (n=114)	total (n=490)
female	49.7%	24.5%	35.5%	26.3%	35.9%
mean age	29.9 years (range 19-56)	33.5 years (range 20-67)	33.4 years (range 19-57)	27.8 years (range 20-45)	30.9 years (range 19-67)
length of imprisonment more than 3 years	54.2%	69.3%	50.5%	71.6%	61.1%
drug user	83.2%	not surveyed	56.1%	94.6%	

Health

The health status of prisoners is very heterogenous throughout the four countries studied. The spread of blood-bourne virus (BBV) infections varies greatly between countries (see **fig. 1**): 18.7% of the whole sample of 490 inmates in the four countries report a HIV infection and 32.2% a HCV infection (HCV-testing is mostly not offered in prison). While in Hungary almost nobody reported an infection with HIV or HCV, the proportion in the other three countries is up to 50% for HCV and 40% for HIV, prisoners in Estonia and Lithuania being most affected.

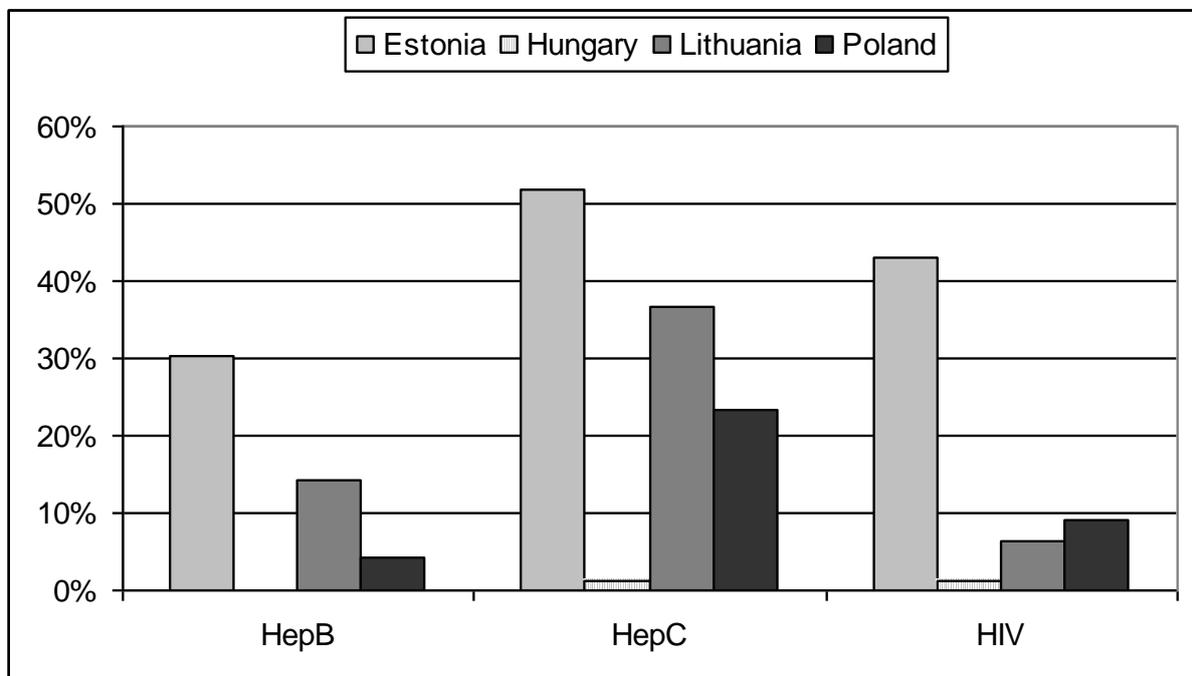


Fig. 1: Status of infection

Other common health problems include e.g. dental problems, psychological problems (often depressive symptoms), digestive and sleep disturbances, while tuberculosis is reported only marginally in all countries.

Drug use

The study shows that drug use takes place inside prisons (see **fig. 2**) although to a lesser degree than outside. The drug use experiences both inside and outside prison vary between the four countries substantially. Tobacco is the most commonly used substance, and the only legal one in prison. 67% of the women and 66% of the men report tobacco smoking in prison. For most substances the lifetime prevalence is lowest among the Hungarian sample and highest among the Estonian and Polish sample. According to members of the focus group in Lithuania approx. 50% of all prisoners are users of illegal drugs; “It is quite uncommon if somebody doesn’t use drugs”, said one respondent. Prisoners’ estimation about the spread of drug users in Lithuania is between 60-80%. On the other hand Hungarian data show a low presence of drug users in prisons. In Lithuania amphetamines are the most commonly used substance inside prison, while in Estonia benzodiazepines are more common, and the Hungarian sample reports only very little drug use.

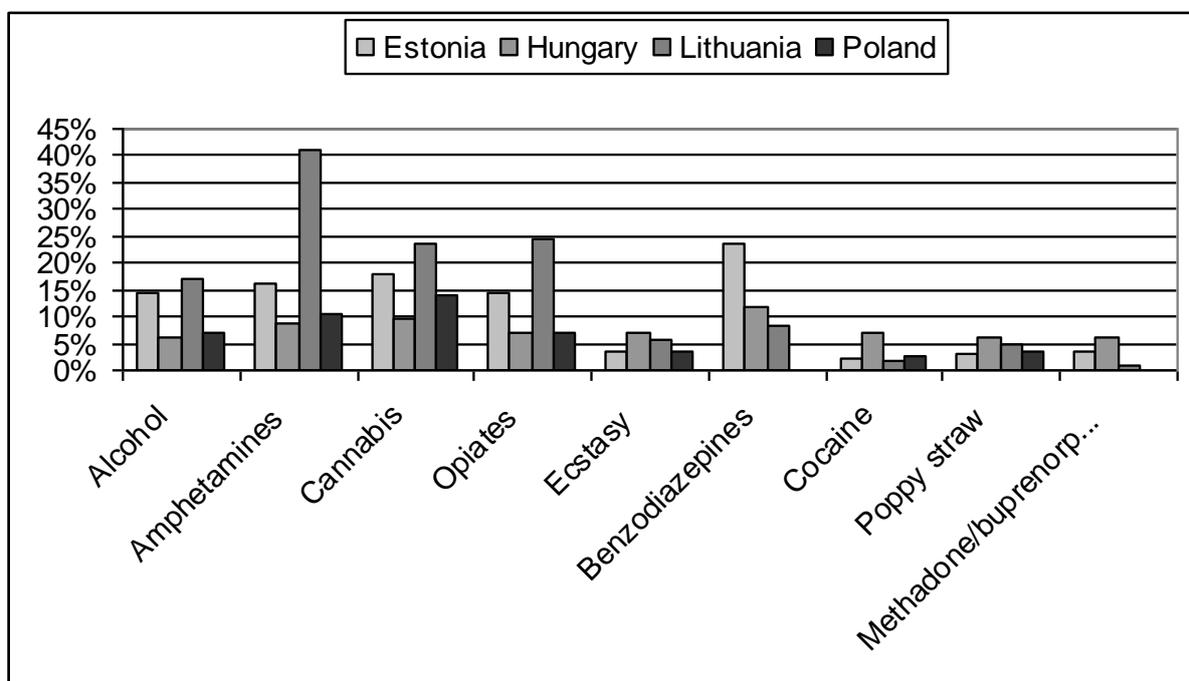


Fig. 2: Illicit drug use inside prison

Risk behaviour

The high prevalence of BBV infections in most of the prisons compared to community levels is in itself a massive threat for prison health care. On top of that risk behaviour, especially needle sharing, has been reported in many interviews (see **fig. 3**). If heroin or home-made opioids etc. are used, the drugs are mainly taken intravenously. In Lithuania inmates estimate, that approx. 40 people share one syringe while staff estimates no more than 10 people share one syringe. Prisoners state that everybody is sharing the same syringe as there is just one syringe available. Syringes are used until they are totally unusable; a new one would cost 6-9 packages of tobacco. Sharpening of the needle is done by using the window glass. Some prisoners describe the procedure: Those prisoners who are HIV-negative are boiling the needle for some minutes or try to use their own, the rest is sharing. According to the prisoners nobody cares for infections once the drugs are available. Additional risk behaviour takes place in the prisons to a rather large extent; tattooing is reported by almost half the sample (47.4%), other behaviour is reported less often: sharing a razor blade by 12.5%, and body piercing by 9.1%. Estonian inmates report that everybody is using their own needles for tattooing and felt this the least likely way of transmission.

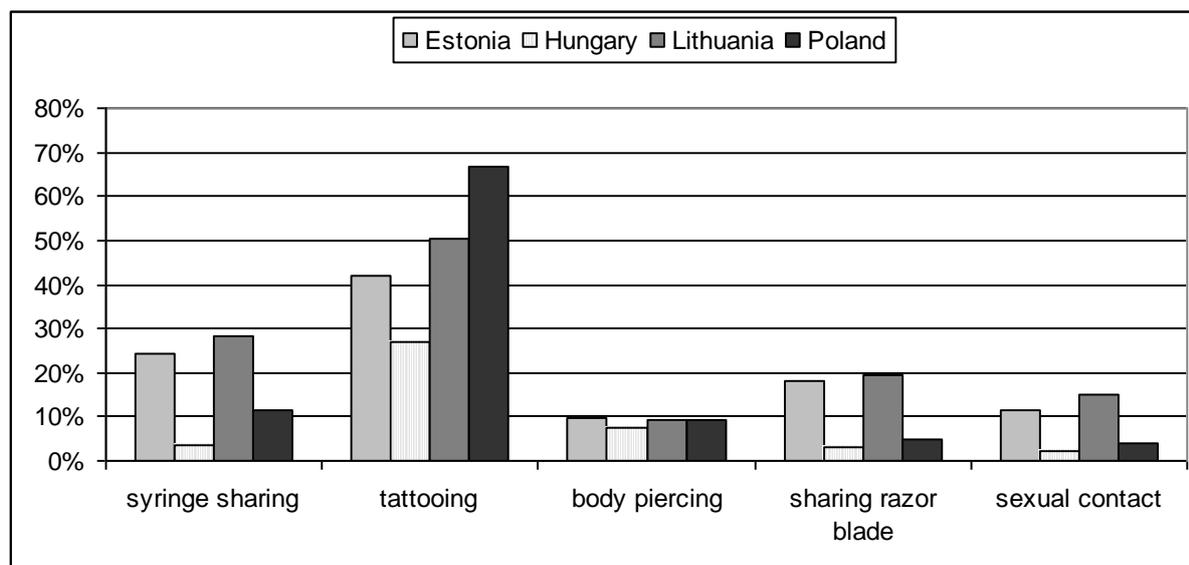


Fig. 3: Risk behaviour

Health and drug services

Measures to control drug use are mainly oriented towards supply reduction (controlling drug smuggling, drug testing) and to a lesser extent towards demand reduction. However, the acquisition of drugs in prison is perceived mainly as easy or very easy by 39.5% of the respondents and 60.5% said it's either very or rather difficult.

In all four countries few special drug prevention units, drug free and/or therapeutic wards have been installed. These units mostly are characterized by better living conditions and insofar are attractive for prisoners to apply for. Better living conditions thus are given as reward for abstaining from drugs. Often there are not enough places in these units to meet the needs, resulting in long waiting lists. In Estonia prisoners might get on the drug free unit 6-12 months before release. One important obstacle for not introducing harm reduction measures in prisons is the basic abstinence-orientation to be found in many prison visits throughout the research. Although there are many (former) opioid users incarcerated, only Poland has introduced OST yet (in a few prisons). The basic problem in introducing OST seems to be on the one hand the lack of possibilities to continue treatment after release. On the other hand opioid addicted prisoners often get into the prison institution after they spent days, weeks or even months in police detention where they already run through withdrawal processes. In Estonia both inmates and staff are often reluctant towards OST, inmates sometimes report bad experiences with community-based OST.

The drug services most often desired by the inmates were health education training (44.8%), detoxification with medication (39.7%), individual counselling (38.4%), prison drug services (35.4%) and peer-support (33.9%).

In some countries more confidentiality of drug services has been demanded by prisoners. Especially psychological drug treatments are seen as problematic because prisoners fear that personal and confidential information could be disclosed. In several countries visited the information policy regarding health care delivery and treatment is perceived by prisoners as insufficient or intransparent (e.g. provision of pills). This partly leads to mistrust and a negative attitudes towards prison health care. This is reflected by staff comments, that rumours about HIV- treatment (HAART) is influencing the inmates decisions and can contradict medical advice.

In several countries visited a discrepancy could be observed in the perceptions of prison health care by prisoners and officials. Whereas 20.6% of prisoners are rating the quality of health care services as rather good or very good, 79.3% as rather bad or very bad (see **fig. 4**), the professionals (doctors, nurses) often are assessing the quality of prison health care as partly higher than in the community, or as sufficient to

meet the health care needs of prisoners.

The treatment quality stated by the inmates does not differ that much between countries. In Hungary almost one third of inmates stated the treatment quality to be very good or rather good, while in the other countries it is less than a fifth.

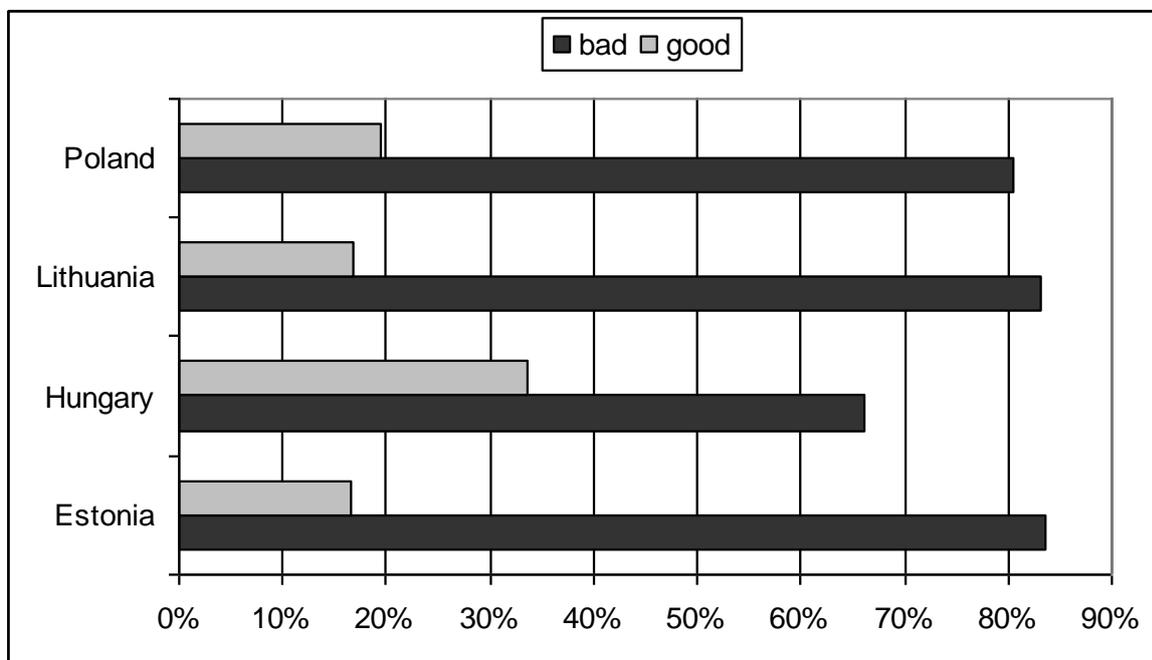


Fig. 4: Rating of quality of health care services in prison

It became clear that general prison conditions like overcrowding affect the health status of prisoners and are posing serious problems to health care delivery in the sample prisons visited. Thus, reducing overcrowding is at the same time improving living, health and also working conditions for those who have to live and work in prisons.

Growing expenditures for healthcare in prisons pose enormous threats due to the economic crisis, and restricted budgets in the countries visited. This is also felt by staff and inmates when medication, treatment or additional food is not available to meet all needs.

Discussion

In the countries visited in this study, rates of drug users, drug injectors and BBV infections (HIV/HCV) in prison populations are much higher than those found in the general population outside of prisons. This is primarily related to (injecting) drug use and to unsafe injection practices, both in the community and in prisons, and also to unprotected sexual contacts and tattooing in prisons. As the majority of our sample is resp. was drug users and therefore not representative for prisoners in general, characteristics concerning health and drug use are overrepresented.

Differences between the four countries related to the prevalence of drug use and of infections among the inmates became clear. Estonia and Lithuania having the highest rates of infectious diseases. The type of drugs used differs as well as general drug use prevalence, which is rather low in Hungary. However, also in Hungary on a local level data are indicating risk potential (at least in the Budapest Prison), where a recent study revealed that drug use before imprisonment has been stated by 58% of the respondents, daily use of benzodiazepines before imprisonment by 29% and intravenous drug use by 33% (Fliegau, 2010).

Health and drug services are available in the prison setting of all countries, mainly focussing on abstinence-oriented approaches. Therapy within the closed setting of a prison necessarily leads to problems of

confidentiality, mistrust etc. Harm reduction measures as well as opioid substitution treatment (OST) are rarely implemented, and if rather poor and patchy, thus exposing both prisoners and staff to health risks of infectious diseases.

Reducing overcrowding affects the health status of prisoners positively and should be initiated and/or maintained in all countries visited. Although overcrowding (measured by the occupancy level, see table 1) can only be found in Hungary on a national level, overcrowding can occur also temporarily in single institutions.

With regard to a decrease of drug use and related infectious diseases, the ‘Comprehensive Package for the prevention, treatment and care of HIV among IDUs’ provided by the UNODC – as a systematic reaction towards HIV epidemics – needs to be applied in all details in order to make a difference to the current mostly abstinence-oriented approaches. The ‘Comprehensive Package’ includes nine interventions:

1. Needle and syringe programmes
2. Opioid substitution treatment (OST) and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral treatment (ARV)
5. Prevention and treatment of sexually transmitted infections (STI):
6. Condom programmes
7. Targeted information, education and communication
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of Tuberculosis

None of the four countries has implemented all these interventions, therefore efforts are needed to further develop the prison health care services. Some barriers to this development have been identified and key requirements to overcome will be outlined in the following part (see also Stöver et al., 2007).

Barriers to improvement of health care in prisons and requirements to ensure sustainability

Looking at good practice examples in the prisons the countries visited and examples from other countries demonstrate that it is possible to overcome barriers to implement effective and efficient health care services especially for incarcerated drug users. It is important to acknowledge the requirements that need to be in place to overcome the various problems that occur. There are certain requirements that need to be formulated at all relevant levels: attitude towards and knowledge about drug dependency and health risks for all key actors, necessary changes both at the policy and practice level. Guidelines, protocols, advices need to be formulated from evidence-based practice, as opposed to moral and value judgements. Research has demonstrated that crucial elements of health care services are already well established and well evaluated in prisons and the wider community, providing a firm foundation for other countries and prison administrations to further develop their own services.

1. Overcoming institutional challenges

Despite obvious damaging health risks for prisoners and prison staff (Bögemann, 2007; Stöver and Michels, 2010) the obstacles to and arguments against target group specific and evidence-based services for drug users within prisons have remained disturbingly constant through the years (Stöver and Lines, 2006). Prisons are by definition places of secure custody and this security-based ethos infuses policy in all areas of prison life, including the provision of health care. Therefore experts stress the necessity to regard prisoners also as patients (Coyle, 2007) with specific and defined ethical basis (Hayton, 2007; Restellini, 2007). Prisons are also rooted in a culture of surveillance, in which prohibitionist approaches towards drug use are even more firmly entrenched than in the outside community. Both of these characteristics are sources of resistance to the implementation of adequate health care services, they affect prevention, treatment, care and support. The security-based ethos has meant that prison systems have traditionally

viewed health threats from a perspective of institutional security, rather than from one rooted in health care or human rights. As a result, prisoners living with HBV/HCV, TB or HIV/AIDS, and drug users have often been dealt with as security risks to be contained and controlled, rather than individuals in need of compassionate and specialized health services. The most blatant manifestations of this coercive approach have been policies of mandatory HIV testing and of isolating HIV-positive prisoners, which was common in Estonia and Lithuania.

While such policies have been largely – but by no means totally – eliminated in European prisons in favour of voluntary testing and integration, the attitudes underlying them remain in force. According to this coercive security-based ethos, OST, syringes, condoms and bleach are seen only as potential weapons and or instruments for criminal behaviour (e.g. trafficking methadone, hiding drugs in the body).

A recent study found that security constraints common to most prisons may lead health care workers to engage in risky behaviours (like re-capping found syringes or below-average hand-washing rates) that increased their risk of blood-borne infections. (Stöver and Lines, 2006).

2. Overcoming abstinence orientation as pre-dominant response

One important obstacle for not introducing harm reduction measures in prisons is the basic *abstinence-orientation* to be found in many prison visits throughout the research. This accounts not only for doctors, nurses and other responsible persons in the prison service but for prisoners themselves. This goal is identical with the goal of the sentence itself (to enable prisoners to live a life without committing criminal offences, i.e. drug consumption, dealing). Despite the fact that drug use occurs in prisons and where the consequences to health are clearly visible, the goal of abstinence remains, and it encourages at the expense of considering other goals, such as methadone maintenance for those who do not wish or are not able to cease using drugs during imprisonment, and syringe exchange programmes to prevent the spread of communicable diseases. Harm reduction measures for instance are seen in the model of prison as a time of abstinence as conflicting with the needs of prisoners and staff, and also as condoning criminal activity within a criminal justice setting. Estonian interview partners state a change of attitudes towards harm reduction measures (becoming more reluctant again) with a change of staff within the Ministry of Justice.

The reasons for resistance of inmates against the introduction of harm reduction measures and other target-oriented health care services for prisoners are manifold, but basically to be found in the very structure of closed settings like prisons, including fear of being known as a drug user respectively addict, fear of losing privileges, fear of not getting onto work or qualification programmes, fear of partners, family and relatives knowing they are using drugs in prisons.

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

3. Information, education and communication

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

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

Prevention programmes with a harm reduction orientation must therefore reflect these particular condi-

tions and individual responses and behaviour in order to be effective. Community-based strategies cannot simply be transferred into the prison setting without responding to the particularities of the risk environments and the limitations available for behaviour change (e.g. lack of access to sterile syringes). If prevention messages are to be accessible and relevant to the target group, specific living and risk conditions must be identified and prevention strategies tailored to these circumstances and different target groups (Stöver and Lines, 2006). The use of modern educational methods (e.g. interactive methods) and of visual aids is now well established. The WHO recommends:

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

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

Target group specific education is needed which is directed to the various and heterogeneous needs and resources of different prisoner groups and staff groups. This would include new strategies of transporting prevention messages (e.g. interactive ways, role plays of safer use and safer sex (see with many practical examples: Stöver and Trautmann, 2001), as well as peer education initiatives for both prisoners and prison staff) (Stöver and Lines, 2006). But within the prison environment it is not only the prisoners who need HCV/HBV/HIV/AIDS services, as prison staff may be placed at increased vulnerability to HCV/HIV infection because of unsafe working environments. In many cases, misinformation about routes of transmission of infectious diseases – in particular the false belief that prison staff are placed at risk of HCV/HIV infection via casual contact with HCV/HIV-positive prisoners – leads to both anxiety among prison workers and to human rights abuses of prisoners living with HIV/ AIDS. Therefore educational and training programmes for staff are essential.

4. Adjustments in regulations and legislation

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

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

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

programmes, and the ethical treatment of prisoners.

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

5. Reduction of prison populations and prison reform

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

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

Action to reduce prison populations and prison overcrowding should accompany – and be seen as an integral component of – a comprehensive strategy to prevent the transmission of infectious diseases in prisons, to improve prison health care generally, and to improve prison conditions. This should include the development of non-custodial strategies to reduce the over-incarceration of drug users, and to establish government targets for reducing prison overcrowding generally. Finally measures to reduce the size of the prison population would have great benefit and achieve considerable savings (Black et al., 2004).

6. Commitment and political and management leadership

Political and management leadership already in the process of finding a consensus in implementing or expanding target group specific health care is necessary. Government officials, policy makers, and other relevant national and international stakeholders should take over responsibilities and develop leadership, which in a hierarchically structured and organised setting like prisons is of crucial importance.

The importance of political commitment and leadership has already been pointed out on international level. According to the Declaration of Commitment – United Nations General Assembly Special Session on HIV/AIDS ‘strong leadership at all levels of society is essential for an effective response to the [HIV/AIDS] epidemic’(Declaration of Commitment – United Nations General Assembly Special Session on HIV/ AIDS [aka UNGASS Declaration], June 2001). This is particularly important among prisoners who face higher risks and lack the necessary services and support to deal with health problems.

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

Government officials, senior prison authorities, the judiciary, senior health officials, and other informed individuals and groups, including health professional associations, civil society organisations, people living with HIV/ AIDS, prisoners/former prisoners, and prison managers and prison staff, have a crucial role to

play in mobilising political support for prison-based harm reduction interventions, and in supporting government actions necessary to effectively combat health damages in prisons.

7. Overcoming resistance from prisoners and prison staff

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

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

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

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

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

Resistance against substitution programmes

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

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

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

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

Engaging prison staff with harm reduction services – Several examples can be shown that prison staff can successfully and within a short period of time support harm reduction measures. The analysis of the introduction of harm reduction measures like needle exchange programmes in prisons (see also Meyenberg et al., 1999) convincingly shows that staff once educated and informed about the targets of specific programmes can be engaged in harm reduction measures.

8. Human rights legislation and international guidelines

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

With HBV/HCV and HIV/AIDS, the principle of equivalence has taken on new and additional urgency, and a growing number of important international health and human rights documents have specifically applied it to hepatitis HIV/AIDS (Lines and Stöver, 2006). The WHO has shown important leadership in this regard. In 1993, WHO published Guidelines on HIV infection and AIDS in prisons (1993), specifically applying the principle of equivalence to HIV/AIDS. *Principle 1* of the guidelines emphasizes, ‘All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination ... with respect to their legal status’. Since 1993, WHO has published a series of important documents on the issue of HIV/AIDS in prisons. They include Prison, drugs and society (2001); the Moscow Declaration (2003); a policy brief on reducing HIV transmission in prisons (2004); Status Paper on prisons and Tuberculosis (2007), Trencin statement on prisons and mental health (2007), Women’s health in prison (2009), The Madrid Recommendation: Health protection in prisons as an essential part of public health (2010), and a status paper on prisons, drugs and harm reduction (2005) and finally the Health in Prison Guide (Møller et al., 2007). All have been important, both in highlighting the necessity of health care in prisons equivalent to that in the community and in providing advocates and NGOs with tools to fight for national policy change.

Another development since the mid-1990s that has helped drive health policy change and respect for human rights is the establishment of networks of NGOs and/or prison officials to share and promote models of best practice, and in some cases to engage in advocacy initiatives. Perhaps the most well known and influential of these has been the WHO Health in Prisons Project (HIPP, see WHO, 2011), established in 1995. Annual HIPP conferences and networking meetings have highlighted numerous prison health issues, including TB, HBV/HCV, HIV/AIDS. Similar networks created during this time but with a specific focus on HCV, HIV/AIDS and harm reduction include the European Network on Drugs and Infections Prevention in Prison (ENDIPP, see European Commission, 2008) and the Central and Eastern European Harm Reduction Network (CEEHRN, now EHRN, see EHRN, 2010). While the latter does not focus exclusively on prisons, it does provide an important forum for NGOs working on health in prisons.

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

9. The need for protocols, standards of care and guidelines

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

Clear protocols and standards are necessary to ensure the human rights of prisoners are maintained and also allow for detainees to address concerns on the basis of treatment which does not adhere to such standards. The Council of Europe has developed rules for the care of prisoners in the EU, the purpose of which are to establish minimum standards for prison administrations; to serve as a 'stimulus to prisons and administrations' so they develop policies based on good practice and principles of equity; to encourage prison staff to adopt a professional attitude that reflects the 'important social and moral qualities of their work' and to provide conditions to optimise this and to provide realistic criteria for prison administrations and those responsible for inspecting prisons on which to base their judgements of performance and 'measure progress towards higher standards' (Council of Europe, 1993).

10. Continuity of treatment

Prisoners should begin to be prepared for release on the day the sentence starts as part of the sentence planning process. All staff and NGOs available and working in prisons (see chapter 3.5) 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 (e.g. antiretroviral treatment),
- cooperating with external drug services or doctors in planning a prisoner's release (e.g. continuation of OST in the community),
- involving self-help groups in the release phase; and
- taking effective measures in prison to prevent prisoners from dying of a drug overdose shortly after release.
- The challenge for prison services in facilitating a successful return to the community for prisoners without relapsing is not only to treat a drug problem but also to address other issues, including employability, educational deficits and maintaining family ties.

Aftercare

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

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

- In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-offenders are most likely to relapse and re-offend.

Working with families and maintaining family ties

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

Throughcare

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

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

The Scottish Prison Service has general considerations required for throughcare:

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

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

11. Opioid Substitution treatment (OST) in prisons

In order to meet the requirement that prisoners have access to the same treatments offered outside prison, prisoners should be permitted to participate in methadone treatment in detention, both those who had already started substitution treatment before imprisonment; and those who apply for participation in methadone treatment after incarceration, while in prison, and who meet the requirements for this treatment (Stöver and Weilandt, 2007).

Data from international studies show that some key elements have to be considered when starting substitution treatment (see also Kastelic, 2007; Kastelic et al., 2008):

- Continuity of care is required to maintain the benefits of methadone maintenance treatment.

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

12. Needle exchange programmes in prisons

Despite the fact that the results of evaluations and practical experiences are encouraging, needle exchange programmes remain a somewhat exotic preventive measure within prisons (only available in about 65 prisons in 10 countries worldwide). In the countries visited for this study, no needle exchange programme has been implemented, although high risk behaviour has been analysed. The resistance of staff members, politicians and trade unions against needle exchange programmes and harm reduction measures in general is blocking the introduction of successful HIV/AIDS and Hepatitis preventive measures. Also prisoners expressed their resistance due to several reasons of fears regarding negative consequences of becoming known as 'addicts'. Syringe exchange schemes are still a hot political issue because they are supposed to symbolise the failure of keeping prisons 'drug free'. Needle exchange programmes are still subject to political decisions and strategies.

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

One important lesson to be learned is that these measures are part of a broader health goal and should therefore be embedded in a global comprehensive prison-based drug and health promotion strategy. This process was part of the success of needle exchange programmes. To this end, additional harm reduction measures are discussed and some are being introduced in prison health care services in some countries. Despite these advances, prison based harm reduction measures are progressing slowly compared to the speed of the spread of infectious diseases (Stöver and Nelles, 2003).

Conclusions

Although drug dependence is defined as a disease, drug users are often put into prison because of their drug using behaviour, be it directly (offences against drug laws) or indirectly (offences in order to obtain or finance drugs). This leads to many health-related problems within prison walls and in connection with the community. Depenalisation of drug users and measures regarding alternatives to imprisonment should therefore be further envisaged and encouraged.

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

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

staff.

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

In 2007 the European Commission (EC) stated that “Harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equivalence adopted by UN General Assembly, UNAIDS/WHO and UNODC, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services (European Commission, 2007, conclusion 5). Programmes against physical, sexual, and psychological violence have to be developed in order to reduce health risks for all prisoners. Other future challenges are treatment forms for the increasing number of poly-drug users and sufficient prison-community linkages to establish sustainable pathways of through-care.

Research is lacking, especially on risk behaviour and longitudinal studies, which bring about more insight into the transition period from prisoner’s return into the community. The long-term effects of interventions regarding sustainability are mostly unknown.

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Veröffentlicht / Published:
24. August 2011 / August 23, 2011

Eingereicht / Received:
15. August 2011 / August 15, 2011

Angenommen / Accepted:
22. August 2011 / August 22, 2011