DRUG-TREATMENT SYSTEMS IN PRISONS IN EASTERN AND SOUTH-EAST EUROPE

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COUNCIL OF EUROPE
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*All references to Kosovo, whether the territory, institutions or population, in this text shall be understood in full compliance with United Nations Security Council Resolution 1244 and without prejudice to the status of Kosovo.

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Abbreviations and definitions

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral therapy
BiH	Bosnia and Herzegovina (= FBiH + Republika Srpska)
BSS	Behavioural Surveillance Survey
CCH	central correctional hospital
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
FBiH	Federation of Bosnia and Herzegovina
FPS	Federal Penitentiary Service of the Ministry of Justice, Russia
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HRP	harm reduction programme
IBBS	Integrated Bio-Behavioural Survey
IDU	injecting drug user
KAP	Survey of Knowledge, Attitudes and Practices (ages 15-64 and 15-24)
LGBTI	lesbian, gay, bisexual, transexual/transgender and intersexed
MDR TB	multi drug resistant tuberculosis
MMT	Methadone Maintenance Treatment
MoHSD	Ministry of Health and Social Development in Russia
MoH	Ministry of Health
NGO	non-governmental organisation
OAT	opioid agonist treatment, a.k.a. opioid substitution treatment
PCF	Programmatic Cooperation Framework – Joint Council of Europe and European Union project
PWID	people who inject drugs
PWUD	people who use drugs
RF	Russian Federation
SPSU	State Penitentiary Service of Ukraine
STI	sexually transmitted infections
TB	Tuberculosis
UN	United Nations
UN CAT	UN Committee Against Torture
UNODC	UN Office on Drugs and Crime
VCT	voluntary counselling and testing
WHO	World Health Organization

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Furthermore, our special thanks go to all involved in the production of this Final Report, especially David Marteau, Christina Padberg and Daniela Jamin.

Frankfurt and Strasbourg, March 2017

Foreword

With Winston Churchill's permission, I would give another twist to the idea that one can judge a community by the way it treats its most vulnerable members: prisons are not only a litmus test for the state of a society, but they are part of society. And they mirror society – the good, the bad and the ugly – occasionally sampled, often magnified or with a time-lag.

In varying degrees, the state assumes responsibility for those it decides to hold in custody. The state's responsibility is proportionate to the control it has over the situation and its outcome. It follows that the authorities' duty of care includes the responsibility to make reasonable arrangements to ensure the safety and physical integrity of persons committed to prison. It is equally true that people sent to prison do not leave their human rights outside the prison gates, whether or not they use drugs.

Another important factor is that prisons are permeable social structures: people committed to custody come from the community and they interact with others who work in prison, or who intervene in prisons in whatever capacity or frequency, or who visit other people who are in prison. Whether by repeated occurrence or ultimate ambition, by and large people in prison go back into the community.

Prisons reflect society. The psychoactive experience and drugs are no exception. People in prison use, peddle and traffic. Some already use drugs or are addicted before admission; others take drugs for the first time in prison. Squalid living conditions or an impoverished social environment, together with loss of autonomy and self-determination, are known contributory factors in the use of psychoactive substances.

There is no doubt that use of psychoactive substances and drugs can be dangerous and can cause severe harm. Recreational drug use and self-medication are not advisable and do entail risks. Nevertheless, the approach to drug use in the community can minimise risk, embrace harm reduction and encourage or facilitate the treatment and rehabilitation of heavy or addicted drug users. These measures have proved their worth in treatment and in prevention, both as regards first use and in the escalation from low risk to risky to harmful use.

In the same way as in the community, the response to drug use in a custodial setting can help users, or it can increase the risk of harm.

Experience shows that the repressive component of drug policy can stigmatise people who use drugs, and can discourage them from seeking help or speaking out about their issues, their drug problem and the underlying causes. It may lead to people taking drugs that are unreliable or with unpredictable effects; it may also lead to administering the drugs in unhygienic or otherwise unsafe conditions; it can even be conducive to heavier use. This is also true in custodial settings.

People in prison sometimes become heavy users there. Some inject drugs and they often share injecting material – even crude, improvised, frighteningly inappropriate equipment – which is seldom sterilised and therefore serves to communicate diseases. Prison disciplinary systems can discourage prisoners from seeking assistance for a fellow inmate who may be overdosing on heroin, if they could themselves face disciplinary actions that could entail more time in prison. A life that might have been saved could in this way be lost.

Conversely, experience shows that an approach to drugs in prison that puts a premium on harm reduction – without condoning drug use – can encourage safer practices or even facilitate transit towards moderate use, treatment and abstinence. This fits the human rights agenda.

This study on drug-treatment systems in prisons in Eastern and South-East Europe offers a wealth of information about the situation in nine countries and in Kosovo*. It casts a light on good practices and also on the challenges of drug treatment, prevention, substitution treatment, and syringe- and needle-exchange programmes.

These measures have proved their efficacy in reducing drug use and drug-related harm, such as disease transmission, and are supported by practitioners, researchers and scientists around the world. They are also endorsed by a number of specialised United Nations agencies. These responses are sensitive to human rights and make sense in human and humane terms, and in social terms. The economic benefits of these responses are also undeniable, given that, according to a study by the London School of Economics, their yield against investment is twenty to one.

Jan Malinowski

Executive Secretary
of the Pompidou Group
of the Council of Europe

Executive summary

This research project on drug-treatment systems in prisons in Eastern and South-East Europe looks in detail into the situation of drug users among criminal justice populations and the corresponding health-care responses in nine countries in Eastern and South-East Europe – Albania, Bosnia-Herzegovina, Georgia, Moldova, Montenegro, Russia, Serbia, "the former Yugoslav Republic of Macedonia" and Ukraine – and Kosovo*.

It was conducted between 2013 and 2016, and is a first attempt to collect relevant data on drug use among prison populations and the related responses in the nine countries and Kosovo*.

Although the places chosen are quite heterogeneous in size, structure, legislation, economy, culture and language, they are all in a process of economic, social and cultural transition. This has triggered reforms of some of their prison systems and policies but it has also led to financial and political instability and lack of leadership due to frequent changes in the prison systems' top management.

The Pompidou Group has been working for several years in Eastern and South-East Europe on prison-related topics and has developed a sizeable network of experts and expertise there. Working together with local government and civil society partners, the Pompidou Group has developed solutions that aim to improve the health of prisoners in accordance with human rights principles.

Many of the places included in this research are in phases of transition: financial and economic burdens are mirrored in prisons. Safety is the priority task of prisons and it consumes a large part of the financial resources that are available for the management of prisons. Health issues are often lower on the (political) agenda of ministries and prison administrations, and thus governors.

Drug use is perceived as one of the main problems faced by prison systems because it threatens security, dominates relationships between prisoners and staff, and leads to violence, bullying and mobbing for prisoners and often for their spouses, families and friends in the community.

Looking at the (often limited) data on the health status of prisoners in these nine countries and Kosovo*, almost all diseases are over-represented in prisons compared to the general population. The same is true for illicit drug use and dependence in prisons, which are disproportionally higher than in the community.

The prevalence of infectious diseases – particularly human immunodeficiency virus (HIV) and Aids, hepatitis B and C, and tuberculosis (TB) – is also often much higher in prisons than outside. Apart from TB, transmission of communicable diseases is mostly driven by the sharing of drug injecting equipment. Estimates of HIV prevalence range from <1% to 20%, which is disproportionally higher than in the community.

High rates of injecting drug use, if coupled with lack of access to evidence-based prevention measures, can result in a rapid spread of HIV and hepatitis B and C. Within the places studied there is much evidence that high-risk behaviour is continuing in prisons: studies indicate that more than half of the drug injecting population report in-prison injection drug use, of whom the majority shared injection equipment with several prisoners.

In many places there is an almost complete unavailability of effective addiction treatment – e.g. opiate substitution or agonist treatment (OAT) – or the potential of such treatment has not yet been fully exploited. Detoxification treatment alone or short-term continuation and interruption of treatment can have negative effects on the health of drug-dependent persons. However, some places have been applying state-of-the-art addiction treatment for quite some time (e.g. "the former Yugoslav Republic of Macedonia").

In most cases, the prevention and treatment of infectious diseases clearly lack harm-reduction interventions. Among the places considered in this study, Moldova is the only country with existing harm-reduction measures in prisons (e.g. prison-based needle-exchange programmes).

Models of good practice already exist in some of the places covered by this study. Nevertheless, an extra effort is needed to learn from one another by exchanging and encouraging best policies and practices in the countries.

The experts' general recommendation is to support drug-treatment interventions, and continue prison-based drug policy debates in the places covered by this research project, and introduce reforms that would refocus current drug-control regimes towards a more balanced approach. That would include amending existing drug legislation and making sure that prisons are not filled with people sentenced for drug use per se or for possession of small amounts for personal use.

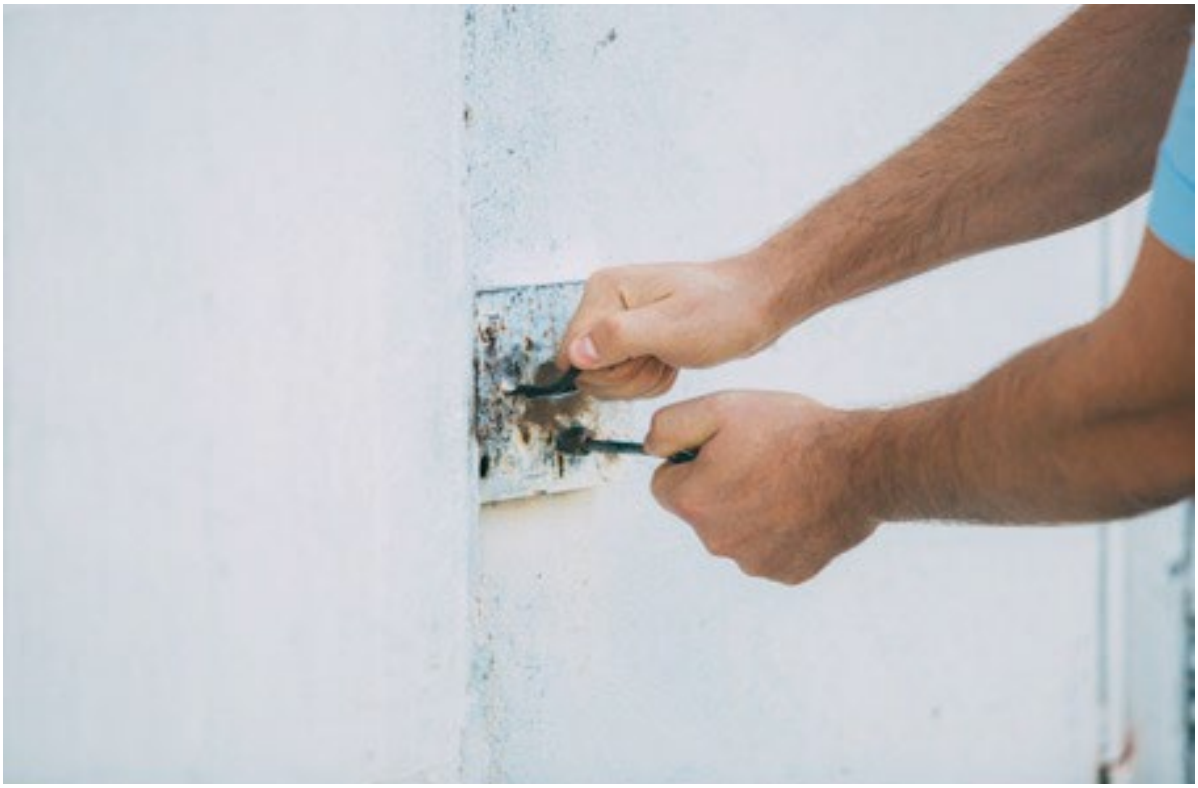
Chapter 1

Background

1.1. THE PRISON CONTEXT

Prison is generally a rather bleak, sometimes hostile, sometimes even dangerous environment. This is not intended as a criticism of those who work in and around the prison system. Nor does it make assumptions about the overall characteristics of the prisoner population (all types of people go to jail for all sorts of reasons). It is simply a fact. Official statistics on mental health and violence support this statement.

Of course, one could also argue that in most cases prisons could be even worse places than they actually are, given the antiquated conditions in which people are housed and the prevalence of mental health problems – including addiction – and violent behaviour that characterise the prisoner population.



Which of these conclusions should be most predictive of drug use, drug injecting and sharing of injection equipment in prisons? Should we expect these behaviours to be at their worst in prison? Or does drug use, injecting and sharing reflect some degree at least of self-control and environmental influence that reduces the worst-case scenario of prison life, including violence, boredom and regret? To try to answer this question we have to consider the predictive utility of different models of addiction.

1.2. DRUG USE AND RELATED HEALTH PROBLEMS IN PRISONS

Drug use, blood-borne virus infections (including HIV/Aids and viral hepatitis)[1] and airborne infections (TB) are serious health problems in prisons and the criminal justice systems of most countries worldwide. The frequency of such infections makes these institutions important settings for the provision of effective drug-related services and the prevention of infectious diseases to help reduce the damaging effects of drug use on health, prison safety and security, and on the broader community (through increased reoffending and the public health impact of onward transmission of infections on release).

A large proportion of the people who enter criminal justice systems and prisons have a history of drug use and injecting. Many of these individuals continue to use drugs while they are in prison. The prison environment may have a positive impact on some drug users, helping them to stop or reduce their drug use or to use less frequently, but for others prison will be an environment where they switch to more harmful patterns of drug use or even start using drugs.

Because they are often overcrowded, stressful, hostile and (sometimes) violent places, prisons are high-risk environments in which individuals from poor communities or from ethnic and social minorities, migrants and people who use drugs are over-represented. Many among prison populations carry a range of health burdens.

A European study of health problems in prisons highlighted three main issues: substance abuse, mental health problems and communicable diseases.[2] These three problem areas are closely inter-related. Some of the harms associated with drug use 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 TB (and HIV/Aids) in some countries;
- restricted access to harm-reduction services and treatment for drug dependence and blood-borne/airborne viruses;
- increased risk of death by drug overdose after release;
- increased risks of transmission of (prison-acquired) infections;
- exacerbation of complex and intertwined additional health problems;
- increased risks of reoffending after release.

Although alternatives to imprisonment have been introduced in many countries, an increasing number of people who have used or continue to use drugs enter prisons each year. Only some are in prison as a result of conviction for a drug offence. Most of them are there for other drug-related offences, typically acquisitive crime.

Generally, the number of drug users with problematic consumption patterns in prison populations has increased dramatically across many European countries over the past two decades.[3] In a European overview, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) calculated that every sixth prisoner is thought to be a problem drug user.[4] 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 drug users has been associated with increased incarceration and subsequently increased drug consumption in prison communities across many European states.[5] For example in Kosovo* the numbers of drug-related offences compared to all crimes that resulted in imprisonment was as follows: in 2012, drug-related crimes (549) represented 37% of all cases (1 484); in 2013 drug-related cases (578) represented 45% of the total (1 284).

This fact inevitably affects life in penal institutions. Drugs have become a central theme, a dominant 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. In many respects daily routine in prisons is dictated by drug-dependent inmates and drug-related problems: drug-related deaths, drug-induced medical

1. Fazel, Bains and Doll 2006.
2. Tomasevski 1992.
3. EMCDDA defines problematic drug use as "injecting drug use or long duration/regular use of heroin/cocaine and/or amphetamines". This definition can include other opioids, e.g. methadone. Drug consumption is deemed problematic if it is combined with other risky behaviour, causes damage to other people or has negative social consequences.
4. Hedrich et al. 2012.
5. EMCDDA 2012a.

emergency, increased number of people who use drugs, hierarchies of dealers, debts, mixed drugs, drugs of poor quality, widely variable purity of drugs and the risks of infection (particularly HIV and hepatitis) resulting from the shared use of contaminated injecting equipment and drugs. In many countries drugs have become the predominant medium and currency in prison subcultures. Many routine activities among prisoners are directed towards the acquisition, smuggling, consumption, sale and financing of drugs.

Prison managers are faced with increased public pressure to keep prisons drug-free. Although drug use and the possession of syringes and paraphernalia for injection or tattooing by the inmates are prohibited by internal regulations, a significant proportion of prisoners continue to take injectable drugs, despite the fact that non-safe injection practices are a major route for the transmission of HIV and hepatitis C virus (HCV). Injecting drug use is especially unsafe in prison: as they have no access to clean injection equipment, those who inject drugs while in prison are more likely to share injection equipment and they share this used equipment with significantly more people than they would when engaging in injecting drug use in the community. They also share it with fellow prisoners who have an increased likelihood of carrying HIV and serious viral and bacterial infections (e.g. endocarditis and septicaemia).

Few prison managers talk frankly and in public about drug use in prisons, and few of them establish adequate drug services or develop new drug strategies. People who confirm that drug use is prevalent in prisons and that prison is a high-risk environment are frequently blamed for failing to maintain security in prisons, so a considerable number of prison managers continue to deny or ignore drug use in prison.

Furthermore, many prison physicians, nurses and health-care workers mistakenly believe they can cure most inmates' drug problems by temporarily forcing them to stop using drugs. However, in order to be effective and sustainable, drug treatment needs to address the root causes of addiction. Such responses illustrate why dealing with people who are dependent on drugs in detention is difficult. The goal of rehabilitating convicts 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 increasingly difficult. The current judicial situation is paradoxical: a realistic solution has to be found to a significant problem that is not supposed to exist – drugs in prisons.

1.3. THE RESEARCH

This research project on drug-treatment systems in prisons in Eastern and South-East Europe began in the context outlined above. The study aimed to look in detail at the situation of drug users among criminal justice populations, and the corresponding health-care responses, in nine countries – Albania, Bosnia-Herzegovina, Georgia, Moldova, Montenegro, Russia, Serbia, "the former Yugoslav Republic of Macedonia" and Ukraine – and in Kosovo*.

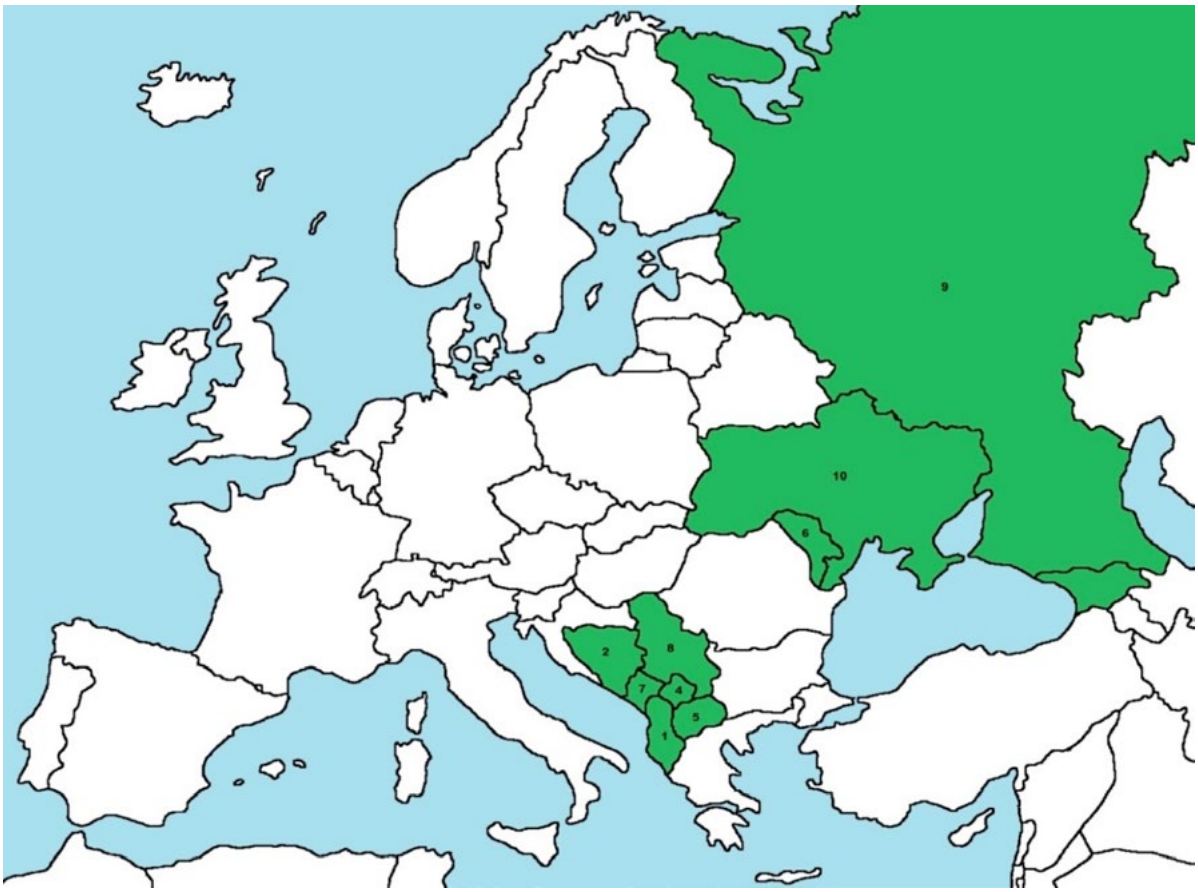
The rationale for the selection of these places was that the EMCDDA (2012a) study had already collected data on the situation of drug users in a range of prisons in European Union (EU) member states, but no such information was available for the nine countries mentioned above and for Kosovo*. This study, conducted in 2013-16, was a first attempt to collect relevant data on drug use among people committed to a prison establishment and the related responses in the nine countries and Kosovo*.

Although the places covered by this study are quite heterogeneous in structure, legislation, economy and language, they are all in a process of economic, social and cultural transition, which emerged as a dominant structural influence on certain developments.

The Pompidou Group has been working for several years with them on prison-related topics and has developed a sizeable network of experts and expertise throughout these places. Working in conjunction with local government and civil society partners, the Pompidou Group has identified solutions that aim to improve the health of prisoners in accordance with human rights principles. The Pompidou Group's Drugs in Prisons Programme supports, among other activities, research into drug-treatment systems that is intended to identify and disseminate examples of good practice throughout Eastern Europe.

We produced a spate report containing the country reports of the 10 places studied. References will be made to the "Country Report" (e.g. Country Report/Georgia).

Figure 1: Places covered by the study



Legend – 1: Albania; 2: Bosnia and Herzegovina; 3: Georgia; 4: Kosovo*; 5: "the former Yugoslav Republic of Macedonia"; 6: Moldova; 7: Montenegro; 8: Serbia; 9: Russia; 10: Ukraine

1.4. PRISONS AND PRISONERS

Prisons differ from one country to another, as do prisoner populations. Prison regimes vary in terms of severity of punishment, human rights and basic conditions such as sanitation and food.[6] Prisoner populations differ in the typical primary offences and backgrounds, age and gender. But within all prisoner populations some common features can be identified. One of these is that most prisoner populations include a high proportion of people with a background of mental health problems, one of which is dependence.[7] One behavioural aspect strongly associated with addiction to certain drugs, in particular to opiates, is injecting. There is a range of serious health risks associated with injecting, and with the sharing of injecting equipment, especially the transmission of blood-borne diseases (HIV/hepatitis). In many places, therefore, injecting drug use in prison, which frequently involves the sharing of contaminated injecting equipment, is a major public health concern.

The situation in prisons and drug services in the nine countries and Kosovo* can only be understood within the context of the individual structural conditions of each of these places. Each of them is in a process of considerable economic, cultural and political transition, changing from a centrally planned economy to a market economy. Aside from economic restructuring, the ideological foundation of each nation state had failed and new models have had to be adopted, encompassing developments in civil society, pluralism, the rule of law, human rights and democracy, developments that took place in a very short period of time.

As a result, all post-communist countries are burdened with the reconstruction of the basic elements of their societies (e.g. health and social services for sick, disabled and marginalised persons). The transition process is characterised by the changing or creation of institutions, implementation of new legislation and the emergence of new political forces. These new political systems are still fragile, slow and often lack transparency.

6. International Centre for Prison Studies, 2013, 2016.
7. Pompidou Group/Council of Europe 2013.

Consequently, there is uncertainty across various sectors of society regarding these governmental structures. These situations have persisted over a prolonged period. In some of the places studied, these transitions have led to regional devolution or even military conflict, as in Georgia and Ukraine, or in the Balkan region.

The creation of new and private markets has also affected the custodial system in a number of ways: laws have established new offences, standards of health care have been revised and already poor resources and budgets have been cut.

The increase in drug consumption and drug trafficking within these places has often been reported.[8] Many explanations have been offered as to why drug use has increased in post-Soviet societies, ranging from economic theories of compensation for poverty and misery, to social and psychological disaffection and uncertainty in society, and also increased opportunity from the higher frequency of international travel and opening of borders.[9] The increase in drug use and drug markets in these places is mirrored in their prisons: a growing number of prisoners have a history of drug use and/or drug dependence; and, vice versa, a large number of drug users in the society have a history of incarceration.

The management of drug users poses severe problems and costs, not only for the prison system but also for the police while a person is in police custody. Often no professional health-care workers are involved in the provision of health care for arrestees. Furthermore, there are reports, e.g. from Russia, that police have utilised the situation where persons suffer from opioid withdrawal syndromes in order to coerce them to implicate another person and to act as an agent in police provocation. The European Court of Human Rights has adjudicated and communicated many cases against the Russian Federation that involve evidence of police use of drug-dependent people to conduct police entrapment (police provocation) against their drug-dependent peers. There are media reports of police providing narcotics to drug-dependent arrestees in exchange for coerced confessions and statements.

According to non-governmental organisations (NGOs), excessive criminalisation of the possession of small amounts of opioid drugs jeopardises the effectiveness of harm-reduction and treatment programmes, including the needle-exchange programme. This undermines HIV prevention, and can lead to a surge in morbidity from HIV as a consequence of an inability to use these services.

1.5. PRISON POPULATION

Table 1 gives a detailed breakdown of the prison population in the places covered by this project. A wide span in absolute population numbers becomes immediately apparent, ranging from 877 prisoners in Bosnia and Herzegovina: Republika Srpska to 646 085 in Russia, which has the third largest prison population in the world. There is also a significant differential in the imprisonment rates per 100 000 inhabitants, ranging from 64 to 447 across the nine countries and Kosovo*, with a mean average incarceration of approximately 200 prisoners per 100 000 inhabitants across all nine countries and Kosovo*. Set against the Western Europe average of 120 detainees per 100 000 population,[10] the social, health and economic burden that the majority of the nine countries and Kosovo* in this study have to bear becomes very apparent. The number of pre-trial detainees/remand prisoners among the prison population indicates the degree to which un-sentenced individuals are incarcerated, awaiting their trial and left in uncertainty. The proportion of pre-trial and remand prisoners as a percentage of the total national prison population ranges from 9.9% (Bosnia and Herzegovina: Republika Srpska) to 47.2% (Albania). For comparison, the corresponding average proportion of pre-trial and remand prisoners held in institutions across the 28 EU countries is 22.1%.

The size of female prisoner population also varies significantly, from 1.6% of the total prisoner population in the case of Bosnia and Herzegovina: Republika Srpska to 8.2% in Russia. In the 28 EU member states the average proportion of women in prisons is 5.2%.[11]

The proportion of juveniles/minors/young people (usually under 18 years old) within the total prisoner population ranges from 0.2% in Bosnia and Herzegovina Federation to 2.5% (Kosovo*). The average for the 28 EU countries is 0.9%.[12]

8. UNODC 2014a.
9. www.unodc.org/southeasterneurope/.
10. Writer's own calculations, based on World Prison Brief.
11. Writer's own calculations, based on World Prison Brief.
12. Writer's own calculations, based on World Prison Brief.

The ratio of foreign prisoners is generally low in comparison with Western European prisons (22.2%)[13] and ranges between 0.9% (Moldova) and 7.3% (Kosovo*) of the total prisoner population; only Montenegro (22%) holds significantly more foreign prisoners.

The number of establishments is also relatively low: across seven of the countries studied and Kosovo* the numbers vary from three (Montenegro) to 28 (Serbia). Only in Ukraine (148) and Russia (984) are there significantly more institutions.

Finally, there is a split in occupancy levels: Republika Srpska/Bosnia and Herzegovina, Georgia, Kosovo*, Moldova, Montenegro and Russia have numbers of prisoners below the official capacity; the other places have prisoner populations in excess of the 100% occupancy level, ranging from 102.1% (Bosnia and Herzegovina: Federation) to 125.6% (Albania).

The ratio of prisoners per 100 000 of the national population has decreased in only three of the places studied; in the others the ratio has increased, sometimes markedly (in Kosovo* from 11 in the year 2000 to 100 in 2014; in Serbia from 52 in 1996 to 148 in 2015). There has been no corresponding decrease in occupancy levels below 100% in half of the places studied. This indicates sustained levels of overcrowding that could cause a deterioration in the good order of institutions, affecting the health and quality of life of prisoners and the working conditions of prison staff.

13. own calculations, based on World Prison Brief.

Table 1: Prison population in the 10 countries

Country	Prison population total (including pre-trial detainees / remand prisoners)	Prison population rate / per 100,000 of national population	Pre-trial detainees / remand prisoners (percentage of prison population)	Female prisoners (percentage of prison population)	Juveniles / minors / young prisoners incl. definition (percentage of prison population)	Foreign prisoners (percentage of prison population)	Number of establishments / institutions	Official capacity of prison system	Occupancy level (based on official capacity)
Albania	5 455 at September 2015[14]	189[15]	47.2% (September 2015)	1.7% (September 2014)	1.6% (September 2015 - under 18)	1.7% (1.9.2013)	22 (2015)	4 537 (April 2015)	125.6% (April 2015)
Bosnia and Herzegovina: Federation	1 722 at 31.12.2014[16]	73[17]	12.5% (31.12.2014)	2.9% (1.9.2012)	0.2% (1.9.2012 - under 18 at date of sentence)	2.6% (1.9.2012)	8 (2008)	1 844 (1.1.2013)	102.1% (1.1.2013)
Bosnia and Herzegovina: Republika Srpska	877 at 31.12.2015[18]	67[19]	9.9% (31.12.2015)	1.6% (31.12.2015)	1.3% (31.12.2015 - under 18 at date of sentence)	2.7% (31.12.2015)	6[20]	1 459 (31.12.2015)	60.1% (31.12.2015)
Georgia	10 236 at 30.9.2015[21]	274[22]	14.0% (30.9.2015)	3.1% (30.9.2015)	0.5% (30.9.2015 - under 18)	3.0% (30.9.2015)	15 (2015)	21 398 (30.9.2015)	47.8% (30.9.2015)
Kosovo/ Kosova	1 816 at 1.10.2014[23]	100[24]	32.8% (1.10.2014)	2.7% (1.10.2014)	2.5% (1.10.2014 - minors)	7.3% (1.10.2014)	12[25]	2 447 (1.10.2014)	74.2% (1.10.2014)
"The former Yugoslav Republic of Macedonia"	3 034 at October 2014[26]	147[27]	13.4% (October 2014)	3.5% (of convicted prisoners, October 2014)	0.3% (of convicted prisoners, October 2014 - under 18)	3.2% (1.9.2013)	13[28]	2 531 (October 2014)	c. 119.9% (October 2014)

14. (national prison administration)
15. based on an estimated national population of 2.89 million at September 2015 (from Eurostat figures)
16. (Government report to the Human Rights Council)
17. based on an estimated national population of 2.35 million at end of 2014 (unofficial estimate)
18. (Republika Srpska prison administration)
19. based on an estimated national population of 1.3 million at 2015 (from Census figures)
20. (2015 - Banja Luka, Bijeljina, Doboj, East Sarajevo, Foca, Trebinje)
21. (national statistical office)
22. based on an estimated national population of 3.73 million at September 2015 (national statistical office)
23. (via U.S. State Department human rights report)
24. based on an estimated national population of 1.81 million at beginning of October 2014 (from Eurostat figures)
25. (2014 - 6 detention centres, 4 prisons, 1 prison hospital, 1 witness protection centre)
26. (via U.S. State Department human rights report)
27. based on an estimated national population of 2.07 million at October 2014 (from Eurostat figures)
28. (2014 - 11 prisons, 2 juvenile correctional institutions)

Country	Prison population total (including pre-trial detainees / remand prisoners)	Prison population rate / per 100,000 of national population	Pre-trial detainees / remand prisoners (percentage of prison population)	Female prisoners (percentage of prison population)	Juveniles / minors / young prisoners incl. definition (percentage of prison population)	Foreign prisoners (percentage of prison population)	Number of establishments / institutions	Official capacity of prison system	Occupancy level (based on official capacity)
Moldova	7 643 at 1.7.2015[29]	215[30]	21.5% (1.7.2015)	6.3% (1.9.2013)	0.3% (of sentenced prisoners, 1.7.2015 - under 18)	0.9% (1.9.2013)	17 (2015)	7 425 (1.7.2015)	102.9% (1.7.2015)
Montenegro	1 083 at September 2014[31]	174[32]	29.6% (September 2014)	2.6% (September 2014)	0.3% (September 2014 - under 18)	22.0% (31.12.2013)	3 (2013)	1 100 (1.1.2014)	98.5% (September 2014)
Russia	646 085 at 1.1.2016[33]	447[34]	18.2% (1.1.2016)[35]	8.2% (1.1.2016)	0.3% (of convicted prisoners, 1.1.2014 - under 18)	4.6% (1.9.2013)	984 (December 2015)[36]	723 695 (1.9.2013	94.2% (1.9.2013)
Serbia	10 500 at April 2015[37]	148[38]	18.9% (31.12.2013)	4.1% (31.12.2013)	1.0% (of convicted prisoners 31.12.2013 - under 18)	3.5% (31.12.2013)	28 (2011)	9 200 (31.12.2013)	109.0% (31.12.2013)
Ukraine	69 997 at 1.1.2016[39]	c. 193[40]	23.7% (1.1.2016)[41]	4.5%[42]	0.7% (1.1.2016 - prisoners in young prisoner colonies)	1.7% (1.9.2011)	148 (2016)[43]	122 184 (1.1.2013)	120.4% (1.1.2013)

29. (national prison administration)
30. based on an estimated national population of 3.55 million at beginning of July 2015 (from Eurostat figures)
31. (via U.S. State Department human rights report)
32. based on an estimated national population of 621,900 at September 2014 (from Eurostat figures)
33. (national prison administration)
34. based on an estimated national population of 144.5 million at beginning of 2016 (from Russian State Statistics Committee figures)
35. (prisoners held in pre-trial SIZO institutions or facilities functioning as SIZOs)
36. (December 2015 - 218 pre-trial SIZO institutions, 726 corrective colonies, 8 prisons, 32 juvenile colonies)
37. (national prison administration)
38. based on an estimated national population of 7.1 million at April 2015 (from Eurostat figures)
39. (national prison administration - not including prisoners in Crimea and Sebastopol and those areas of Donetsk and Luhansk that are not under the control of the Ukrainian authorities)
40. based on an estimated national population of about 36.3 million at beginning of 2016 (from Ukraine State Statistics Department figures)
41. (prisoners held in pre-trial institutions)
42. (of convicted adults in prison colonies, 1.1.2016)
43. (29 pre-trial institutions, 113 colonies for adults, 6 colonies for juveniles.)

1.6. PRISON CONDITIONS

Conditions still fall short of international standards in many prisons in the places covered by this study.[44] At times these substandard conditions pose a serious threat to the health of prisoners. Overcrowding rates are high in some places (see above), whereas others have successfully managed over the past 10 years to decrease the prison population substantially. However, poor sanitation and a lack of adequate light, food and medical care, especially access to drug treatment and to anti-viral and antiretroviral treatments, are persistent problems.

Several decisions by the European Court of Human Rights have confirmed that Russia's prisons are severely overcrowded and lack adequate health care.[45] Several cases considered by the Strasbourg Court have indicated a failure of prison health systems to provide adequate basic health care, and have found conditions in Russian prisons to be detrimental to health and life.

Shortcomings have also been identified in reports by the Council of Europe Anti-Torture Committee (Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment – CPT) that incorporate specific recommendations for their resolution. In a 2013 CPT report, for instance, the Ukrainian authorities were asked to take urgent and effective steps to ensure adequate health-care delivery in prisons. In this example, the areas of concern were that:

- all medical examinations of prisoners should be conducted out of the hearing and out of the sight of law enforcement and non-medical custodial officers;
- record keeping should be secure, and confidentiality should be guaranteed;
- special training should be provided for health-care professionals working in penitentiary establishments;
- communication of information from health-care staff to custodial staff should be limited to what is needed to prevent a serious risk to the detained person or others;
- newly admitted persons should be properly interviewed and thoroughly examined by qualified health-care staff no later than 24 hours after their admission.

However, there are also examples where overcrowding of prisons has been substantially reduced in a very short period of time. For example, under the punitive criminal justice policies of a previous government in Georgia, the prison population rose by 300% between 2003 and 2010, generating one of the highest national incarceration rates in the world. Non-custodial alternatives were rarely used. Within a few years this changed substantially, though Georgia still retains a high incarceration rate of 274 prisoners per 100 000 inhabitants.

Some of the reports indicate that some categories do not benefit from a decreased prison population: research shows, for example, that in some Russian cities up to 65% of drug users have prison experience. While between 2005 and 2012 the general number of Russian prisoners slowly decreased from 823 400 to below 701 900, the number of adults imprisoned for drug crime increased by 251% from 49 794 to 124 955, with every third prison sentence in the courts of large cities being imposed for drug-related offences. In 2010, more than 75% of the 104 000 convictions for drug crimes were for possession for personal use or for drug trafficking in "small amounts". According to experts, of 600 000 people sentenced for drug crime in Russia, one third were sentenced for possession without intent to sell. The erstwhile Federal Drug Control Service reported that "one in every eight inmates in Russia is convicted for drug crimes; the number of drug users in the penitentiary system grew twofold from 2005 to 2011".

A lack of health-care infrastructure has been identified as a key problem in some reports. For example, in Bosnia/Herzegovina the absence of a prison hospital at state level poses a problem. There is often a political or financial reason for such deficiencies. The Psychiatric Clinic in Sokolac, for instance, has been restored, and equipment has been purchased, but three years on it is still not in operation.

Many of the health-care institutions in several places studied are poorly resourced in both staff and equipment; management is often obliged to hire external associate staff – doctors who visit the prison only periodically, once or twice a week, to examine and treat prisoners.

Another problem identified in several places is that there are often no health records, or even personal records, available in prisons, but only informal accounts or anecdotal information from former prisoners to indicate certain developments. Although a medical information system is employed in public hospitals, a patient's status as a prisoner is not recorded at all.

44. www.unodc.org/southeasterneurope/en/criminal-justice-and-prison-reform/index.html.
45. Rhodes et al. 2010.

A lack of official information can lead to severe difficulties in identifying current health and/or social risks for prisoners. In Montenegro, there were no official data on the drugs being used within prison settings. The only data came from community activists.

In some places juveniles are held in the same environment as adults. This makes them vulnerable for a number of reasons, including prison socialisation, the high proportion of relapses among this group and the limited availability of suitable educational activities in these institutions, which significantly impedes reintegration into society.

Prisoner culture has also been identified as a major obstacle to adequate medical treatment of prisoners. In Kosovo*, for example, informal interviews with former prisoners indicate that there is a strong prisoner hierarchy, and that drugs such as marijuana and heroin are being smuggled into prisons, most likely with the involvement of custodial staff.

No information was available on LGBTI issues in most of the prisons studied.

1.7. EXTERNAL FUNDING

Many countries studied are in a phase of profound economic, political and cultural change. They have received a variety of resources to support them in fighting HIV and tuberculosis from the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and in other forms of assistance. Table 2 gives an overview of external funding and shows that for many countries and for Kosovo* GFATM support is coming to an end, and certain budgets are scheduled to be transferred to national funding.

In Montenegro, for example, the only programme that directly targets prisoners and provides informational and educational services in prison was funded by the GFATM. The funding was scheduled to stop in July 2015, and funded activities would stop unless support was secured from other donors or relevant state institutions and included in the state system of support.

In Kosovo*, GFATM funding has been prolonged until the end of 2017. The programme supports the distribution of condoms, the methadone maintenance programme, development of IEC (information, education, communication) materials and testing for HIV, hepatitis B and hepatitis C.

In some countries, e.g. Moldova, difficulties have arisen from a reduction in external funding. The financing of methadone substitution treatment programmes in Moldova is under pressure, because most of the cost of OAT is covered by external funding, primarily coming from the GFATM which plans to reduce its contribution to the Republic of Moldova.[46]

46. Hoover and Jurgens 2009; Subata 2009.

Table 2: External funding

	GFATM Funding	When ending?	Reduction in %	Other external funding	External funding other than GFATM
Albania	No GFATM support since 2012			UNFPA (UN Population Fund) supports risk reduction activities in prisons	Until the end of 2014
Bosnia and Herzegovina	Yes	November 2015	85%	Process of advocacy throughout BiH; firm commitment; setting budget of Federation of BiH for 2017 (Federal Ministry of Justice takes over OAT financing in all prisons in the Federation)	n/a
Georgia	Yes	2018		No	
Kosovo*	Yes	GFATM continues in prisons to end of 2017		No	N/A
Moldova	Yes	2015 or 2017		Soros Foundation Moldova, NGO AFI, Caritas Luxembourg	
Montenegro	Yes[47]	01.07.2015	Funds reduced by 25% in 2011	EU Delegation to Montenegro[48]	EIDHR project does not cover services to prisoners directly, but influences certain policies not specific to drug-using prisoners
Russia	Yes	31.12.2014	no HR		
Serbia	No GFATM after 2014			No	
"The former Yugoslav Republic of Macedonia"	Yes	31.12.2016			
Ukraine	Yes	In 2017			

1.8. RESPONSIBILITY FOR HEALTH CARE IN PRISONS

As in Western Europe, the responsibility for health care in prisons varies from country to country, although in the majority of the places in this review the Ministry of Justice is in charge of health-care delivery: Albania, Bosnia and Herzegovina (Federation of Bosnia and Herzegovina; Republika Srpska), Moldova, Russia, Serbia, Ukraine.

In Kosovo* the Ministry of Health is responsible for health care in prisons. In "the former Yugoslav Republic of Macedonia" a law has been passed transferring responsibility to the Ministry of Health, but full practice has yet to be developed.

In Georgia, a specialised Ministry of Correction is responsible for all matters related to prisons including health care. (Formerly the Georgian Ministry of Health had been responsible for prison health.)

47. Funding 100% of direct services provided for prisoners.
48. European Instrument for Democracy and Human Rights.

In Montenegro responsibility is divided between the Ministry of Health and the Ministry of Justice. For the first six months of imprisonment the Ministry of Health is in charge of health care, and after that the Ministry of Justice takes over responsibility.

New problems can arise from the shift of responsibilities from one ministry to another. For example, in Kosovo* it has been reported that the interface between information systems in the ministries of health and justice is causing interruptions in the recording of health data. This decreases the availability of health information about prisoners, thereby compromising prison clinical services.

1.9. LEGAL REGULATIONS

Legal regulations differ across the nine countries and Kosovo* in, *inter alia*, their definition of drugs, quantities allowed for possession and/or trade, punishment of drug offences, length of prison sentences for drug-related offences, alternatives (if any) to imprisonment, court decisions, community sanctions and whether the option of "therapy instead of punishment" is available.

Russian laws, for instance, distinguish between possession and trafficking of illicit drugs. Drug trafficking is a crime, no matter how small the amount of illicit drugs. The minimal sentence for drug trafficking is four years' imprisonment; the maximum is life when trafficking involves "extra-large" amounts of drugs. Depending on the quantity of an illicit drug in their possession, a person who has no intent to supply might be charged with either an administrative offence or a crime. Russia has four thresholds for quantities of illicit drugs for purposes of administrative and criminal liability: insignificant, significant, large and extra-large quantities. This distinction is missing in other jurisdictions. However, across all jurisdictions, community punishments and prison sentences are likely to vary from region to region and even one court to another.

Harm-reduction interventions are provided in several places, but the level of implementation and practice varies considerably across them. Russia is the only country where opioid agonist treatment is banned by law, both in prisons and in the community.

Chapter 2

Methodology

This research project on drug-treatment systems in prisons in Eastern and South-East Europe was conducted in nine countries – Albania, Bosnia-Herzegovina, Georgia, Moldova, Montenegro, Russia, Serbia, "the former Yugoslav Republic of Macedonia" and Ukraine – and in Kosovo* between 2013 and 2016. Prior to the research, a feasibility study was conducted in 2013 in all but one of the above-mentioned places (Russia being the exception).[49] The feasibility study comprised a desk review, the purpose of which was to:

- estimate the extent of available data in each of the countries and in Kosovo*;
- identify any major obstacles and/or risks to the research project;
- prepare a contact list of existing expertise and experts in each of the countries and in Kosovo*;
- draft an outline specifying the objectives, scope, content and methodology of the research project.

The final report of the feasibility study concluded that the only major obstacles and risks might be associated with researchers not securing permission from all the necessary authorities to visit prisons and/or to talk to prisoners. However, this concern was dissipated when talking to contact personnel and in view of experience gained during previous assessment visits made in 2011-12 to Albania, Serbia, "the former Yugoslav Republic of Macedonia" and Ukraine where no such barriers had been encountered. In fact, there was considerable interest in the research and in general discussion of and learning from European standards or practices related to drug treatment in custodial settings.

Additionally, several experts were identified in the nine countries and in Kosovo* who were able and willing to become involved in the research process. It was considered that their expertise might make a significant contribution to the success of the study envisaged.

Literature on the situation in prisons specific to most of the places had been obtained and studied, contributing to the feasibility study.

Based on these findings, the Pompidou Group started to identify and approach experts in all nine countries and in Kosovo*. Experts already approached in the feasibility study were contacted, as were independent experts who had been identified at conferences or who had been recommended by other contacts. There was a requirement that these researchers must be independent of their national Ministry of Justice or other ministries in charge of health care in prisons. The independent researchers that met this criterion were contacted and contracted. Their task was to study the situation of drug users in prisons, and to evaluate the treatment and support available to prisoners in their country or territory. The product of their work is a collection of reports that are structured to ensure cross-comparability. In two meetings held in Budapest during 2014, the tasks (18-19 February) and the results (15-16 September) were discussed. Between these two meetings the experts were in close contact with the lead researcher and co-ordinator responsible for the overall project.

On the basis of a recommendation letter by the Pompidou Group, the researchers personally contacted the ministries in charge of health care in prisons, requesting the relevant information. All the available data have been included in the country or territory specific reports (see Chapter 5). The overall conclusions and recommendations (see Chapter 6) have been discussed via email and agreed by all of the researchers involved in this study.

Preliminary results were presented by Robert Teltzrow on 2 October 2014 at the annual conference of the WHO Regional Office for Europe's Health in Prison Programme (HIPP) "Prisoner empowerment: drug treatment systems in prisons", which took place in Ireland.

The individual reports were peer-reviewed and data were updated throughout 2015.

49. Stöver 2014.

Chapter 3

Drug use and its consequences among the prison population

Dealing with people who are dependent on drugs in prisons is difficult for various reasons. The goal of rehabilitating convicts must be pursued, but prison managers in many places face rising drug consumption among prisoners and difficult political and economic circumstances that make solving the drug problem ever harder. The current judicial situation is paradoxical: a realistic solution has to be found to a significant problem that is not permitted to exist – drugs in prisons.

3.1. DEFINITION OF KEY TERMS

The terms that describe custodial institutions differ between the places studied. Sometimes distinctions are made between:

- prisons (an institution for shorter sentences),
- penal institutions (for longer sentences),
- correction facilities (institution for juveniles),
- Russian prison institutions (pre-trial institutions; educative or juvenile labour colonies; corrective labour colonies; and prisons),
- remand facilities (for those awaiting trial),
- detention centres (for non-nationals).

The substantial variation in the estimated numbers of drug users across nations is mainly attributable to differences between jurisdictions in defining the term "drug user". Although all the nine countries and Kosovo* report that drug users are a significant and extremely problematic part of their prison population, only a few countries have developed and applied clear definitions of the terms "drug user" and "drug dependence". Likewise, only a few have a comprehensive system to quantify the scale of the problem, despite the perception in most places that this group makes up a significant part of criminal justice and prison populations. The definitions used tend to focus on the duration of drug use and class of drug consumed. Broad, imprecise or even missing definitions make it extremely difficult to compare the situation of drug-using prisoners between different places or countries, or even regions within an individual state.

Several questions arise that make definitions difficult and the planning of health-care and specialist drug services problematic:

- Who defines and identifies a "drug user"? The doctor on admission (by certain drug-related signs or symptoms such as abscesses, puncture marks or positive urine testing)? Or a staff member or prison administrator? Or self-reported drug use (asked by whom)?
- What is the basis of the definition? Are the categories of criminal offence recorded in the prisoner's personal file used as indicators of drug use (e.g. violation of drug laws and/or offences commonly committed to finance drug use)?

- Which categories of drug are included within the definition? If illegal drugs, cannabis solely? And/or opiates and/or cocaine poly-drug use? Alcohol consumption, for instance, was largely excluded from definitions, or not mentioned explicitly.
- What pattern of use is included in the definition? Lifetime prevalence, drug use prior to incarceration (past four weeks, past year?), drug use in prison, occasional drug use? Frequency, quantity, setting? Problematic drug use only, poly-drug use or supplementary use of pharmaceutical products such as benzodiazepines or barbiturates? Which routes of administration are specified (injecting, smoking, inhaling)?
- At what stage are they in a drug-using "career", e.g. an inmate with previous drug use or a juvenile at an early phase?
- Which categories of drug user are included: infrequent, occasional or dependent?

Only a few of the places studied currently differentiate between the drug use and the drug-dependence status of prisoners in accordance with the WHO International Classification of Diseases (ICD-10) classification: "A cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state". ICD-10 classifies psychoactive substance use as mental and behavioural disorders under code F, with the class of substance identified by appended numbers from 10 to 19. Coding is completed by the addition of further characters that specify the clinical presentation of the psychoactive substance user.

In "the former Yugoslav Republic of Macedonia", for example, the "Diagnostic and Statistical Manual of Mental Disorders (DSM IV)" is used for the classification of substance users and substance dependence. The criteria are used for the identification of drug-using prisoners and assessment of their suitability for entry into a treatment programme.

The terms used to describe drugs and drug dependence often remain unclear and lead to blurring of perceptions. This in turn makes adequate responses to these phenomena more difficult.

The professions dealing with drug-related problems and their roles have changed considerably over time. In former Soviet countries, "narcologists" were the only profession authorised to provide drug treatment. This has changed, and drug dependence or a substance-related disorder is no longer seen as a separate disease that can be treated only by a very specific professional group. This change in terminology has not, however, occurred in all places. Perception of drug use has also developed over time. Whereas formerly the concept of the *narkoman* ("drug addict") prevailed, a change in attitude towards drug users in many places has led to a more differentiated perception. However, terminology is highly relevant to the development and maintenance of stigmatisation, and more humane definitions, expressions and notions need to be applied.

3.2. NATURE AND PREVALENCE OF DRUG USE AND RELATED RISKS IN PRISONS AND ON RELEASE

The data in the following chapters are mainly based on studies in Western Europe. However, much of the information and data from our study in nine Eastern European countries and Kosovo* indicates that similar drug-related problems arise in prison settings in Eastern Europe. Developments are to a certain extent comparable.

Many drug users in prisons come from the most disadvantaged groups in society, with a high prevalence of low educational attainment, unemployment, a history of physical or sexual abuse, relationship breakdown and 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 have never had access to health-care and health-promotion services prior to imprisonment. Prison health care, therefore, offers an opportunity to improve their health and personal well-being.[50]

Drug use in prison takes place in extreme secrecy, and drug seizure statistics based solely on the confiscation of needles/syringes and positive urine-test rates indicate only part of the story of drug use behind bars. Patterns of drug use vary considerably between different groups in the prison population; drug use among women differs significantly from that among men, with different levels and types of misuse, and different motivations and behavioural consequences. Specific drugs used inside prisons also vary considerably, sometimes involving prison-manufactured drugs or alcohol. Consumption modes vary widely too, especially of new psychoactive substances.

50. Patel 2010.

Many places report changes in the patterns of drug use (both in volume and type of drug) when preferred drugs are scarce.[51] Studies and observations by prison officers indicate widespread switching to alternative drugs (e.g. from opiates to cannabis) or to any substitute drugs with psychotropic effects (illegal drugs and/or medicines), no matter how damaging they might be. Some prisoners appear to switch drugs as a strategy to evade controls such as mandatory drug testing (moving, for example, from cannabis to heroin), even if only on an experimental basis, as cannabis is retained by the body in fatty tissue and can be detectable in urine for up to 30 days after consumption.

Besides tobacco, cannabis (used for relaxation purposes) is the most commonly consumed drug in many prisons. Some studies have shown that more than 50% of prisoners use cannabis while in prison: prevalence on entry varies between 38% in France, 50-55% in the United Kingdom (England and Wales), 65% in Switzerland and 74% in Greece to 81% in the United Kingdom (Scotland).[52] Studies indicate that both prison staff and inmates consider that cannabis provides psychological relief and has a positive impact on the social ambience in the particular setting of prisons. Similarly in Eastern European countries cannabis consumption in prisons is very widespread (see country or territory specific reports). Tackling cannabis use in prison needs to take these effects into account and to include harm-reduction measures tailored to the individual users and their therapeutic needs.[53]

A far smaller percentage of prisoners report that they inject drugs in prison.[54] The extent and pattern of injecting and needle-sharing vary significantly from prison to prison. Prisoners who use drugs in the community usually reduce their use in prison, and only a minority of prisoners inject drugs on a daily basis.

According to various studies undertaken in Europe, between 16% and 60% of people who injected before their incarceration continue to inject in prison. Although they inject less frequently than outside prison, prisoners are far more likely to share injecting equipment than are drug injectors in the community, and to share this equipment with a significantly greater number of people.[55] 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 safe equipment there.

Although injecting drug use in prison seems to be less frequent than in the community, each episode of injection is far more dangerous than outside due to the lack of sterile injecting equipment, the high prevalence of sharing and the already high prevalence of infectious diseases.

The profile of drug injectors and drug injecting in prison becomes more complex when the different patterns of behaviour that may apply to this group are explored. Indeed, the need for further intensive, in-depth research becomes even more apparent when the possibility is examined of a typology of drug injecting and prisons. The following "types" are all possible:

- A group that injects in the community, but not in prison. This would be the group that makes a definite decision not to engage in high-risk behaviour while incarcerated.
- The group that first injects in prison, having no previous history of injecting in the community; according to the empirical work of the European Network of the Prevention of Infectious Diseases approx. 5-10% of drug users start injecting while in prison. If members of this group (as is common among most in-prison injectors) share injecting equipment, then they would provide the clearest evidence of prison being a high-risk environment. We can really only speculate about the characteristics of this group. Prison may be a particularly depressing and/or threatening experience for them, and they may perceive extreme drug-using behaviour as a means of escape. Or they may simply be more impressionable, and more susceptible to the influence of those already involved in injecting in jail.
- A similar group comprises members who smoke drugs such as heroin in the community, but who inject in prison, perhaps for reasons of economy – as injecting may be described as a more cost-efficient method – or because the smell of heroin smoke is more easily detectable by prison staff. This group is interesting because its members have crossed one particular boundary by using "harder" drugs, and have then moved on to a more "extreme" method of using their main drug.
- A group with a history of injecting in prison but who no longer do so. This group may comprise individuals who have stopped injecting completely, or others who continue to inject while in the community where

51. Todts et al. 2008.
52. Sahajian F., Lamothe P. and Fabry J. (2006) for France; Heidari E. et al. (2007) and Stewart D. (2009) for England and Wales; Niveau G. and Ritter C. (2008) for Switzerland; Fotiadou M. et al. (2004) for Greece; Scottish Prison Service (2008) for Scotland.
53. Ritter, Broers and Elger 2013.
54. Shewan, Stöver and Dolan 2005.
55. Stöver H. et al. (2008) for numbers who continue to inject in prison; Jürgens, Ball and Verster (2009) on sharing equipment.

clean injecting equipment is available, but not in prison, where there is typically no such availability. Like group (i), they have identified and resisted high-risk behaviour.

- The "occasional" in-prison injectors. For this group, injecting may be opportunistic and impulsive. This behaviour may involve the sharing of injecting equipment.
- The independent injectors. These individuals are disciplined about their injecting in terms of risk, and have their own injecting equipment, which they will not share or lend.
- The closed circle injectors. This group will share, but only within their own group. One can speculate that the rationale behind this is reduced risk, but this argument fails if any member of the group has a blood-borne viral infection, diagnosed or otherwise. An alternative explanation could be that the closed circle ensures that injecting behaviour is more covert, more controllable and less likely to be identified and acted upon by staff.
- The "renters". This very high-risk group will basically hire out injecting equipment, in return for money, drugs or favours.
- The "hirers". The group who rent out injecting equipment.[56]

There are obvious differences between these groups or types in terms of potential risk, especially in relation to infection from contaminated equipment. The "renters", for example, are clearly at greater risk than the independent injectors. While it is definitely the case that one of the few consistencies among sharers in prison is that they will attempt to clean equipment before using it, there are degrees of likely effectiveness associated with different methods. Examples of more risky methods include licking the needle before injecting, simply pumping air through the needle and syringe, flushing with water or making rules about who is injecting last. These examples retain a high risk of viral infection and could potentially include "fatal errors", but at the same time they indicate that prisoners are willing to take precautionary measures which, given the unavailability of community resources such as sterile injecting equipment, could be described as second-best solutions or better-than-nothing strategies, which are intended to at least reduce risk.

Cleaning with available disinfectant is likely to be a significantly more effective method of cleaning, although it raises issues of the availability of cleaning agents and the deteriorating effect of strong cleaning agents (such as bleach) on injecting equipment. While there is evidence of high levels of knowledge about risk behaviour among drug injectors, there is also evidence of prevailing mistaken beliefs that could have serious effects on health (for example, the fallacy among some injectors that one cannot be re-infected with HCV; see Long et al. 2004 for an overview).

One final point in discussing this typology. Allowing for obvious logical qualifications (one can only inject for the first time once, for example), it is entirely feasible that individuals can move from one category to another. This generates a dynamic typology that in terms of explanation is beyond the medical model and poses a set of challenges to the predictive utility of the "drug, set and setting" model.[57]

Prisons are high-risk environments for the transmission of HIV and other blood-borne infections for several reasons:

- a disproportionate number of inmates come from and return to backgrounds where the prevalence of HIV and blood-borne virus infection is high;
- the authorities fail to officially acknowledge the presence of HIV and blood-borne viruses, thus hindering education efforts;
- activities such as injecting drug use and unsafe sexual practices (consensual or otherwise) continue to occur in prison, while sterile injecting equipment and condoms are rarely provided to prisoners;
- tattooing and piercing using non-sterile equipment are prevalent in many prisons; and
- epidemics of other STIs such as syphilis, coupled with their inadequate treatment, lead to a higher risk of transmitting HIV through sexual activity.

There were early indications that HIV could be transmitted extensively in prisons. HIV outbreaks have been documented in some of the prison systems, demonstrating how rapidly HIV can spread in prison unless effective action is taken to prevent transmission.[58]

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56. See Shewan, D.,; Stöver, H. Dolan, K.: Injecting in Prisons. In: Pates, R.; McBride, A.; Arnold, K. (ed.): Injecting Illicit Drugs. Blackwell: Oxford, 2005.
57. See Shewan, D.,; Stöver, H. Dolan, K.: Injecting in Prisons. In: Pates, R.; McBride, A.; Arnold, K. (ed.): Injecting Illicit Drugs. Blackwell: Oxford, 2005.
58. WHO 2007, p. 11.

Although smoking heroin ("chasing the dragon") instead of injecting the drug plays an increasing and significant role all over Europe, this route of administration is not widespread in prison. Drugs are expensive in prison; injecting maximises the effect of a minimal amount of drugs and is not as easily detected as smoking (both by 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 began injecting while in prison.[59]

In addition to illegal drugs, legal drugs such as tobacco, alcohol and prescribed pharmaceuticals often contribute to substance dependence and related health problems among prisoners.[60] Many prisoners have a long history of regular use of legal drugs. Poly-drug use is common among people entering custody, often involving co-dependence on a combination of alcohol, opiates, stimulants and benzodiazepines. Dual diagnosis, the co-existence of mental health and substance-use problems, which carries a higher risk of suicide among prisoners,[61] has also increased in recent years.

3.3. EPIDEMIOLOGY OF DRUG USERS IN PRISONS

Studies from several countries have identified substantial proportions of drug users within prisoner populations. In 1999 it was reported that 68% of all new admissions to US prisons tested positive for an illegal drug via urine screening, and similar findings have been reported across Europe, North America and Australia. ENDHASP estimated that 46.5% of prisoners across Europe would be users of illegal drugs prior to imprisonment.[62] The EMCDDA estimated that at least half of the EU's 365 000 prison population (in EU before 1 May 2004) had a drug use history. In the United States this figure has been calculated as high as 70%.[63] In Australia, Butler reported that 73% of female prisoners and 64% of male prisoners had used an illegal drug at some point, with 23% of females and 18% of males having used heroin. In South America and Africa the situation is less clear, not least because of a lack of systematic research in these regions.[64]

A number of factors are likely to contribute to the high number of drug users within prison populations. In EU countries, for example, the number of drug-law offences has been steadily rising in most countries in recent years, as shown by EMCDDA figures from 1995 (439 000 offences) to 2000 (665 000).[65] The overall number of people sent to prison has also been rising steadily; although the increase in drug-law offences is likely to be a contributor to this trend, it does not provide a full explanation. Indeed, this assumes that a rise in drug-law offences reflects an increase in the number of illegal drug users, and the relationship between these figures remains unclear. For example, O'Mahony (1997) found in a study of the male prisoner population in Ireland that while 66% of the total sample had a history of heroin use, only 7% were in prison as a result of a conviction for an offence against the Misuse of Drugs Act. Similarly, it has been reported that half of the drug users in prison in Denmark and Italy in 1998 had been imprisoned for general offences, that is, offences other than violations of the drug laws. While there remains considerable debate concerning the relationship between drug use and general crime, the two are clearly associated. It remains unclear exactly why the number of prisoners is increasing in so many countries but it is fairly safe to assume that, as overall prison numbers increase, so too will the numbers of problematic drug users held in custody. Furthermore, a significant proportion of the problematic drug users in prison will have co-existing psychiatric and mental health problems.[66]

A significant proportion of prisoners in the 28 EU member states are thought to be drug users: "up to 80% tobacco and up to 50% for cocaine, heroin and amphetamines consumption".[67] In many countries the term "drug user" has not finally and precisely been defined. This problem also applies to the nine countries in this study and to Kosovo*. A wide range of perceptions and definitions and related connotations exists (see above in Chapter 3, "3.1. Definition of key terms").

59. Boys et al. 2002.
60. Ritter et al. (2011); Levy and Stöver (2013).
61. Shaw, Appleby and Baker (2003).
62. Hiller et al. (1999) for the USA; European Network of Drug and HIV/AIDS Services in Prison (1997).
63. EMCDDA(2003) for the EU; US Department of Justice (2000) for the USA.
64. For Australia, see Butler (1997); see also Dolan and Crofts 2000.
65. For the development of drug-related crime in Europe see www.emcdda.eu.int and then: http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5305.
66. Singleton et al. 1999.
67. EMCDDA 2012a.

Data on the prevalence of drug users in prisons in Eastern Europe suggest similar rates to Western European prisons.[68] In Ukraine, for example, 14% of all inmates have been incarcerated for drug-related offences, excluding crimes committed to finance their drug use, although the actual number of prisoners with either intravenous drug use experiences and/or current injection habits is much higher. For Ukraine it is said that between 37 and 47% of the prison population have experienced intravenous drug use prior to imprisonment. How many of these individuals continue to inject in prison remains unclear.

The most commonly used drug in Montenegro is cannabis. Among injecting drug users, the most commonly used drug is heroin, and a very small percentage (0.8%) of this group inject a mixture of heroin and cocaine.

In "the former Yugoslav Republic of Macedonia", the drugs/substances most commonly used in prison are marijuana, heroin, sedatives (benzodiazepines), anti-parkinsonians and antidepressants, but many drug users in prison will typically use a combination of different substances. The medical staff believe that only 20-30% of the drug-dependent persons who receive methadone maintenance treatment do not also use other drugs. The vast majority of prisoners enrolled in OAT are poly-drug users who use additional prescription drugs. Drug users report that they borrow or buy tablets from one another, and those prisoners who are prescribed central nervous system medicines give them to other prisoners or share. Sometimes they make and drink wine from fruit, in particular during holidays, when according to the local tradition "everyone drinks alcohol". For the wine production they can use any fruit, such as pears, apples or melons, and mix them with 10 litres of water, 2 kg of sugar, and yeast or a few pieces of bread. After five days the fruit has fermented and the wine is ready. Some years ago a few drug users made tea from tatula (*Datura stramonium*), which grew in the prison grounds. Drug users who drank the tea had hallucinations. This was noticed by staff, and the plants were destroyed.

In Kosovo*, as in most of the other places studied, cannabis is the most prevalent drug (apart from tobacco) in prisons.

As Table 3 shows the number of drug-dependent prisoners is quite high.

Table 3: Numbers of drug users

	Numbers imprisoned for violating drug laws	Estimated number of drug-dependent prisoners	Estimated number of IDUs in prisons
Albania	516	175	5 000-7 500 (country wide); 12% of prisoners inject drugs while in prison (Boci, Neli and Wolff 2011)
Bosnia and Herzegovina	one third of all prisoners (about 850)	700	600
Georgia	2500	unknown	45 000 (country wide)[69]
Kosovo*	No data	9% of all prisoners	60-70% of prisoners
Moldova	320	385	No data
Montenegro	172	13-15% of all prisoners	No data
Russia	124 955	56 400	33 796
Serbia	2 336	4 698	1 503
"the former Yugoslav Republic of Macedonia"	181(first time) and 203 (recidivists)=384[70]	627 (registered drug users, the vast majority opiate users), but 24% of prisoners used drugs in prison in 2009 (EMCDDA 2012a)	1-2% of all drug users in prisons
Ukraine	10 300 on 1 Sep 2014; 14% of all sentenced prisoners	2 266[71]	37-47%[72]

68. UNODC/Eurasian Harm Reduction Network 2012.
69. Sirbiladze and Tavzarashvili 2012.
70. "The former Yugoslav Republic of Macedonia", Ministry of Justice 2014.
71. That is 3.1% of all prisoners and detainees in Ukraine. According to SPSU official information, these prisoners were officially registered as drug-dependent prisoners on 1 January 2016. However, the number of people who require medical help for drug addiction can be several times more.
72. Azbel et al. 2013; UNODC 2014b.

3.4. DRUG USE AND RISK BEHAVIOUR IN PRISONS

People who inject drugs are over-represented in prisons. For instance, in Ukraine the monitoring data show that in certain prisons about 70-75% of female prisoners are PWID.

The use of illicit drugs in prisons always carries a degree of risk, from unknown quality and purity, time pressure to consume the drug and unhygienic/unsafe conditions – mostly toilets and other locations. This applies especially to intravenous drug use. Because it is a clandestine, punishable behaviour, intravenous drug use in the prison setting can be particularly high risk.

In Ukraine, every sixth person convicted in 2011 was convicted for drug crimes (25 457 out of total 154 356); more than 55% of all drug crimes involved possession of drugs for personal use.[73] These data – reflected in reports from other places studied – indicate that the process of criminalisation of drug users who are arrested with mainly small quantities of drugs, consistent with personal consumption, is the main reason for imprisonment of drug users and is responsible for the high proportion of such drug users among the prison population.

In Russia, research indicates that needle sharing is common in prisons. In one study,[74] 66% of PWID reported sharing equipment. Qualitative studies report that a "syringe would do the rounds and rounds and rounds of the whole camp. And then you get loads of syphilis, Aids. Someone would shoot up once and then in the course of the next two months about 20 people would be in the isolation ward with viral hepatitis".[75]

A rapid increase in dependence on different psychoactive substances, heroin and pills has also been reported in other places (e.g. "the former Yugoslav Republic of Macedonia").

Interviewees in this study from "the former Yugoslav Republic of Macedonia" reported that, because it is not possible to find or buy a sterile needle in the prison, there are drug-dependent persons sentenced to imprisonment who inject drugs/substances via old needles that they sharpen on walls or concrete paving, or with sandpaper. Their estimate was that only 1–2% of drug users inject drugs/substances in prison.

The absence of a prison medical information system in Kosovo* means that very little information is available about substance use in its prisons – data come only from informal interviews with former prisoners.

In the report from Ukraine it became clear that drug injection and high-risk sharing of injection equipment (often involving many injecting partners) was frequent among HIV-infected Ukrainian prisoners. In a recently released study involving HIV-infected persons from prisons in Odessa and Kyiv, Ukraine, 56.8% reported within-prison injection drug use, of whom 74.1% shared equipment at an average of 4.43 users per needle.

There is often an observable gap between what is said officially by prison or health-care management and statements by interviewed prisoners, although statements from both sides do accord sometimes. Officials in Montenegro report that there are no prison-made drugs. Interviewees confirmed this, saying that no drugs are manufactured in prison other than alcohol made from grapes during summer.

Although in some places there are reports of trends in increasing alternative drugs usage (new psychoactive substances such as krokodil and legal highs) this seems not to have influenced the use of the established drugs.

For example, the problem of synthetic cannabinoid use in prisons in England and Wales, where a random mandatory drug testing programme is in force, may be in part driven by the desire to avoid positive tests since these substances are not currently detected by such tests.[76]

Existing data do not give a realistic picture of the status quo in Albanian prisons. Anecdotal data, however, and a number of studies (Boci, Neli and Wolff 2011) indicate that Albanian prisoners engage in a range of high-risk behaviours within prison settings, such as drug and alcohol use, unsafe sex (men having sex with men) and tattooing. The lifetime prevalence of illegal drug use among people entering prison in Albania is 57.8% – frequency of drug: marijuana 47.8%, cocaine 28.9%, heroin 21.1%, ecstasy 11% – and 15.6% use drugs while in prison: marijuana 15.6%, heroin and cocaine 3.3%, ecstasy 1.1% (ibid.).

Very few data are available on same-sex and unprotected sexual contacts in prisons. In a study in Bosnia fewer than 3% of convicts said they had same-sex relationships without protection in prison. A good part of health education is focused on this subject in Bosnia, in addition to general measures of protection and promotion of safer sex and healthy lifestyles.

73. Skala 2012.
74. Frost and Tchertkov 2002.
75. Sarang et al. 2006.
76. UK: HM Inspectorate of Prisons 2015; EMCDDA 2016.

Sexual contacts are reported to be a regular occurrence in prisons in Kosovo*.

In addition to intravenous drug use and unprotected sexual contacts, tattooing, piercing and skin penetration are modes of transmission of infectious diseases. In an Albanian study, tattooing prior to imprisonment was reported by 64.4% of respondents, predominantly by non-professional tattooists (81%), and 30% reported being tattooed while in prison.

In "the former Yugoslav Republic of Macedonia" tattooing is forbidden in prisons and is punished when confirmed, but interviewees report that some prisoners are tattooed (by other inmates) in prison, although this is considered very rare as most of the tattooed prisoners arrive already tattooed from outside. "They make it unprofessional and unsafe, but there are some "smart" ones who are doing that, although for that you can go in isolation."

In Georgia, by contrast, one third of the prisoners reported acquiring tattoos while in prison.

Tattooing is widespread in the prison system in Montenegro; over half of participants (51.8%) reported being tattooed in prisons.

Tattooing is practised in all prisons in Bosnia, and is very often dictated by trends, from types of tattoo to technique. One of the most common trends is to be tattooed with the symbol of an organised gang, inside or outside the prison, with the tattoo serving to signify belonging to a group. It should be noted that the quality of tattooing in prisons is rising, with developments in technology and Internet access having a huge impact.

3.5. HEALTH OF DRUG-USING PRISONERS

Because prison populations are often composed of individuals who face greater HIV risk factors than the general population, HIV and Aids are significant health threats to prison populations and prison staff. In some settings the HIV burden for prisoners may be up to 50 times higher than that of the general population.[77] Risk factors for tuberculosis (TB), hepatitis A, B and C, and sexually transmitted infections are also greater for incarcerated individuals than for members of the wider population. These infections tend to exacerbate one another, as in the case of HIV/TB co-infected individuals. TB infection is the leading cause of death among HIV-infected individuals in sub-Saharan Africa, and a major cause of death in prisons. As a result of these factors, HIV/Aids represents a significant challenge to the prison and governmental authorities at local and national levels.

77. UNAIDS (2014).

Unprotected sex, multiple sexual partners, low and inconsistent condom use, intravenous drug use incorporating the sharing of syringes, needles and drug-use paraphernalia, tattooing and body piercing are among the principal drivers of the global HIV epidemic. Prisoners are a key vulnerable population contributing to the epidemic.[78]

HIV

There is often no clear picture regarding the prevalence of HIV and HBV/HCV in prison systems. Documented cases or data are limited; accurate data are difficult to access and no mandatory virus tests are carried out on prisoners. According to the Albanian General Prison Administration, there were four known HIV cases among Albanian prisoners.

In an official survey, conducted as part of a national sentinel survey, in the first six months of 2011, 8.3% of prisoners in Ukraine were identified as HIV positive (in 2010 this figure was 11.2%).[79] According to the 2011 bio-behavioural survey, the HIV prevalence among prisoners in Ukraine was 13.6% (33.0% among females and 10.1% among males), and 2.2% among prisoners aged 15–19 years.[80] However, in the first representative study in Ukraine, conducted in 13 prisons located across four regions of Ukraine, the prevalence of HIV was found to be as high as 19.4% (78 of 402 respondents), which is nearly 12 times higher than in the general population.[81] Again, HIV prevalence among female prisoners (28.4%) was higher than among males (17.3%). Half of all HIV-positive respondents in this study had been previously unaware of their HIV status; the majority (56% of 78 HIV-infected inmates) were in need of antiretroviral therapy (ART), and only five (6.4%) were receiving it.

A similar picture arises when looking at the situation in Russian prisons: according to the official statistics of the medical service of the Federal Penitentiary Service of the Russian Federation (FPS), as of the end of 2014, 8.2% of all prisoners had been diagnosed with HIV. The number of people with HIV in Russian prisons is increasing: from 56 335 prisoners in the first half of 2013 to 57 604 people in the first half of 2014. Of these, only 10 314 (18%) patients were receiving antiretroviral treatment in 2013 and 11 736 (20%) in 2014.[82] According to official statistics presented by the head of the Russian FPS medical service, about 8 000 HIV-infected persons enter custodial settings (pre-trial) every year.[83]

HIV prevalence in Russian prisons is 28 times higher than in the general population.[84] Studies have identified cases of HIV seroconversion within prisons,[85] and HIV infection has been strongly associated with a history of imprisonment in Russia;[86] outbreaks have been documented of HIV transmission via injecting drug use in prisons.[87] Studies report that access to timely HIV antiretroviral treatment is often inadequate and patchy due to a scarcity of trained personnel and medication.[88]

In Georgia, HIV prevalence was low – 0.35%, corresponding to the low prevalence in general population.

TB

According to the World Health Organization, in 2013 Russia was among countries with a high TB burden, and it has a treatment success rate for all new cases of 65% – the worst in the world. Russia is second worst in the European Region in terms of TB-related mortality and ranks third globally in total cases of multi-drug-resistant TB (MDR TB), after China and India.[89] In the last decade, the TB epidemic in Russia has intensified and is characterised by an increase in patients with resistance to two or more TB drugs, high mortality among patients co-infected with TB and HIV, and high prevalence of TB in the penitentiary system.[90] Sarang et al. (2015) report that Russian prisons are overcrowded and lack basic hygiene and infection control. Demand for medical services outstrips supply, and HIV and TB prevention are lacking. HIV and TB treatment are reported to be patchy, with no second-line drugs available for resistant forms.

78. Jürgens, Ball and Verster (2009).
79. Balakireva et al. (2012).
80. Analysis of HIV/AIDS response in penitentiary system of Ukraine. Summary report on the comprehensive study. Kyiv, 2012.
81. Azbel et al. 2013; Kruglov et al. 2008.
82. Vorobey (2014).
83. Russia, Federal Penitentiary Service medical department 2012.
84. Vorobey (2014).
85. Sarang et al. 2006.
86. Heimer et al. (2005).
87. Jürgens, Ball and Verster (2009).
88. Wolfe, Carrieri and Shepard (2010).
89. WHO (2013).
90. Frolova et al. (2008).

It has been estimated that more than 50% of the total population of Russia belongs to a risk group for TB,[91] and being incarcerated, including pre-trial detention, is one of the most important risk factors for the contracting of pulmonary TB.[92] Drug users are especially vulnerable to contacting tuberculosis in prisons due to a high prevalence of HIV among PWID, which is estimated to average 37% nationwide but reaches 74% in some Russian cities.[93] Studies also show that drug use prior to imprisonment constitutes an important risk factor for TB infection among detainees in remand prisons.[94] While epidemiological data on TB prevalence among drug users outside prisons are lacking, a limited number of studies based on self-reports indicate a prevalence of 4.7% in Orel and 6% in Yekaterinburg.[95]

TB prevalence in Russian penitentiaries is 21 times higher than in the general population.[96] Evidence from across the country suggests that the penitentiary system is one of the principal locations for the transmission and development of tuberculosis, including its resistant, multi-resistant and cross-resistant forms.[97]

In just ten years between 1992 to 2002, overall TB incidence in the Russian prison system increased sharply from 860 per 100 000 to 2 028 per 100 000.[98] Many people get tuberculosis while in prison. A study from the north of Russia shows that most prisoners with TB had developed it within the first 1-2 years of imprisonment, and prevalence of TB among patients in prison general hospitals had reached 12.8%.[99]

Viral hepatitis

Hepatitis C is widespread among prisoners with a history of injecting.[100] In Russia, as elsewhere, hepatitis C mostly affects intravenous drug users (IDUs), among whom, according to more conservative estimates, 1.3 million people are infected.[101] Sentinel surveillance data reveal extremely high HCV prevalence rates among IDUs, ranging from 45% to 90% in some cities (mid-range estimate: 69%).[102] Injecting drug users are completely excluded from HCV treatment programmes.[103] The number of individuals diagnosed with viral hepatitis in the penitentiary system was 51 147 in 2013, and 57 742 in 2014.[104] However, there must be many undiagnosed cases, particularly as treatment is not offered.

The general focus on HIV can sometimes lead to a neglect of other infectious diseases, such as HCV. In "the former Yugoslav Republic of Macedonia", for example, data from the staff interviewed in Idrizovo Prison established that there were no HIV-positive drug-dependent persons in the prison. Staff co-operated with an NGO to provide voluntary testing for HCV and HIV, or they received support for tests from the Global Fund project. In 2009 and 2010 they tested 200 drug-dependent persons enrolled in MMT/OAT and found that 92 of them were hepatitis C positive.

91. Koretskaya (2002).
92. Balabanova Y. et al. (2005); Lobacheva et al. (2005).
93. Mathers et al. (2008).
94. Lobacheva, Asikainen and Giesecke (2007).
95. Russian Harm Reduction Network (2008).
96. Vorobey (2014).
97. Drobniewski et al. (2005).
98. Bobrik A. et al. (2005).
99. Kosmak and Kopylova (2008).
100. Arain, Robaeys and Stöver 2014.
101. Mathers et al. (2008).
102. Andrey Rylkov Foundation (2013).
103. Ibid.
104. Vorobey (2014).

Table 4: Numbers of prisoners living with HIV, HCV, HBV or TB

	HIV	HCV	HBV	TB
Albania	4	N/a	n/a	n/a
Bosnia and Herzegovina	1	<30% PWID of all prisoners	<30% PWID of all prisoners	4: with regular therapy in special security hospital
Georgia	0.35%	No data	No data[105]	98
Kosovo*	1 (recently; first case among prisoners)	No data	No data	No data
Republic of Moldova	114	152	148	152
Montenegro (data from the only research done in prison, in 2011)	0%	20.1%	1%	Not available
Russia	55 000	No data	No data	29 000
Serbia	7	1670	80	24
"The former Yugoslav Republic of Macedonia"	0	164 (31 March 2014)	70 (31 March 2014)	6 (31 March 2014)
Ukraine	6 657 on 1 June 2014 including 2 526 on ART (SPSU data)	59.9%	No data	3 893 (including 378 in pre-trial establishments - SIZO)

Co-infections HIV/TB; HCV, syphilis and HIV

Little is known about co-infections among prisoners in the nine countries studied and Kosovo*. The available data from Ukraine indicate that rates of co-infection are up to 34 times higher in prisons than in the community.

Co-infections with HCV, syphilis and HIV are widespread and over-represented in Ukrainian prisons. It is noteworthy that the number of infected prisoners knowing their sero-status is low: HCV 11%, syphilis 33%, HIV 49.3% (see country report: Ukraine).

Aids-related mortality accounts for a high percentage of all deaths in prisons. In Ukrainian prisons Aids-related deaths amounted to approximately one third of all deaths, and TB accounted for 9.9% of deaths.

Finally, because there is no specific screening, diagnosis and classification system (ICD-10, or DSM V) in place in most of the areas studied, there is a lack of data concerning the number of mentally ill prisoners. However, anecdotal reports show that a large number of prisoners with drug-use and drug-dependent history are suffering from mental disorders, and are kept in the system in the same way as other prisoners without receiving proper attention for their mental health problems. This situation raises a serious concern for their future, as untreated or undiagnosed mental health problems can result in an increased demand for drugs in the prison system and increased suicide risk, which creates a range of risks and challenges for prisoners, prison staff and the community.

3.6. SOCIAL STATUS, STIGMA AND DISCRIMINATION OF DRUG USERS IN PRISON

In general, in most of the places studied, the attitude to people who use drugs is characterised by stigmatisation[106] and imprisonment. Pejorative expressions like *narkoman* ("drug addict") demonstrate that drug users or drug-dependent prisoners are regarded as unreliable and need to be controlled. These processes are often expressed by (hidden) discrimination that means exclusion from work (not being appointed cook, denied work therapy) and loss of other benefits (denied home leave) or privileges (visit limitation). Drug users' cells are often located in specific, often isolated areas of the prisons, and drug users are often regarded as occupying the lower strata of the prisoner hierarchy. Reports refer to instances of violation/torture in the treatment of drug users in prison.[107]

105. These are currently being surveyed. No data available at the time of writing.
106. Vienna Declaration (2010).
107. www.ohchr.org/Documents/HRBodies/HRCouncil/DrugProblem/ICHRDPTorture.pdf.

The fear of being stigmatised and discriminated against often leads drug-dependent prisoners to hide their condition and not seek medical support. This is confirmed by data from Montenegro. Other prisoners as well as prison officers and medical staff may contribute to stigmatisation and exclusion.

In Georgia inhuman and degrading behaviour towards drug-using prisoners has been identified in substitution programmes. Prior to a change of government in October 2012, inmates with a history of substance use and dependence were frequently subject to additional inhumane and degrading treatment from prison staff. In a qualitative study with 30 individuals who had served a prison term for drug use or possession for personal use, the majority of respondents described extreme cruelty at Gldani prison (No. 8 Penitentiary Institution).

Stigmatisation and discrimination affect prisoners' daily life in many ways. This is illustrated very vividly in the report from "the former Yugoslav Republic of Macedonia", where stigma has been reported to be a big issue in prisons: drug users are described as being mostly stigmatised by other prisoners, but also to a lesser extent by non-medical staff and medical staff at the centre for the treatment of dependence. Prisoners describe cases where dependent persons do not request treatment with methadone, although it is needed, because they do not want to be victimised by other prisoners. Other cases in Skopje Prison show that when drug-dependent persons discontinue methadone they are rewarded by other inmates with cigarettes and food. The staff at Idrizovo Prison report that instructors usually do not want to allocate jobs to drug-dependent prisoners because they have shown variable motivation for work and work performance as a result of their drug dependence. Their drug-dependent status means that these prisoners are denied privileges once they have lost a job, or even when they have actually secured work.

In anecdotal evidence, prisoners in Albania describe hierarchical problems and indicate that discrimination is ever present between prisoners themselves and from prison staff. The most commonly reported mistreatment was humiliation or offensive behaviour towards prisoners who had no support in or outside the prison: those who were poor, those who had no family and those who were perceived as being weak or otherwise vulnerable. For drug users, particularly those with a repeated history of incarceration for drug use and possession of small amounts, the most common mistreatment consists of discrimination and stigmatisation. Other forms of mistreatment include the use of force, against "undefended" drug users (i.e. those without family or other support networks) and often against Roma drug users, forcing them to clean the premises or perform other services. There are no reported or registered cases of egregious violations of human rights or physical or psychological torture.

The Ukrainian prison system strategy states that special attention should be paid to human rights and respect for the dignity of patients, incorporating a non-judgmental attitude to patients, because only by overcoming stigma and discrimination is it possible to achieve a significant increase in the effectiveness of treatment.

Chapter 4

Responses to drug use: prevention, treatment, harm reduction and aftercare

Access to, and provision of, health-care and drugs services in prisons is characterised by a unique combination of factors: security and risk environments, prison culture, often limited resources and a restricted range of options for health service provision.

4.1. RESPONSES TO DRUG USE IN PRISONS – WHAT WORKS?

In general, drug services in prisons comprise initial 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. It is essential to recognise that drug dependence (whether it involves opiates, cocaine, tobacco, alcohol or other drugs) is not criminal or hedonistic behaviour, but a chronic disease, characterised by a long process of relapses and attempts at stabilisation, which consequently requires continuing care and support. It should be treated in the same way as other chronic illnesses, incorporating diagnosis and a treatment plan. It is essential that any drug treatments and intervention strategies are not developed in isolation, but linked to other relevant initiatives and strategies. A prison drug strategy should be part of and in line with the national drug strategy.[108]

All drug services available in the community should also be provided in prisons, to the same quality, size and level of accessibility as those outside. Guidelines developed by the United Nations – Standard Minimum Rules for the Treatment of Prisoners ("the Mandela Rules")[109] and Rules for the Treatment of Women Prisoners ("the Bangkok Rules")[110] – and the World Health Organization (WHO) Health in Prisons Programme (Moscow Declaration 2003) agree with the Council of Europe principles for the provision of health-care services in prisons, which state that: "there should be health services in prisons which are broadly equivalent to health services in the wider community" (the principle of equivalence).[111]

The goal of drug-treatment services in prisons must be, at the very least, that prisoners leave in a healthier state than when they arrived and the aim should be, as the best outcome, that they are psychosocially stabilised and their treatment is continued after release. The ultimate goal of all treatment for drug dependency, on an individual level, is to achieve abstinence from the drug (or drugs) or at least a sustained reduction in drug consumption, with or without medication-assisted treatment. At a system or institutional level, the overarching twin aims are reducing reoffending and improving health and rehabilitation.

108. WHO Europe 2005.
109. UN 2015.
110. UN 2011.
111. WHO Europe 2002; Council of Europe 2006.

The introduction of prevention, treatment and harm-reduction measures in prisons is still inadequate throughout Europe compared to developments achieved in the last 30 years in the community. An EU report emphasises this lack of equivalence, noting that interventions in prisons in the EU are still not in accordance with the principle of equivalence adopted by the United Nations General Assembly, UNAIDS (the UN Joint Programme on HIV/Aids), WHO and UNODC, which calls for correspondence and equality between the health services and care (including harm reduction) available inside prison and the services and care available to society outside prison.[112]

It is well established that good drug treatment for prisoners can reduce both drug use and rates of reoffending. The *Lisbon agenda for prisons* 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). Therapeutic communities, opioid agonist treatment, intensive psychosocial support and/or supervision on release and the 12-step abstinence-based programme have particularly strong evidential support. This means that pharmacological, psychosocial and other supportive "wraparound" interventions are effective strategies for stabilising prisoners. The inclusion of integrated medical and psychosocial services in a comprehensive package, together with a range of options that meet the needs of drug-dependent prisoners, is critical for effective drug services.

The Patel Report[113] on prison drug treatment 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.

The background is more often one of risk than of opportunity. As it says in the guide to the essentials in prison health produced by the World Health Organization's European office:

> Coping with drug use in prison is difficult for several reasons. Drug use is illegal in prisons. If discovered, it leads to harsh consequences for the time spent in prison including loss of privileges (such as home leave), segregation, higher control frequencies (such as cell searches) and discrimination by non-drug-using prisoners (fear of transmitting infectious diseases). In the prison subculture, drug users are often perceived to be in the lower ranks: they are blamed for new supervisory and control procedures that aggravate the custodial conditions.[114]

112. UN 1990; WHO 1993; UNODC 2006.
113. Patel 2010.
114. WHO Europe 2007.

Prison health services often face a dilemma regarding therapeutic resources. Staff of prison health-care units and security staff have to deal with the consequences of drug use, but the causes of drug use usually remain beyond their reach. The prison staff and administration often lack the capacity to respond adequately to the health problems of drug users, especially when these users are only in prison for short periods of time. Prisons are not therapeutic institutions, but time in prison should not be considered lost. The opportunities that prisons may provide, in terms of health care, social support and involvement of community health agencies, should be taken. Prisons can provide an opportunity to help drug users, many of whom have not had any previous contact with helping or treatment agencies. People often change the drug use patterns they had before imprisonment, voluntarily or not. Because of a lack of drugs, they might stop using altogether, reduce the quantity they consume or change the route of administration. Some might stop injecting because of a lack of sterile needles and syringes. Others start injecting in prisons in order to use the reduced drug supply more efficiently. However, some drug-dependent prisoners stop smoking because the smoke is easier to detect by prison custodial staff than injecting or swallowing.

Measures designed to achieve abstention from drug use in prison, or at least a reduction in harmful drug-using patterns, include:

- counselling on drug-related issues by trained prison staff or specialised personnel, integrated with external drug services;
- housing for drug-using prisoners in specialised units with a treatment approach and multidisciplinary staff;
- provision of printed and audiovisual material in different languages, with the involvement of prisoners and external counselling agencies in its production.

Strategies to reduce risk that are applied outside prison are often regarded as undermining the measures taken inside prison to reduce the supply of drugs. Supporting the safer use of illegal drugs (such as by providing bleach and sterile injecting equipment) and at the same time confiscating the drugs can appear to be a fundamental contradiction. Studies show, however, that harm-reduction measures can be provided safely and without compromising the measures aimed at reducing drug use in prisons (WHO/UNODC 2012).

Prison drug policies should allow for:

- screening, assessment, counselling and treatment on a voluntary basis;
- the establishment and maintenance of a personal distance from the drug-using subculture, since drug users who are motivated to undergo a treatment programme have to be able to do so in a protected environment, which is a challenge to many prisons in view of overcrowding;
- throughcare and aftercare, which are essential elements of efforts to reduce relapse and reoffending and build trust with caregivers;
- provision of the diversity of measures that are offered outside prisons: social services, drug-care units, drug counselling and treatment services (including harm reduction);
- discouragement of the importation and trafficking of drugs in the prison system.

This study of nine countries and Kosovo* indicates that the burden of drug use on penitentiary systems is high and that the above-mentioned requirements are often not being met adequately due to economic, political and professional reasons. Moreover, structural conditions like pre-release programmes and throughcare (including probation services) are still in an initial phase, if they exist at all. Finally, harm-reduction measures and ARV/HCV treatment are still not very widespread. Worldwide, PWUD in prisons do not benefit from many effective services currently available in the community, and most of the places studied are no exceptions.

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

An integrated drug-treatment system, such as that developed in the United Kingdom (England),[115] is needed for a comprehensive response to the complex phenomenon of drug dependence. Drug-free and pharmacological interventions, together with stimulus for self-help, are key to the success of drug services. Psychosocial drug treatment and clinical substance dependence management must be integrated and harmonised. Drug-free orientation and pharmacological treatment are not contradictory strategies; on the contrary, they can complement each other with psychosocial drug treatment and rehabilitation.

115. Stöver and Lines 2006.

Inside prisons, the use of illegal drugs is a criminal offence and abstinence-based interventions are therefore generally viewed as compatible with the goal of prison systems to eradicate drug use. Abstinence is compatible with and reinforces the aims of custody in general and is envisaged as enabling prisoners to avoid committing criminal offences after release.

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

The cognitive behavioural therapy approach has different levels of intensity (low/medium intensity programme; gender-specific; and short duration). The aim is to gain social learning experience, and to understand and treat drug-related problem behaviour associated with substance-related offending.

The 12-step approach is based on social learning within a peer approach, with new group members given instructions in ways to lead 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, regardless of the specific drug, and they may last for 15-18 weeks.

The structured therapeutic community approach is based on hierarchical treatment and aims to teach new behaviour, 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 drug dependence.

Referral to these programmes is based on individual risks and needs. The different approaches allow individual prisoners to be directed towards the treatment most suited to the severity of their problem and fitting their personal characteristics and circumstances. Some cognitive behavioural therapy programmes are suitable for people who are stabilised on opioid agonist treatment, either as part of the process of working towards abstinence or towards better stabilisation, while the 12-step and therapeutic community models require participants to be entirely drug-free before starting 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'."[116]

These approaches can be matched with, on the one hand, voluntary drug testing that aims to provide an incentive for prisoners to stay drug-free because they are recovering from drug dependence or because they wish to continue receiving particular privileges (such as release on temporary licence or a better job in the prison), or on the other hand, having something meaningful to do such as work, education and structured programmes, which seems to be a key determinant in remaining drug-free.

4.1.2. Abstinence-oriented treatment and therapeutic communities in prisons

Abstinence-oriented treatment for prisoners is generally provided in special facilities (therapeutic communities). Most member states of the Council of Europe 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. They are drug-free environments implementing an intensive treatment approach that requires 24-hour residential care and comprehensive rehabilitation services. Residents are expected to take from 3 to 12 months to complete the programme. In general, therapeutic community treatment models are designed as total-milieu therapy, promoting the development of social values, attitudes and behaviour through positive peer pressure. Although each therapeutic community provides different services, most programmes are based on a combination of behavioural models with traditional group-based, confrontational techniques. As high-intensity, often multi-stage programmes, therapeutic communities are provided in a separate unit of the prison. Many 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.

Relatively little research has been done on the effectiveness of therapeutic communities and the sustainability of abstinence. However, according to the UN and EMCDDA there is evidence of the effectiveness of therapeutic communities. The unsolved problem is that therapeutic communities are often not linked with interventions for safer drug use and the prevention of death after relapse on release. It is suggested that prisoners' experience in treatment should be followed up after release.

116. Patel 2010.

4.1.3. Contract treatment units and drug-free units

Drug-free units or wings or contract treatment units aim to allow prisoners to keep a distance from the prison drug scene and they 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 not to bring 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 away 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 to continue treatment after release. 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.

4.1.4. 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, such as those of the same age or – in this context – other prisoners. Peer education targets individuals and groups who cannot effectively be reached by existing services with the overall aim of facilitating improvements in health and reducing the risk of transmitting HIV or other blood-borne diseases. Peer-driven interventions make systematic use of the 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 et al. (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 of risk behaviour both inside and outside prison. Peer educators who are living with HIV may also be ideally placed 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 overdoses in prisons involves illegal (injecting drug use) or forbidden (same-sex activity and tattooing) and stigmatised (same-sex activity) practices. Peers may therefore be the only people who can speak candidly to other prisoners about ways to reduce the risk of contracting infection. In addition, peer educators' input is 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 discuss realistically the alternatives to risky behaviour that are available to prisoners and are better able to judge which educational strategies will work in their prison and in the informal power structure among prisoners. Finally, peer-led education has been shown to be beneficial for the peer educators themselves: individuals who act as peer educators report significant improvements in their self-esteem.[117]

4.1.5. Opioid agonist treatment (OAT)/medication-assisted treatment

Prisons are not the right place for treating drug-dependent men and women, and authorities should develop policies for alternatives to imprisonment. As long as these alternatives are not available, prison services are faced with this specific population in need of treatment, care and support. Even when alternatives are available, there will still be people with drug use in prisons, but less. Research has shown that substitution treatment is the most effective way to treat opioid dependence, to reduce the risk of HIV and hepatitis C transmission, and to reduce the risk of overdose.[118]

The need for access to treatment for opioid dependence in prison was internationally recognised more than 30 years ago. In 1993, WHO issued guidelines on HIV infection and Aids in prisons (WHO 1993), stating that:

117. Marteau, Palmer and Stöver 2010.
118. Grinstead et al. 1999; Van Meter 1996.

- Drug-dependent prisoners should be encouraged to enrol in drug-treatment programmes while in prison, with adequate protection of their confidentiality.
- Such programmes should include information on the treatment of drug dependency and on the risks associated with different methods of drug use.
- Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison.
- In countries where opioid agonist treatment is available to opiate-dependent individuals in the community, this treatment should also be available in prisons.

In 2004, in a position paper on substitution maintenance treatment, UNAIDS, UNODC and WHO concluded that the provision of substitution maintenance treatment for opioid dependence is an effective strategy for preventing HIV/Aids and it should be considered for implementation as soon as possible in communities at risk of HIV infection.[119]

Failure to implement effective drug treatment, and HIV and hepatitis C prevention measures, could result in the further spread of HIV and hepatitis C infection among injecting drug users in the wider prison population, and could potentially lead to generalised epidemics in the local non-injecting drug-user population.

Injecting drug users who do not enter OAT are up to six times more likely to become infected with HIV than those who enter and remain in treatment. The death rate of people with opioid dependence in OAT is one third to one quarter the rate in those not in treatment.

The most common form of OAT is methadone maintenance treatment. Methadone has been used to treat heroin and other opiate dependence for decades. The more recently developed buprenorphine is also quite common in many countries. Both have been proved to bring about a major reduction in the risk of HIV infection by reducing opioid use, reducing the sharing of drug injection, needles and syringes, and improving the health and quality of life of opiate-dependent people.

OAT is, therefore, an effective strategy for preventing the transmission of HIV and hepatitis C. It should be implemented as soon as possible in prisons at high risk of HIV infection.[120]

Before starting treatment, drug users must be provided with relevant information, especially about the risk of overdose and the potential risks of multiple drug use and interactions with other medications. They should also be informed about the primary physician's obligations to the state, to the prison and to the prisoner.[121]

Medication-assisted treatment for opioid dependence (substitution treatment, agonist pharmacotherapy, agonist replacement therapy or agonist-assisted therapy – OAT) is defined as the administration under medical supervision of a prescribed opioid substance, pharmaceutically related to that producing dependence, to people with substance dependence so as to achieve defined therapeutic aims.

OAT is a form of health care for heroin- and other opioid-dependent people. It uses prescribed opioid agonists or partial agonists that have some properties similar to or identical with heroin and morphine in their action on the nervous system, alleviate withdrawal symptoms and block cravings for the illicit opioid. Examples of opioid agonists are methadone, sustained-release morphine, codeine, buprenorphine (a partial agonist-antagonist) and, in some countries, diamorphine. Most of these substances, except for diamorphine, are characterised by a long duration of action and the absence of "rush".

Antagonists, which reverse the effects of opioids, are also used in treating opioid dependence. They occupy the same receptor sites in the brain as opioids and, therefore, block the effects of opioids. However, they do not stop craving. If a person takes an antagonist followed by an opioid, the euphoric effects of the opioid are nullified as they cannot act on the brain. If the antagonist, which has a higher affinity for opioid receptors, is taken after the opioid, an opioid-dependent person will go into opioid withdrawal (so antagonists are contra-indicated for people who have not been detoxified from opioids). Naltrexone is the opioid antagonist most commonly used in treating opioid dependence. Naloxone is only used for the emergency reversal of opioid overdose situations. Buprenorphine is a partial agonist-antagonist and is being used increasingly to treat opioid dependence. There are combinations of naloxone with buprenorphine (1:4 ratio) to prevent the abuse of the medication via injection.

119. Stöver, Hennebel and Casselmann 2004.
120. Stöver and Thane 2011.
121. WHO 2004a.

4.1.6. Harm-reduction programmes

In their broadest sense, harm-reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs.[122] The Status paper on prisons, drugs and harm reduction defined harm reduction measures in prisons as follows:

> In public health relating to prisons, harm reduction describes a concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health.[123]

Harm reduction acknowledges that many drug users cannot totally abstain from using drugs in the short term and aims to help them reduce the potential harm from drug use, in part by helping them to stop or reduce the sharing of injecting equipment so as to prevent the transmission of HIV or hepatitis which, in many ways, is an even greater harm than drug use. A harm-reduction approach recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse.

In addition, the definition adopted by WHO acknowledges the negative health effects of imprisonment.[124] These include the impact on mental health, the risk of suicide and self-harm, the risk of drug overdose on release and the harm resulting from inappropriate imprisonment of people who in fact require facilities unavailable in prison, especially when overcrowded.

All drug-treatment services, whether residential or community-based, should incorporate a distinct harm-reduction element to reduce the spread of blood-borne viruses and risk of drug-related deaths, notably deaths from overdose.[125] Specific harm-reduction interventions include:

- needle-exchange services, that is, the provision and disposal of needles, syringes and other clean injecting equipment (such as spoons, filters and citric acid) in various settings;
- advice and (peer) support on safer injection and reducing injecting, and reducing the initiation of others into injecting;
- advice and information to prevent transmission of blood-borne viruses (particularly hepatitis A, B and C, and HIV) and other infections related to drug use;
- vaccination for hepatitis B;
- access to testing and treatment for hepatitis B and C and HIV/Aids;
- counselling related to HIV/hepatitis testing (pre- and post-test);
- advice and support on preventing the risk of overdose;
- risk assessment and referral to other treatment services.

As shown above, many prisoners continue to use drugs in prison, and some people start using and injecting drugs while in prison. Despite often massive efforts to reduce the supply of drugs, the reality is that there is a demand, and drugs can and do enter prisons.

In prisons, as in the community, harm-reduction measures have been successfully implemented during the past 20 years throughout Europe as a supplementary strategy to existing programmes oriented to drug-free treatment. Harm reduction does not replace the need for other interventions but adds to them, and should be seen as a complementary component of wider health-promotion strategies. The following hierarchy of goals should guide drug policy, in prisons and in the community:

- securing survival;
- securing survival without the person sustaining irreversible damage;
- stabilising the addict's physical and social condition;
- supporting people dependent on drugs in their attempts to lead drug-free lives.

Harm reduction is addressed in the manual on *Risk reduction for drug users in European prisons*, which has been translated into seven languages. The main aims of this manual are:

- to raise awareness of health problems connected to drug use and drug-related infections;
- to initiate and support a discussion about risk reduction in response to these health problems;

122. UK Harm Reduction Alliance, available at www.ukhra.org.
123. WHO Europe 2005.
124. WHO 2014a.
125. Stöver et al. 2008.

- to contribute to knowledge, skills and insight into the problems and encourage a positive attitude towards risk-reduction activities by both inmates and staff;
- to disseminate information relevant for health promotion by a range of means;
- to stimulate and support risk-reduction activities for both inmates and staff.

The *Manual* also contains information for prison staff about health and workplace safety, drugs, addiction, infectious diseases and the services needed. Interactive material about risk situations and risky conditions in prisons has been included for inmates.

4.1.7. Comprehensive package

Unprotected sex, multiple sexual partners, low and inconsistent condom use, intravenous drug use incorporating the sharing of syringes, needles and drug-use paraphernalia, tattooing and body piercing are among the principal drivers of the global HIV epidemic. Prisoners are a key vulnerable population contributing to the epidemic.[126]

This is not just a problem for European prisons. For example, the challenges and gaps in the field of HIV/TB in sub-Saharan African prisons may be summarised as follows:

- high rates of imprisonment leading to severe overcrowding and unhealthy conditions;
- high HIV prevalence rates among the general population;
- presence of high-risk and vulnerable populations in prisons, including women and children;
- prevalence of high-risk behaviours for the transmission of HIV in prison settings;
- high prevalence rates of HIV infection and other related infections (TB, hepatitis, sexually transmitted infections) among the prisoner population;
- increased staff vulnerability to HIV and TB;
- poor or inadequate and inaccessible health services in general;
- structural/cultural barriers to the provision of HIV-prevention commodities in prison settings;
- inadequate and dilapidated infrastructure.

Access to HIV/TB prevention, treatment, care and support for people in detention is a crucial element of any national HIV response. Prisoners are part of society and will return to society at the completion of their sentence. Health and prevention in prison settings is a public health issue that has not been given due consideration by public health agencies.[127] The vast majority of people in prison eventually return to their communities. Any diseases contracted in closed settings, or made worse by poor conditions of confinement, become matters of public health.[128]

In addition to access to HIV/TB prevention, treatment, care and support for people in detention, the crucial elements of any national HIV and TB response must include early diagnosis and treatment of all TB cases.

The TB notification rate in prison settings is from 11 to 81 times higher than in the general population. The situation is worsened by the emergence and spread of drug-resistant TB, particularly extensively drug-resistant (XDR) TB.[129]

Prisoners are mainly sexually active males aged between 19 and 35, which places them at high risk of HIV infection. Rape and sexual aggression among prisoners, or between prison staff and prisoners, have received little attention in the places examined,[130] although they are reported as a genuine problem in prison systems in many other countries across the world.

Prisoners and prison staff often come from communities with a high prevalence of infectious diseases, including HIV/Aids.[131] Risk behaviours for HIV and other infectious diseases that begin in the community often escalate during incarceration. Evidence suggests that, in sub-Saharan Africa for example, unprotected sexual activity is the most prominent HIV risk behaviour and responsible for the majority of infections, whereas the sharing of razors, tattooing or piercing instruments and injecting drug use are generally less problematic.[132]

126. Jürgens, Ball and Verster 2009.
127. Stöver, Knorr and Weilandt 2006.
128. See, e.g., WHO Europe 2003. See also WHO Europe 2010b: The Madrid Recommendation.
129. Mukadi, Maher and Harries (2001); Stöver (2014).
130. SADC (2011).
131. Jürgens, Nowak and Day (2011).
132. Simooya et al. (2001); Goyer and Gow (2001).

Like all persons, prisoners are entitled to receive the highest attainable standard of health care. This right is guaranteed under international regulation: access to health care should be at least equivalent to that provided in the community, in accordance with the United Nations Standard Minimum Rules, which state that "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[133]

The provision of high-quality medical care, coupled with decent living conditions, facilitates the well-being of both prisoners and prison staff. It should be the objective of prison management that prisoners leave prison in a similar or better state of health than on the day they entered.

Consideration must also be given to the full range of health needs of prison staff, with the increasingly complex social and psychological demands that prison settings place on staff. Among the problems that people who work in prison settings currently face are overcrowding, intercultural conflicts, within-prison gang crime, language issues, drug use, poor environment, frequent instances of staff shortages and inadequate professional training. Additionally, prison staff members are at risk of exposure to serious infectious diseases such as TB. Staff members are frequently subject to threats of violence, are confronted with desperate situations and have to manage their own stress in addition to the distress of others. People working in prison settings also face stigma, and in several countries a colony style of prison service, including obligatory relocation (with or without family) and barrack accommodation, compounds the psychological stress and increases vulnerability to infectious diseases and other health risks. This can lead to compensation phenomena such as burnout, alcohol/drug use, depression and inability to come to terms with traumatic workplace experiences. Ongoing prevention and care interventions for prison staff must therefore be kept in mind when designing measures to improve health in prison settings.[134]

Equivalence of prevention, treatment, care and support can best be achieved by integrating community and prison services. Integration ensures that poor co-ordination, discontinuity of care and duplication of effort are avoided wherever possible. In some countries responsibility for health in prison and health in the community is divided between separate government departments. In such circumstances a joint strategic approach agreed by these departments will be essential to the cohesion of disciplinary/operational functions and health services in prison settings.

HIV and TB programmes must involve contributions from civil society, in addition to the public sector, to create high-quality services for targeted groups in the prison setting. Relevant NGOs, some of which may be community-based, can assist with planning, implementation and evaluation of comprehensive HIV services in prison settings, other detention facilities or secure hospitals; they can also facilitate the participation of prisoner representatives or former prisoners at every stage.

Interventions for the prevention of HIV/Aids and TB, and treatment, care and support for these diseases in the prison setting should be designed as both evidence-based and specific to the target group. Evidence-informed planning involves the prioritising of interventions with the highest proven beneficial impact and the targeting of these interventions on the locations and populations where they will have most effect.

In 2013 the UNODC, ILO, UNDP, WHO and UNAIDS developed and published a package on *HIV prevention, treatment and care in correctional settings and other closed settings: a comprehensive package of interventions*, which contained 15 key interventions:

- Information, education and communication.
- Condom programmes.
- Prevention of sexual violence.
- Drug dependence treatment, including opioid agonist treatment.
- Needle and syringe programmes.
- Prevention of transmission through medical or dental services.
- Prevention of transmission through tattooing, piercing and other forms of skin penetration.
- Post-exposure prophylaxis.
- HIV testing and counselling.
- HIV treatment, care and support.
- Prevention, diagnosis and treatment of tuberculosis.

133. Principle 9 of the Basic principles for the treatment of prisoners, UN (1990).
134. Bögemann H., "Promoting health and managing stress among prison employees". In: WHO Europe (2007).

- Prevention of mother-to-child transmission of HIV.
- Prevention and treatment of sexually transmitted infections.
- Vaccination, diagnosis and treatment of viral hepatitis.
- Protecting staff from occupational hazards.

These 15 interventions are essential to scaling up prevention, treatment and care of HIV and other infectious diseases in prison and other closed settings. The purposes of concentrating on these activities are to:

- share practical experiences across all of the above-mentioned 15 interventions;
- identify barriers and obstacles to the implementation of these interventions; and
- identify and share models of good practice.

These activities require stakeholders from the ministries of justice and health, prison administrators and key prison personnel to join with representatives of NGOs and civil society working in custodial settings to find solutions to the identified problems in the 15 focus areas. The intention is to take a practical-level perspective and to assist prison authorities and civil society/NGOs to further scale up HIV prevention, treatment, care and support in correctional settings. As already stated, overcrowding makes prison an ideal breeding ground for the transmission of TB and drug-resistant TB. The lack of effective infection control combined with certain structural limitations play an important role in perpetuating airborne disease transmission in prisons. To successfully address HIV, those countries where injecting drug use occurs should prioritise the implementation of needle syringe programmes (NSPs) and evidence-based drug-dependence treatment – specifically opioid agonist treatment (OAT) – with HIV testing and counselling, and access to antiretroviral therapy.

Furthermore, available evidence indicates strongly that most harm-reduction programmes implemented in the community can also be introduced in prisons without compromise to security or any increase in illicit drug use.[135]

Prisoners have been overlooked by HIV/TB prevention, treatment and care programmes around the world for a very long time. Restrictions in access to preventive commodities, testing, treatment, support and other relevant HIV/Aids services indicate that we are far from achieving equivalence of care.[136]

Historically this is relevant to HIV-related activities, programmes and action plans across the world but, at a relatively early stage of the epidemic, international bodies had already developed guidelines and recommendations for prisons. Milestones in the development of equivalent health care and adequate HIV/Aids services for prisoners are:

- WHO (1993), "Guidelines on HIV infection and Aids in prisons";[137]
- UNODC/WHO/UNAIDS (2006), Aids prevention, care, treatment and support in prison settings: a framework for an effective national response;[138]
- WHO (2007a-e), *Interventions to address HIV in prisons*, Evidence for Action series: Effectiveness of interventions to address HIV in prisons; HIV care, treatment and support; Needle and syringe programmes and decontamination strategies; Prevention of sexual transmission; Drug dependence treatments;
- UNODC/UNAIDS/World Bank (2007), HIV and prisons in sub-Saharan Africa;[139]
- the African Declaration of Commitment on HIV in prisons (2009), by which 27 sub-Saharan African countries committed themselves to promote and protect the rights of people deprived of their liberty and to provide comprehensive, evidence-based TB and HIV prevention, treatment, care and support in prisons;[140]
- Southern African Development Community (SADC) (2011), Minimum standards for HIV and Aids, TB, hepatitis B and C and STIs prevention, treatment, care and support in prisons in the SADC region;
- WHO (2014), Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, bringing together all existing guidance relevant to five key populations, including people in prisons and other closed settings, and updating selected guidance and recommendations, to increase awareness

135. Kerr et al. (2004).
136. Zurhold and Stöver (2015) ; Michel et al. (2015).
137. WHO (1993).
138. UNODC with WHO and UNAIDS (2006).
139. UNODC with UNAIDS 2007.
140. AHPPN (2009).

of their needs; improve access, coverage and uptake of effective and acceptable services; and catalyse greater national and global commitment to adequate funding and services;[141]

- UNAIDS (2015), Background Paper, demanding urgent action for the prison population to be taken within the UNAIDS Fast-Track Strategy (2016-21).[142]

These and other publications, conferences, workshops and research recommendations have led to changes in perceptions, views, attitudes, policies and practices in many sub-Saharan African prisons: HIV-prevention services have been introduced or expanded. Prisoners are now identified as an extremely vulnerable group with special HIV/Aids, STIs and TB-related needs: "Expanding the response to HIV in prisons in the coming years, and supporting efforts by governments and civil society in this area, are an urgent necessity".[143]

4.1.8. Provision of disinfectants

The provision of bleach or other disinfectants to prisoners is an option to reduce the risk of transmission of blood-borne viruses through the sharing of injection equipment, particularly when sterile injection equipment is not available. Many prison systems have adopted programmes that provide disinfectants to prisoners who inject drugs as well as instructions on how to disinfect injecting equipment before re-using it. Evaluations of such programmes have shown that it is feasible to distribute bleach in prisons and does not compromise security.[144] Studies in the community have, however, raised doubts about the effectiveness of bleach in decontaminating injecting equipment. Today, disinfection as a means of preventing HIV is regarded only as a second-line strategy to syringe exchange programmes (WHO 2004b).

Cleaning guidelines recommend that injecting equipment should be soaked in fresh full-strength bleach (5% sodium hypochlorite) for a minimum of 30 seconds. More time is needed for decontamination if diluted concentrations of bleach are used. A review of the effectiveness of bleach in preventing hepatitis C infection (Kapadia 2002) concluded that "although partial effectiveness cannot be excluded, the published data clearly indicates that bleach disinfection has limited benefit in preventing [hepatitis C virus] transmission among injection drug users". In prisons, the effectiveness of bleach as a decontaminant may be even further reduced.

4.1.9. Needle and syringe exchange programmes

In the community, needle and syringe exchange programmes are widely available in many countries and have been proved to be the most effective measure available to reduce the spread of HIV and hepatitis through the sharing of contaminated injecting equipment. In prisons, however, needle and syringe programmes remain rare, although they have been successfully introduced in about 70 prisons in a growing number of countries, including Germany, Kyrgyzstan, Luxembourg, Moldova, Romania, Spain, Switzerland and Tajikistan (UNODC 2015). Evaluations of existing programmes[145] have shown that they:

- do not endanger staff or prisoners, and in fact make prisons safer places to live and work;
- do not increase drug consumption or injecting;
- reduce risky behaviour and transmission of disease, including HIV and hepatitis C virus;
- have other positive outcomes for the health of prisoners, including a drastic reduction in overdoses (reported in some prisons) and increased referral to drug-treatment programmes;
- have been effective in a wide range of prisons;
- have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons; and
- have been successfully used in prisons alongside other programmes for preventing and treating drug dependence.

When prison authorities have any evidence that injecting is occurring, they should introduce needle and syringe programmes, regardless of the current prevalence of HIV and the hepatitis infection rate.

Despite the massive over-representation of injecting drug users in custodial settings worldwide, the availability of harm-reduction measures in prisons lags far behind the availability of these interventions in the

141. WHO (2014b).
142. UNAIDS (2015).
143. Ibid.,; see also recommendations.
144. Stöver and Trautmann 2001; Correctional Service of Canada 1999; Dolan et al. 2005; Dolan, Wodak and Hall 1999.
145. Dolan, Wodak and Hall 1999; Lines et al. 2006; Stöver and Nelles 2003.

general community. Illustrating this gap most vividly is the provision – or lack thereof – of needle and syringe programmes. For example, in 2007 the Commission of the European Communities found that, although 24 of the EU member states had needle and syringe programmes in the community, only three of those countries had introduced them into prisons. This disparity led the Commission to conclude that:

> Harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equivalence adopted by United Nations 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 countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services.[146]

The Commission's findings were confirmed and expanded a 2008 report from the Regional Office which monitored states' progress in achieving the goals of the Dublin Declaration[147] . This report found that, of the 53 signatory countries, condoms were available in prisons in only 18, substitution treatment in 17 and syringe exchange programmes in six. A review by the International Harm Reduction Association in 2009 found the situation had only marginally improved: nine countries in Europe and central Asia had introduced syringe exchange in prisons and 28 had substitution treatment.[148]

4.1.10. Transferring harm-reduction strategies into the prison setting

Despite the evidence that prisons can successfully introduce harm-reduction measures, with positive results for prisoners, staff and ultimately for the community, many are still afraid that introducing such measures would send the wrong message and make illicit drugs more socially acceptable. Many prisoners are in prison because of drug offences or because of drug-related offences. Preventing their drug use is an important part of their rehabilitation. Some argue that acknowledging that drug use is a reality in prisons would be acknowledging that prison staff and prison authorities have failed. Others say that making needles and syringes available to prisoners would mean condoning behaviour that is illegal in prisons. However, since HIV and hepatitis B and C seriously threaten prisons and communities, harm-reduction measures must be introduced to protect public health. Making available to prisoners the means necessary to protect them from the transmission of HIV and hepatitis C virus does not mean condoning drug use in prisons. Introducing needles and syringes is not incompatible with a goal of reducing drug use in prisons. Making needles and syringes available to drug users has not increased drug use but has reduced the number of injecting drug users contracting HIV and other infections.

4.1.11. Involvement of community services

In the past decade, there have been new approaches aiming to divert individuals away from prison and into treatment alternatives as well as (for prisoners) into a range of services in prisons. Specific legislation in several countries has been introduced with the purpose of enhancing links between the criminal justice system and health services to reduce the number of drug users entering prison. Despite these developments, the number of prisoners with drug dependence has continued to grow. As drug users often serve short sentences, they return to their communities and many return to their old drug-using habits. Support services need to be continued in order to sustain successes achieved while in custody. This indicates that criminal justice agencies need to improve their links with drug services.

4.1.12. Pre-release units and aftercare

Prisoners should start preparing for release from the outset, 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 get prisoners off drugs and keep them drug-free 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; and

146. European Commission 2007.
147. Matic et al. 2008.
148. Cook 2009.

- taking effective measures such as the 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 like employability, educational deficits and the maintenance of family ties.

Many prisons undertake efforts to reduce relapse and to provide social reintegration. Protocols are 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. Peer groups have been developed to support treated drug addicts to prevent relapse.

Several studies show that effective aftercare for drug-using prisoners is essential to maintain gains made in prison-based treatment.[149] Nevertheless, prisoners often have difficulty in obtaining assessments and payment for treatment on release under community care arrangements. In view of the increased risk of overdose death, especially in the first two weeks after release, it is important to prepare prisoners with drug problems for the risk of overdose and to ensure the close follow-up of released prisoners with any drug problems[150] .

4.1.13. 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 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 use 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.

In Germany, Section 35 of the Opium Law allows prisoners to undergo treatment instead of punishment when the sentence is no more than two years. Estonia has also developed such an alternative.

4.2. RESPONSES TO DRUG USE IN PRISONS IN THE NINE COUNTRIES AND KOSOVO*

Introduction

Responses to drug use in prisons depend to a great extent on available financial and human resources. Other influential factors include legal regulations, attitudes of staff (doctors, nurses, security), priorities of responsible persons within the ministries in charge and, finally, developments in the community (progress which has generally been more advanced than corresponding responses to drug use in prisons). A lack of funds has meant that monitoring of interventions has often been weak, which has had a negative impact on the results of health care.

In Georgia, the new leadership of the Ministry of Correction has taken some effective steps to improve health-care delivery in the penitentiary system, and prison health-care reform has been assisted by a dramatic reduction in the number of prisoners. According to the Ministry of Correction, the health budget increased by 100% between 2012 and 2014. Primary health-care units have been established in all prisons, employing multidisciplinary teams and corresponding in full to Georgian health-care standards. If the treatment of a prisoner is not possible in the medical unit within the penitentiary establishment, he/she can be transferred to the Central Correctional Hospital. In cases where a prisoner cannot be treated there, he/she may be transferred to a civil sector medical establishment. TB patients are treated in a separate TB Hospital (the Medical Establishment for Tuberculosis Inmates in Ksani). Dental services are available in all penitentiary institutions. Voluntary counselling and testing for HIV/Aids and ARV treatment is available to all inmates, delivered by the same health facility (National Aids and Clinical Immunology Center) as the civil sector, using the same protocols and medicines as the civil sector. The same applies to TB and HCV testing and treatment. There has been a general breakthrough in the country in the availability of HCV treatment – joint efforts by civil society organisations and the government have resulted in a 60% reduction in the price of HCV medications. As a result, this treatment is now available free to 1 000 prisoners, and at a significantly reduced price to 10 000 patients in community settings.

149. Zurhold, Haasen and Stöver 2005.
150. WHO 2010.

In view of the part that drug use can play in the spread of infectious diseases in many countries, problem drug users have become of increasing importance to health care, both in the community and in prison settings. However, reports from South-East Europe generally, and from the "the former Yugoslav Republic of Macedonia" in particular, show insufficient awareness by officials of the spread of drug addiction and related infectious diseases in prisons.

The basic problem underlying this lack of awareness is the fact that drug dependence is not perceived as an illness but as an offence. This is the main impediment to treating drug-dependent prisoners adequately. According to experts, there is a certain amount of denial in the treatment of addiction in prisons, with institutions and administrations making erroneous claims that no drug problems exist within their walls, as is the case with the State Penitentiary Service of Ukraine (SPSU).

However, in some jurisdictions a guarantee of adequate health care has been explicitly expressed in law. According to Georgian legislation, the right to health of prisoners held in the penitentiary system is guaranteed by the "Code of Imprisonment".[151] The relevant chapter of the code (Organising Health Service) defines the main principles of the health service and the requisite health status of an inmate. The regulation on medical service for inmates is also referenced in a Georgian law concerning "Health protection". The law protects against any act of discrimination towards prison patients in respect of medical care. In the field of health protection, the rights of prison inmates are additionally defined in Georgian legislation on the "Patient's rights", according to which a person who is under preliminary detention or is already in prison has the same right to health as patients in the civil sector.

The current "Prison Health-Care Strategy 2014-17" of Georgia recognises the need for the treatment and rehabilitation of prisoners with dependency problems as one of its strategic objectives. The document states the need to expand methadone detoxification, introduce long-term methadone maintenance treatment and develop evidence-based rehabilitation programmes for inmates affected by substance use and dependence.

In "the former Yugoslav Republic of Macedonia", an explicit "Strategy for Health Care of Prisoners 2012-14" has been developed, featuring an action plan, five protocols for health care, 12 guidelines for different areas of health care of prisoners and a programme for psychosocial support for prisoners dependent on drugs. The strategy also emphasises that formal arrangements have been taken to ensure that there is an increasing perception of the substantial importance of prison health care.

Although many important steps have been taken to improve treatment responses for drug users in Albania, drug treatment and rehabilitation remain of low priority and have yet to receive adequate attention from government and donor agencies. Moreover, the majority of health providers have little knowledge or experience of substance abuse, overdose prevention, early diagnosis or treatments. The prison system does not provide specialised services, and has yet to develop a treatment plan or separate ward for treating drug-dependent prisoners. Prisoners with drug problems generally take a similar pathway through the prison system to that of other prisoners. Those who have been taking opioid agonist treatment to treat heroin dependence while in the community can continue that treatment during their prison sentence. The methadone maintenance therapy (MMT) programme, which is supported by the NGO Aksion+, can be provided either during the pre-trial phase or in prison.

It has been reported that medical services in Bosnia lack sufficient capacity and, on account of reduced human resources, there are often situations in which prisoners are left without professional medical services from 17:00 until 08:00 the next day.

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151. Article 24 (1) of the Imprisonment Code of Georgia, ensures the right to health care for prisoners. In particular, an accused/convicted individual has the right to use necessary medical services. In case of necessity, an accused/convict has access to medication/medical remedies allowed in the establishment for pre-trial detention/deprivation of liberty. If so requested, an accused/convict shall be authorised to purchase at own expense more expensive or similar medication and medical remedies than those procured by the relevant establishment. In cases of reasonable requests, with the permission of the Chairman of the Department, an accused/convict is authorised to invite a personal doctor at his/her own expense. In accordance with Article 119 of the Imprisonment Code of Georgia, the medical service for accused/convicts shall be provided in accordance with the medical service requirements established in the country in the field of health care. The state of health of an accused/convict is assessed on an annual basis. Any ill accused/convict is provided with emergency treatment (Article 120 (2)). The Imprisonment Code of Georgia ensures the possibility of undergoing treatment in doctoral-medical units set up in each establishment (Article 121 (1)). Furthermore, pursuant to Article 121 (2), if it is not feasible to provide treatment for an accused/convict in a doctoral-medical unit, he/she will be transferred to the medical establishment of the department or to a public hospital. Psychiatric aid for convicts is guaranteed by Article 122 of the Imprisonment Code of Georgia. In particular, if, based on the ambulatory examination, the convict displays signs of a psychiatric disorder then the Ministry's Psychiatric Commission will decide whether or not to impose coercive psychiatric treatment in hospital. Then, the administration of the establishment shall apply to the competent forensic establishment to conduct a court-psychiatric examination. The administration of the custodial establishment is liable to apply to the court in 48 hours for imposing coercive psychiatric treatment based on the conclusion of the Ministry's Psychiatric Commission if the latter identifies the necessity of imposing coercive psychiatric treatment.

Confidentiality

Confidentiality is another key issue in the treatment of drug-dependent inmates in most prison systems. The status and structure of the health-care and drug service in prisons are very important related factors that can affect service accessibility. Where prisoners doubt the confidentiality of health-care services, they tend to avoid utilising these services. For example, in "the former Yugoslav Republic of Macedonia" the drug-dependent persons sentenced to prison or detained who were interviewed had confidence in the medical staff and considered it safe to share their problems with them. The doctor from Skopje Prison reported that patient records and data were secure and protected, but there were cases where security staff requested a urine analysis to test for the presence of drugs in respect of some drug-dependent persons sentenced to prison or detained. Staff in Idrizovo Prison reported that patients' records were carried to the doctor by the security staff who provided an escort in the ambulance or by inmates who were assigned work in the prison ambulance. Security staff or other persons are not present during examinations in outpatient facilities.

The medical records in Montenegro are kept in the main infirmary of the Health Centre in the Remand Prison (including personal files of prisoners), but the entries in those files were very cursory (with no detail as to complaint, diagnosis or examination); according to the nurses, this was a consequence of understaffing and the extreme workload imposed upon clinical staff. The same applied to the filling of registers on hunger strikes, laboratory investigations, traumatic injuries and X-ray examinations, and a logbook of daily activities.

With regard to the confidentiality of medical consultations, according to internal house rules, custodial staff should only be present during such consultations if this has been assessed as necessary by health-care personnel. However, the delegation found that a prison officer was present as a matter of course during medical examinations of prisoners. The confidentiality of medical records was not always respected. At times, personal medical documentation on prisoners was shared with the prison director at his request. Doctors acknowledged that this practice was well established, but they appeared to be unaware that they were infringing the rights of their patients (prisoners). Further, the delegation observed that personal medical files of sentenced female prisoners were kept on the shelves of the consultation room of pavilion F of the Institution for Sentenced Prisoners (KPD), where they were potentially accessible to custodial staff. The confidentiality of medical documentation should be observed in prisons in the same way as in the wider community.

As prisons often represent neglected areas of public health policy, the authors reviewed a range of national strategies for mentions of prisons (see Table 5).

Table 5: Are prisons and harm reduction mentioned in relevant policies?

	National Drug Strategy – Prisons	National Drug Strategy – Harm Reduction	National HIV/ Aids Strategy – Prisons	National HIV/ Aids Strategy – Harm reduction	Other relevant policies
Albania	no	yes	yes	yes	
Bosnia and Herzegovina	yes	yes	yes	yes	Harm-reduction policy in Federation of Bosnia and Herzegovina
Georgia	yes	yes	yes	yes	
Kosovo*	yes	yes[152]	yes	yes, condoms distributed	none
Moldova	yes	yes	yes	yes	
Montenegro	yes	yes	yes	yes	
Russia	no	no	yes	no	
Serbia	yes	yes	yes	yes	
"The former Yugoslav Republic of Macedonia"	yes	yes	yes	yes	City drug strategy has chapter on harm reduction
Ukraine	yes	yes	yes	yes	

152. Needle exchange is included, but not implemented because the authorities in Kosovo* deny the existence of drug use in prisons.

Treatment instead of punishment and alternative punishments

In 2011 Russia introduced a norm that allows judges to sentence people to "treatment instead of punishment". Under this system a person who has committed a minor drug-related crime may have his/her conviction deferred if they agree to undertake drug treatment.

In accordance with Article 82.1 of the Criminal Code or Administrative Code of Russia, "the court may suspend sentencing until the end of treatment and medical and social rehabilitation, but no more than five years" for persons suffering from drug addiction, and only in those cases where they have committed one of the following offences: the first part of section 228 ("illegal acquisition, storage, transportation, manufacturing, processing of narcotic drugs, psychotropic substances or their analogues, as well as the illegal acquisition, storage, transportation of plants containing narcotic drugs or psychotropic substance, or parts thereof containing narcotic drugs or psychotropic substances"); the first part of section 231 ("The illicit cultivation of plants containing narcotic drugs or psychotropic substances or their precursors"); section 233 ("Illegal distribution or forgery of prescriptions or other documents entitling to narcotic drugs or psychotropic substances"). These rules of the Criminal Code provide for various types of penalties: fine, correctional work, compulsory labour, forced labour, restriction of liberty, imprisonment, deprivation of the right to occupy certain positions or engage in certain activities. Currently the degree of application of these options is very low – for example, according to FPS statistics, only 193 people had been given a suspended sentence in 2013 and 239 in the first nine months of 2014.

In Kosovo*, alternative punishments for drug users include suspended sentences, semi-liberty and community service. A suspended sentence may also include mandatory rehabilitation treatment and/or an order for supervision by the probation service. In some instances, judicial cautions are substituted for punishments should the judge feel this would serve as an adequate deterrent. Accessory punishments include deprivation of rights, such as confiscation of the offender's driving licence.

Drug services in prisons

Traditionally, drug services are in the main abstinence-oriented, a predominant objective that is even more common in prison than the community. Abstinence correlates with the task of prisons of educating and supporting prisoners to ideally lead a life without committing further criminal offences, to desist from any further drug use and to reintegrate into society.

In Georgia the recently opened Department of Addictology at the Central Correctional Hospital offers drug-free residential detoxification. Eleven beds are available at the department, staffed by a doctor-narcologist, a nurse and psychologist. However, no long-term post-detox treatment (rehabilitation) is provided.

The system of drug treatment in Russia is built upon abstinence from drugs as the treatment goal. According to the Federal Law on Drugs, the medical treatment can only be provided by the designated state narcological treatment centres, whereas rehabilitation can be provided by generalists within the public sector. Medical treatment is guided by standards developed by the Ministry of Health and Social Development of the Russian Federation.[153] These standards are based on the use of antipsychotic drugs (neuroleptics, tranquillisers), anti-convulsants and nootropes. All approved treatment protocols in Russia stipulate the need to stop using opioid agonists (such as heroin, methadone or buprenorphine) immediately after admission into the treatment programme.

These methods follow the Soviet-era models of repressive psychiatry, which is contrary to international standards[154] and often amounts to avoidable suffering and humiliation for drug-dependent people. The EMCDDA concludes that, for the treatment of opioid dependence, "detoxification under heavy sedation does not work and can actually be harmful."[155] The WHO asserts that: "Opioid withdrawal (rather than maintenance treatment) results in poor outcomes in the long term" and that "opioid agonist maintenance treatment, combined with psychosocial assistance, was found to be the most effective."[156]

In general, the conditions of medical services in Russian penitentiaries are very poor. The Minister of Justice himself has characterised them as "overwhelmingly archaic" because "the medical service at the Federal Service of Corrections today cannot cope with the flow of human material that ends up in the penitentiary

153. Order of provision of medical help on the profile "narcology". MoHSD Order No. 929н of 15 November 2012, available at www.garant.ru/products/ipo/prime/doc/70238588/ [in Russian].
154. Rhodes et al. (2010), 341:c3439.
155. EMCDDA (n.d.).
156. WHO 2009: xi, xii.

facilities".[157] According to a report published by the prosecutor general's office in 2010, more than 90% of inmates had health problems. The same report indicated that 60% of clinics were using outdated equipment, and the prison medical system had been receiving only 24% of necessary funding.[158] Several decisions of the European Court on Human Rights confirm that Russia's prisons are severely overcrowded and lack adequate health care.[159]

Drug-free wards

Some countries provide drug-free wards, with segregated accommodation (at any point from initial reception into prison) for prisoners who are found to have consumed drugs or are suspected of being drug users. This approach is characterised by two different models:

- all people with an identified or suspected drug problem being sent to a drug-free ward;
- drug-free wards being available to drug users who specifically ask to stay there, with other segregated accommodation provided for drug users who are not interested in treatment or abstinence.

As Table 6 shows, treatment for drug dependence is still very limited in prisons and often unavailable in pre-trial detention centres.

Self-help groups

Prison drug services in the places studied are mainly oriented towards the involvement of self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), 12-step Minnesota programmes (an intensive treatment programme, usually of around six weeks' duration) or cognitive behavioural therapy (CBT).

157. Golichenko and Sarang (2013).
158. Parfitt (2010).
159. *Kalashnikov v. Russia*, ECHR (2002).

Table 6: Drug services in prisons

	Drug-free unit		NA		Self-help groups other than NA		CBT		Religious programmes		Any other drug-treatment programmes	
	yes/no	no. of prisons	yes/no	no. of prisons	yes/no	no. of prisons	yes/no	no. of prisons	yes/no	no. of prisons	name of programme	no. of prisons
Albania	No		No		No		No		No		Methadone	18
Bosnia and Herzegovina	Yes	6	No		No		no		yes	15	no	
Georgia	No		No		Yes	3[160]	No		No		Inpatient drug-free detox	1 – Central Correctional Hospital
Kosovo*	No		No		No		No		No		detox (Tramadol plus Diazepam)	No data available
Moldova	No		No		Yes		No		No		Methadone pharmacotherapy	11
Montenegro	No	1	Yes	1	yes	1	no	1	no	1	MMT continuance	1
Russia	Yes		Yes	No data	yes	No data	yes	yes	yes	yes		No data
Serbia	Yes	1	No		no		yes	23	no		no	
"The former Yugoslav Republic of Macedonia"	No	0	No	0	no	0	Yes[161])	2 in Skopje	no	0	no	0
Ukraine	No	0	No	0	No	0	No	0	Yes	Yes[162]	OAT in 6 SIZO	0

160. Minnesota model.
161. Two doctors are trained in CBT.
162. In some prisons.

Opioid agonist treatment (OAT)

There often is a substantial delay between improvements in drug services in the community and the same in prisons. As an example, the gap between the introduction of OAT in the community and in prisons in the countries of the EU is estimated by EMCDDA at 15 years. This indicates that state-of-the-art medicine or interventions like OAT may take a considerable time to be implemented in prisons. However, some EU countries managed to introduce OAT in prisons shortly after the first successes in the community, and so did some Eastern European states, which may serve as good examples (e.g. "the former Yugoslav Republic of Macedonia"). Compared with the 1980s and 1990s, today the evidence for OAT is much more widespread – including for a prison setting.[163]

The WHO considers opioid agonist treatment as one of the most effective treatments for opioid dependence, as it greatly reduces heroin and other illicit opioid use, as well as restricting associated criminal behaviour among drug-dependent people, although it has only a moderate effect on reoffending.[164] The WHO, UNODC and UNAIDS list OAT as a mandatory component of any comprehensive package for HIV prevention among people who inject drugs, including those held in prison settings.[165]

The implementation of OAT is limited in the places evaluated, both in the community (0% in Russia, 2.9% in Ukraine, 16.5% in "the former Yugoslav Republic of Macedonia") and consequently in prisons (see Table 7). In general, OAT services in the community have been implemented only since about 2010. The gap between first introduction in the community and subsequent introduction in prisons is on average 6.5 years. Unlike the EU estimated average of 15 years, some of the nine countries covered by this study have managed to introduce OAT within a very short period of time. In Kosovo* there was just one year between the introduction of OAT in the community and in prisons.

In Georgia detoxification with methadone is available in two pre-trial detention facilities – in Tbilisi (80 slots) and Kutaisi (50 slots). So far this treatment has been focused on short and mid-term interventions (up to 6 months), with the aim of detoxifying inmates with opioid dependence in order to get them drug-free by the time they are transferred to a long-term detention facility.

In Moldova, the methadone substitution treatment programme was approved by Order of the Ministry of Health no. 159 of 20 May 2003. In accordance with Government Decision no. 166 of 15 February 2005, methadone substitution treatment was applied in penitentiary institutions; thus, the Republic of Moldova became the first country in the Commonwealth of Independent States to introduce this treatment in penitentiaries.

However, despite particularly high prevalence rates of opioid-using prisoners in some countries, OAT is either completely prohibited (Russia) or has still to be introduced (Montenegro and Ukraine).

In Ukraine, despite the proven effectiveness of OAT and the adoption of Order No. 821/937/1549/5/156 of 22 December 2012, this health strategy is unavailable for IDUs in prisons. Consequently, when a person has started OAT in the community, the treatment is discontinued upon imprisonment.[166] A little progress was evident in 2013: while no prisons implemented OAT in Ukraine, it was implemented in six of 23 pre-trial establishments during that year[167] or 18 detainees altogether – that is, 18 of the 2 535 officially registered opioid-dependent prisoners.[168] These 18 persons had all been receiving OAT prior to arrest. OAT was given to them in a SIZO prior to detoxification treatments that they were scheduled to receive before being moved from the SIZO to prison.

The mode of provision of OAT and the OAT drugs licensed and dispensed vary considerably from one place to another. In Albania, for example, an NGO provides OAT in prisons, whereas in other countries this is done either by a ministry – of justice, the interior or health – or by clinical staff employed by the correctional institutions.

Often only short-term methadone maintenance therapy is provided for prisoners with drug use/dependence problems (e.g. Albania). However, in some countries ("the former Yugoslav Republic of Macedonia", Serbia) the coverage of OAT in prisons is 100% or very high (Moldova). OAT is available in a little under half of all prisons in Bosnia and Herzegovina, and in some places the coverage is very low (Georgia, Kosovo*). In Ukraine OAT is only available in SIZOs.

Financial difficulties arise in the case of some patients enrolled in OAT in the community once they enter prison. These difficulties include budgetary constraints and/or the lack of a specific budget allocation to fund

163. Hedrich et al. 2012.
164. WHO (2009).
165. WHO (2012).
166. EMCDDA and Ukrainian Medical & Monitoring Centre of Alcohol and Drugs (2011).
167. Zlobinets (2014).
168. Ibid.

OAT in prison. In "the former Yugoslav Republic of Macedonia", methadone is available to every prisoner who needs it, funded by the Ministry of Health's programme for opioid-dependent prisoners, with the exception of Skopje Prison and Bitola Prison, where the cost is met from the prisons' own budgets, as responsibility for funding methadone has yet to be transferred from these two prisons to the Ministry of Health. Buprenorphine is available for drug-dependent persons only at the Clinic for Toxicology where urine tests and check-ups take place. It is also paid by the Ministry of Health.

The precise ratio of OAT patients to the total number of opioid-experienced or -dependent prisoners is generally unknown in the places studied, but in "the former Yugoslav Republic of Macedonia" 43% of opioid-experienced or -dependent users in prisons are in OAT. In Moldova it is 16.4%. In the other places the number of prisoners in OAT is still small compared to the number of opioid users.

Models of commencing OAT as "retoxification" for prisoners with a history of opioid dependence shortly before their release (<6 months) as prophylaxis against the significantly raised risk of fatal overdose[169] have also not been implemented.

Retoxification to decrease the risk of imminent death is not undertaken regularly in "the former Yugoslav Republic of Macedonia". Some drug-dependent persons require dose increases or retoxification with methadone before release from prison. On rare occasions, doctors prescribe retoxification with methadone to drug-dependent persons with psychiatric co-morbidity before release from prison if they have previously discontinued therapy.

Substantial coverage of opioid-dependent prisoners with OAT has now been achieved in "the former Yugoslav Republic of Macedonia": of 746 PWUD, in 2011 more than half (414) were in methadone and 17 in buprenorphine treatment, that is, 57.8%. The number of prisoners in Skopje Prison at the end of April 2014 was 570 (194 convicted and 376 detained), of whom around 50 were drug users and 34 were on substitution therapy. The total number of prisoners in Idrizovo Prison in the same period was 1 558 (1 480 male, 78 female) of whom 468 were drug users, almost all of them opiate users (455 males, 13 female) and of these 195 (41.7%) were receiving substitution therapy (183 on methadone and 12 on buprenorphine).

In some places (e.g. Kosovo*), prisoners may only receive detoxification and an inadequate level of therapy due to the scarcity of treatment alternatives and resources.

In Russia a lack of medical assistance to people suffering opioid withdrawal occasioned by the absence of OAT is a widespread problem. According to the UN Special Rapporteur on torture, "There is no doubt that the withdrawal syndrome can cause severe pain and suffering if medical assistance is not provided accordingly, and that the condition of withdrawal in prisoners creates a strong potential for mistreatment."[170]

In Albania, medication-assisted treatment (maintenance) programmes (buprenorphine) or behavioural, cognitive, counselling, self-help and relapse prevention were totally lacking.

169. Farrell and Marsden (2008).
170. Nowak (2009), A/HRC/10/44, para. 57.

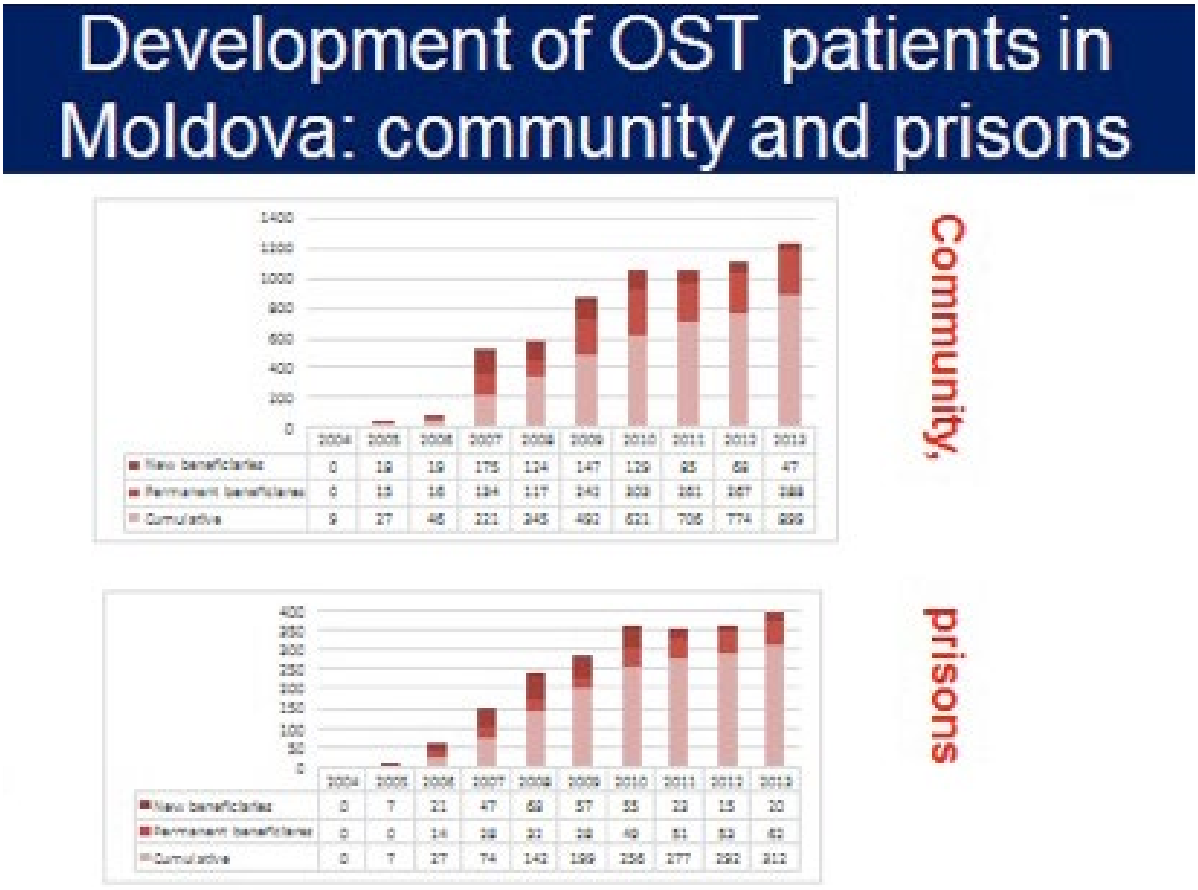
Table 7: OAT implementation in prisons and in the community

	Coverage: prisons with OAT/total no. of prisons	Detoxification with methadone/ buprenorphine – prisons with this service and total no. of prisons	OAT continued in prison?	Date OAT implemented in the community	Date OAT implemented in prisons	No. of OAT patients in prison (+proportion of all opioid-dependent prisoners)	No. of OAT patients in the community (+proportion of all opioid-dependent persons in the community)
Albania	18 prisoners			2005	No methadone programme in prisons; treatment provided by NGO on prison request	34 prisoners have received MMT	~600 under MMT of ~60 000 problematic drug users, 7 500 of whom are estimated to be injecting drug users
Bosnia and Herzegovina	6/15	5 on methadone or Suboxone®; 1 on Suboxone	Yes	1977	2014	not yet available – OAT just started	1 200 (10% of total population of opioid-dependent persons)*
Georgia	2/14	2 out of 14	no	2005	2008	130 (coverage not known)	2 300 (11.5% coverage)
Kosovo*	1/11	None	N/A	2012	2013	10	110
Moldova	11/17	No	Yes	2005	2005	63/385 (16.4%)	
Montenegro	0/1	not available	yes	2005	Approx. 2006 (MMT continuation)	12 (total number of opioid-dependent prisoners is not available)	131/total of opioid-dependent persons in the community is not available
Russia	prohibited	No	no	0	No	0	0
Serbia	29/29	29/29	29/29	2004	2005	143	1 700/30 000
"The former Yugoslav Republic of Macedonia"	13/13	Majority of OAT patients on maintenance, no explicit distinction between detoxification and maintenance	all	Circa 1994 (in day hospital), some individual cases from 1980	Circa 1994[171]	271/43.2% (271 patients in OAT out of 627 drug users, vast majority of them opiate users)	1 650/10 000 IDUs (vast majority are opiate users) in all services: public, private and prison services
Ukraine	0/146 prisons; 6 of 23 SIZO	0	6 in SIZO only	2004	2013	0 of 2 535 registered opioid-dependent prisoners	7 784 persons on 1 Sep 2014 (after Crimea annexation)[172]

171. In the biggest prison in Idrizovo, OAT is provided in a centre with GFATM support in 2005/6. Methadone was originally introduced in prisons in Skopje and Bitola, at almost the same time as in the community.
172. Of the estimated 300 000 opioid users and 270 000 opioid-dependent persons in community, 2.9% are on OAT.

Moldova can be described as a model of good practice: at the end of 2013, OAT was available in seven penal institutions; by the end of June 2014 it was available in 11 penal institutions (see Figure 2).

Figure 2: Introduction of OAT in prisons and in the community, Moldova



Harm-reduction measures

If we use the definition of the International Harm Reduction Development Program of the Open Society Foundation, "Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use, especially the risk of HIV infection."[173] It uses a variety of easily accessible services to meet the needs of drug users and connect them with the wider community while reducing drug-related harm. Since 2001, the Open Society Foundation has prioritised advocacy to expand the availability and quality of needle exchanges, addiction treatment and HIV treatment, to reform discriminatory policies and practices, and to increase participation by people who use drugs and those living with HIV in the development of policies that affect their lives.

Generally, an absence of harm-reduction measures was noted in most of the places studied. Only one country (Moldova) provided prison-based needle and syringe exchange and other harm-reduction measures. Due to a lack of governmental funding and ideological resistance, there is also very low availability in most of the nine countries and Kosovo* of other preventive measures (provision of condoms, disinfectants, individual razors or shaving blades).

Effective and efficient prevention models applied in the community are very rarely implemented in custodial settings. For instance, only about 60 out of more than 10 000 prisons worldwide provide needle-exchange programmes. Prevention of drug-related infectious diseases is therefore almost exclusively limited to significantly less effective interventions such as verbal advice, leaflets and other measures targeted at cognitive behavioural change. With the exception of Moldova, across all the places evaluated, HIV prevention is restricted to the distribution of information, education and communication (IEC) materials via workshops, seminars and printed

173. Open Society Institute, "Skills training and capacity building in harm reduction", 2004.

material. This means that the *HIV prevention, treatment and care in correctional settings and other closed settings: a comprehensive package of interventions* developed by the UNODC has been very inadequately implemented.

Prison authorities in Ukraine have reportedly been reluctant to recognise the existence of male-to-male sex or consensual homosexuality within prisons; condom provision is reported to be irregular and condoms are available only for conjugal visits.[174] Of those prisoners who received free condoms or razors/blades as a result of NGO projects, most reported that distribution occurred only once a month. Of particular concern is the situation in female prisons: 96% of women have never received condoms, 90% have never received disinfecting solutions and 84% have received no razor blades.[175]

The only harm-reduction measure implemented in a prison setting in Montenegro is the continuation of methadone maintenance treatment (MMT) for prisoners who had already started their therapy before being incarcerated. There are no detoxification measures in place, or official recommendations about them. Buprenorphine has not yet been introduced as a substitution treatment.

Despite a huge body of evidence about its effectiveness, no harm-reduction measures have been introduced in Russian prisons to date. The harm-reduction approach was not supported by the Ministry of Health and Social Development of the Russian Federation, the Federal Drug Control Service or the Ministry of Justice and, as indicated above, it is considered to be a threat to the National Drug Strategy.[176]

In "the former Yugoslav Republic of Macedonia", there has been a protocol for condom distribution since 2013, and condoms are distributed mainly in co-operation with NGOs.

Prison-based needle exchange

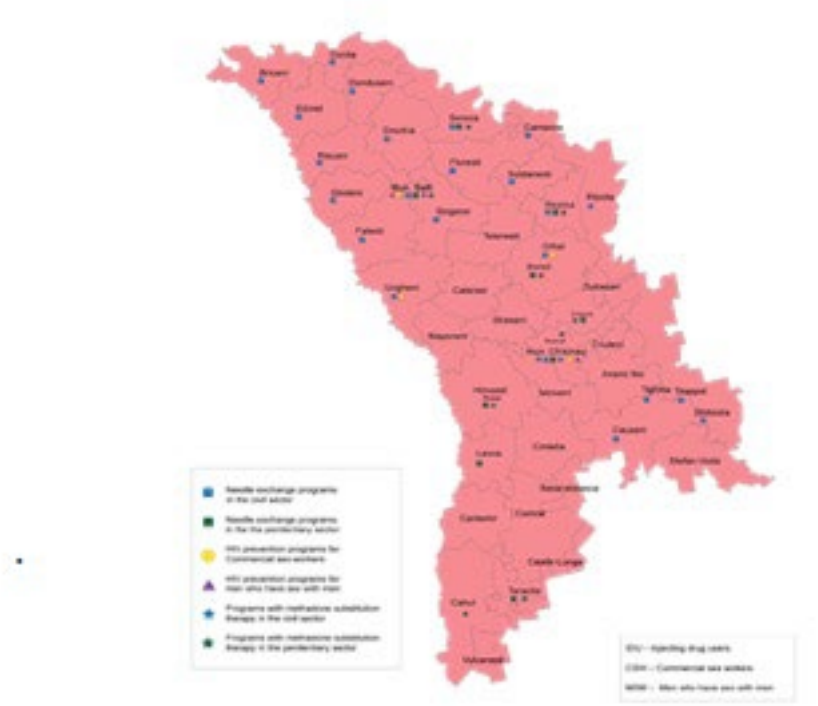
"In public health relating to prisons, harm reduction describes a concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment as well as adverse effects on mental health".[177] An essential part of effective harm-reduction programmes is needle exchange: the provision and disposal of needles, syringes and other sterile injecting equipment (e.g. spoons, filters, citric acid) in a variety of settings.

Needle and syringe exchange programmes in prison are available in only one of the ten places evaluated: the needle-exchange points in prisons in Moldova were accessible 24 hours per day in 11 penal institutions on the right bank of the River Dniester (see Figure 3).

Whereas in the other places, despite the considerable numbers of injecting drug users, needle and syringe exchange services are not viewed as necessary, Moldova started to introduce them very early on. The rationale for the implementation is that a harm-reduction approach in prison aims to reduce the relative risks associated with drug use, from reducing the sharing of injecting equipment, through to the stopping of injecting. Needle-exchange programmes, condoms, lubricants, bleach, safer tattooing and safer sex, complemented by awareness raising, training and education of staff about drug-using problems are all regarded as required and have therefore been provided.

174. UNAIDS (2009).
175. Socioconsulting (2007).
176. Russian President's Office (2010).
177. WHO Europe, 2005.

Figure 3: Development of needle exchange in Moldova: community and prisons



Coverage of the comprehensive package

Of the 15 prevention activities for PWIDs recommended in the penitentiary sector, 12 have been implemented in Moldova. The three activities not currently provided in penitentiaries are:

- vaccination and treatment of viral hepatitis,
- prevention of sexual violence,
- prevention of transmission through tattooing.

Table 8: Comprehensive package

	Information, education and communication	Condom programmes	Prevention of sexual violence	Drug-dependence treatment, including OAT	Needle and syringe programmes	Preventing transmission through medical or dental services	Preventing transmission through tattooing, piercing and other skin penetration
Albania	Yes	In overnight visit rooms only	n/a	Yes	No	No	No
Bosnia and Herzegovina	Yes/15	Yes/15	Yes/15	Yes/6	NO	Yes/15	No
Georgia	13	13		3		yes[178]	0
Kosovo*	Yes	Yes	N/A	Yes	No	Yes	N/A
Moldova	Yes	Yes	No	Yes	Yes	Yes	No
Montenegro	Yes[179]	Not available	Not available	MMT continuation available, all other unavailable	Not available	Yes[180]	Group and individual counselling available provided by NGO Juventas
Russia	yes	No	Yes	no	no	yes	No data
Serbia	Yes, 29	no	No	Yes, 29	no	yes	No
"The former Yugoslav Republic of Macedonia"	All	All	All	all	0	all	0
Ukraine	Yes, provided by NGOs	Yes[181]	No	See Table 7	No	Yes	No

178. When prisoners are treated in any medical establishment, universal prevention measures are taken. This is done as a routine element of any medical procedure, and not really labelled or identified as specific stand-alone transmission prevention.
179. The NGOs Juventas and Narcotics Anonymous deliver IEC materials and workshops to prisoners on topics related to drug use, harm reduction, co-morbidities, etc.
180. Group and individual counselling is available, provided by Juventas. Universal measures of protection.
181. Condom programmes covered 15% of prisoners in 2009; 16% covered in 2013 (UNODC 2014b).

4.3. THERAPEUTIC COMMUNITIES

While in some countries outside Europe therapeutic communities in prisons are a well-developed approach to treating drug addiction, this promising intervention has still to develop in many European prisons. In 2011 Romania began to introduce its version of this therapeutic model in three prisons in Jilava, Rahova and Târgsor. Their reported success raised the interest of the neighbouring countries of Moldova and Serbia, which studied the Romanian model and decided to adopt this approach and add it to their prison treatment systems. In collaboration with the Pompidou Group of the Council of Europe and financed by the Council of Europe and the European Union in a joint programme for the rehabilitation of drugs-using prisoners, the Moldovan Department of Penitentiary Institutions launched a pilot project in February 2015 with the aim of establishing two therapeutic communities, one in a female and one in a male prison, to complement existing services including harm-reduction interventions.

Therapeutic communities are a potent and well-developed methodology for treating drug addiction. It has been introduced worldwide and modified to suit local cultures and traditions and different target groups. Despite these differences, the basic elements of treatment remain the same and the model is based on the same elements. The methodology contains a wide range of behavioural and psychological interventions to help clients change from an addictive lifestyle to a life without drugs. A therapeutic community is a society in microcosm where clients live together 24/7 and experience all aspects of life challenges in a safe environment. Clients have an opportunity to investigate the challenges and to change their perceptions and behaviour in response to these challenges. Therapeutic communities have been proven to be the most potent methodology for treating addiction; when supplemented by a rehabilitation-oriented aftercare programme, they can show high success rates in treatment outcome.[182]

Some of the basic elements of a therapeutic community are:

- mutual self-help
- common philosophy
- common values
- a daily schedule
- clear responsibilities
- hierarchic structure
- role modelling
- clear expectations

Responses to HIV/Aids, TB, hepatitis and other infectious diseases

Although the spread of HIV/Aids, TB and STIs is extensive in prison settings and often over-represented in the prison systems studied, the majority of prisoners are mostly provided with information only; prevention is almost exclusively limited to verbal advice, leaflets and other measures directed to cognitive behavioural change.

Equivalence in health care compared to community services is often not being reached. While, for example, Ukraine's response to the HIV epidemic has achieved progress in HIV treatment and prevention, in prisons these efforts are still far below adequate public health standards. There is an insufficient access to antiretroviral therapy and an almost complete absence of evidence-based drug-dependence treatment and harm-reduction programmes.[183]

In Montenegro a study of risk behaviour among prisoners related to the sero-prevalence of HIV, HBV and HCV showed a significant percentage of prisoners positive to hepatitis C, among whom there were significantly more individuals who were sentenced for crimes related to drug use than for other crimes. It has been confirmed that knowledge about HIV infection is insufficient:

- Slightly over a third of participants showed knowledge of HIV prevention (37.8%);
- Slightly over a quarter of participants showed knowledge of HIV transmission modes (26.5%);
- Using the UNAIDS indicator for knowledge of prisoners, 23.2% of prisoners had sufficient knowledge level;
- Only 1% of participants had a well-formed and desirable attitude to HIV;

182. See also Leon 2000.
183. UNDP (2013).

- There was a need for increased use of anonymous counselling and testing for HIV and other sexually transmitted infections;
- Over half of participants (51.4%) did not know where they could get HIV testing;
- A third (34.1%) of participants did not know their test results;
- Over half of participants (51.2%) believed that HIV testing in prison would not be provided;
- Only slightly over one fifth of prisoners had received counselling and education about HIV and other sexually transmitted infections.

In Albania, STOP Aids and Aksion+ are leaders in the field of STI/HIV and substance abuse prevention, and have systematically carried out series of awareness campaigns and sessions with prisoners, as well as training of prison staff/administration and prisoners. Over the years, these NGOs have identified and trained a considerable number of prisoner peer educators, who continue spreading information and messages about the prevention of HIV/Aids and substance use among prisoners. These NGOs have produced numerous IEC materials and training manuals on HIV/AIDS/STI and substance-use prevention, treatment and management. These topics are also part of the curriculum of the prison education service.

In Bosnia, vaccination against hepatitis B for the population most at risk of infection does not exist in prisons or in the community. Also, therapy for hepatitis C is very difficult, mainly due to the high cost of treatment and the long waiting list, both externally and in prisons.

The situation with HCV prevention and treatment has become especially alarming in some countries, as has the position of people living with HCV. For example, the number of patients with viral hepatitis in the penitentiary system of Russia was 51 147 in 2013, but 57 742 in 2014.[184] No data on the provision of hepatitis C treatment in prisons is available. In 2014 the Ministry of Health purchased at least 310 sets of treatment (48 weeks) with pegylated interferons for the Federal Penitentiary Service.[185] Additional sets may have been bought by the regions, but no specific data are available. According to press reports, treatment with linear interferons is also available in some colonies.[186]

Georgia has launched a national programme to tackle hepatitis C. Convicts will be screened for the disease and treatment will be free in the prison system, where the infection is common. For more detail, see the country report on Georgia in Chapter 4.

Services offering voluntary HIV counselling and testing for prisoners are more widespread, as Table 10 shows.

184. Vorobey (2014).
185. International Treatment Preparedness Coalition (2015) Access to medicines for treatment of hepatitis C in the Russian Federation in 2014 (in press).
186. Ivanovo AIDS Centre (2015).

Table 9: Implementation of the comprehensive package

Intervention	Albania	Bosnia and Herzegovina	Georgia	Kosovo*	Moldova	Montenegro	Russia	Serbia	"The former Yugoslav Republic of Macedonia"	Ukraine
Information, education and communication	√	√	13	√	√	√.[187]	√	√, 29	√	√[188]
Condom programmes	√,[189]	√	13	√	√	n/a	×	×	√	√[190]
Prevention of sexual violence	n/a	√		n/a	×	n/a	√	×	√	×
Drug-dependence treatment, including opioid agonist treatment	√	√	3	√	√	√[191]	×	√, 29	√	×
Needle and syringe programmes	×	×	×	×	√	×	×	×	×	×
Prevention of transmission through medical or dental services[53]	×	√, 15	√	√	√	. √	√	√	√	√

187. NGOs Juventas and Narcotics Anonymous deliver IEC materials and workshops to prisoners on aspects of drug use, harm reduction, co-morbidities, etc.
188. IEC provided by NGOs.
189. Condoms provided only in overnight visit rooms.
190. Programmes covered 15% of prisoners in 2009; 16% covered in 2013 (UNODC 2014b).
191. MMT continuation available, all other unavailable.
192. Answers to this question remained somewhat unclear. Some interviewees said that universal prevention measures are applied whenever prisoners are treated in any medical establishment, but this is done as a routine part of any medical procedure and not specifically identified as disease-transmission prevention.

4.4. RELEASE PREPARATION, PROBATION AND THROUGHCARE

Pre-release preparations must be planned and provided to ensure continuity of care, and access to health and other services after release must be a clear part of the programme preparing for release. However, release planning is challenging due to out-of-area imprisonment and time restraint on preparations, especially in case of release on parole. However, a lack of active referral, case management or other effective approaches to facilitating community reintegration, as well as a lack of continuity of care and treatment between prison and community is a barrier to the re-socialisation and adaptation of persons released from prisons.

In "the former Yugoslav Republic of Macedonia" – according to Article 197 of the Law on Execution of Sanctions[193]– the preparation for a prisoner's release starts with the admission in the prison, and gets more intense in the last three months before release, when the person sentenced to prison or detained should be involved actively in release preparation. In the last months of imprisonment, persons sentenced to prison or detention can look for jobs and accommodation, and can get help from prison staff.

As experiences in "the former Yugoslav Republic of Macedonia" have shown, most prisoners leave the prison with economic instability and limited job possibilities. Especially in the group of prisoners with a drug-dependent history, many of them leave prison with mental health problems or serious medical conditions, including HIV, hepatitis, and tuberculosis. Regarding an inter-agency co-operation in "the former Yugoslav Republic of Macedonia", there is a long-standing practice of good co-operation between the centres for treatment of addiction in the country and the prisons, as well as the Directorate for Execution of Sanctions, resulting in continued treatment of drug-dependent persons entering and leaving the prisons.

However, inter-agency co-operation is often lacking in many places (co-operation with NGOs, health-care services in the community, church, job agency, insurance, pension, ministries, etc.) and involvement of external specialists and civil society is insufficient.

In Ukraine the conditions and procedures for granting social benefits to persons serving sentences for a specified term are defined by the Law of Ukraine "On the social adaptation of persons serving or having served sentences in the form of restriction of liberty or imprisonment for a fixed term" # 5462-VI (5462-17) of 16.10.2012.[194] Social adaptation is defined as a set of activities to help released persons to adapt to the conditions of the social environment, protecting their rights and interests. Social welfare is a set of measures of state support and assistance to persons released from prisons aiming to assist these individuals in employment, professional re-training, adequate housing and living conditions, to prevent exposure to criminogenic factors and recidivism. According to the law, released persons should be provided with medical assistance at their residence or the place of registration in the manner prescribed by the law. Persons who at the time of release require inpatient care are sent to health facilities on the grounds and in the manner provided by the law. In the absence of released individuals' domicile or place of residence, care is provided through the referral agencies, institutions or organisations engaged in the social welfare, including specialised Centres for Social Adaptation.

In Russia, as part of the constitutional right to free medical care, people with HIV and tuberculosis are entitled to free medical care and medicines. The main problem is that, while there is co-operation between the prisons, medical authorities and city Aids and TB services, this co-operation is usually limited to sharing medical information and documents. There are no established case management schemes or probation services where people would be guided to the medical institutions. As pointed out in one publication "The most recent census of prisoners showed that 2.5 million people pass through the remand system every year. Fifteen per cent of prisoners had lost all social links with the outside - an increase of 6% on the previous census. They have nowhere to go; they are no one's concern. They are just released, and that's that."[195] There are only a few NGOs, which operate in large cities, that assist released prisoners with social adaptation, problems with accommodation, documents, medical care, etc. This presents a particular problem for prisoners with deteriorated health conditions. For example, upon release of TB patients from prison, the establishment addresses a notice and medical documentation to the medical anti-tuberculosis specialised institution of the place of arrival of the patient. The patient must apply to a medical specialised agency and register for treatment within 10 days from the date of arrival at the place of residence. But since there is serious lack of counselling and follow-up with the patients, many fail to complete the necessary steps. While there are not many studies focused on the problems of co-operation, one study on TB treatment in Kaliningrad[196] points to this problem. According to this qualitative study based on the interviews with both patients and health professionals, the system of

193. Official Gazette of RM no.02/06, 2010, 2013.
194. http://zakon4.rada.gov.ua/laws/show/3160-17.
195. Reiter (2011).
196. Sarang et al. (2010).

collaboration between the civilian medics and those working in the FPS has several major problems. The first problem is that many patients are released in very bad health conditions, often close to death. Those are mainly patients released on a compassionate release, or *Aktirovka* in Russian – a system of releasing patients in bad health condition. Some experts say they are only released in order to decrease mortality rate in prisons. Civilian medical doctors reported that the treatment of patients in that state is extremely problematic since they have not received proper treatment while in custody. As a result, many people die soon after release. Another problem concerns prisoners who are released at the end of their sentence, who often experience treatment interruptions. It is assumed that the patient will go to the tuberculosis clinic immediately, but in reality, ex-prisoners are overwhelmed with other more urgent social problems such as the lack of documents, money, housing, drug dependency. Therefore people delay visits to the TB or HIV clinics sometimes for months. Despite acute awareness of this problem, people are not provided with enough medication upon release and they often discontinue their treatment.

This breakdown in communication between civilian and prison medical services often leads to interruptions in treatment in both the treatment of tuberculosis and HIV and can lead to a treatment resistance and a decline in the patient's health. According to respondents working in the health services, collaboration is restricted by the fact that medical services are under the jurisdiction of two different ministries (the Ministry of Health and Social Development and the Justice Ministry) as well as the lack of a social support system when prisoners are released.

In Georgia prisoners with diagnosis of TB, Aids, Hepatitis C whose treatment was initiated during their imprisonment, are referred to the relevant facilities in civil sector upon their release.

In Moldova probation is understood as a set of activities of evaluation, assistance, psychological counselling, and supervision in the community of the person in conflict with criminal law (suspect, defendant and convict) with a view to his/her reintegration into the society and community protection from the risk of relapse. The referral of patients in OAT services (such as HIV, TB) is not established. Recommendations on the treatment of opioid-dependent patients with HIV and TB were not included in the national treatment protocols.

In Georgia pre-release programmes are at the embryonic stage. The Ministry of Corrections and Legal Assistance reports that such programmes are functioning in three establishments, including the women's facility. Psychologists and social workers start to work with inmates 4-6 months prior to their release. No specific programmes for inmates with substance-use problems are available although one development is the opening of a "half way house", which serves prisoners before the release and prepares them for re-socialisation. In addition, prisoners diagnosed with TB, Aids, hepatitis C, whose treatment was initiated during their imprisonment, are referred to the relevant facilities in the community upon their release.

In Moldova, since 2009 released prisoners who were on methadone substitution therapy have been receiving a signed document indicating the period of participation in methadone substitution programme, daily dose of methadone and data on the last dose. Based on this document, the patient can be included in the substitution therapy in the community, if he/she lives in the jurisdiction of Chisinau or Balti municipalities. This is a disadvantage for patients who live outside the jurisdiction of Chisinau or Balti municipalities.

According to the qualitative survey done in 2012 (Subata, 2012), there are at present wide gaps of evidence-based knowledge about OAT among medical and NGO staff. There could be risks that a patient received contradictory messages from physicians, nurses, psychologists, NGO specialists and outreach workers, which were directly involved in services. In the absence of common adherence to evidence-based information about OAT by staff, the co-ordinated multidisciplinary approach could not work. There was also a high risk for different myths and false information to prevail among OAT patients and the IDU population.

4.5. SENSITISATION, TRAINING AND EDUCATION OF STAFF IN DRUG-USE PROBLEMS

In the "the former Yugoslav Republic of Macedonia" no ongoing training is provided to either medical staff serving the prisoners and detainees or custodial staff. Almost all those interviewed emphasised the need for education and information to all employees in prisons and prisoners.

In Georgia, the ministry in charge acknowledges the need to educate and train health-care personnel and custodial staff in relation to drug use and the problems that might be associated with it. The Penitentiary and Probation Training Centre of the Ministry plans to include relevant topics in the training curricula for system personnel and/or for jobseekers at the Ministry of Corrections of Georgia.

In "the former Yugoslav Republic of Macedonia" a one-day workshop called "Specific treatment for drug addicted prisoners" was conducted in Skopje in October 2013, with the co-operation of the European Commission and financed through its TAIEX programme. The prison staff from Idrizovo Penitentiary Correctional Facility (PCF) – re-socialisation staff, security and medical staff – had an opportunity to upgrade their skills and build their professionalism in working with drug-dependent prisoners.

Almost all people interviewed emphasised the need for education and information for all employees in prisons and prisoners.

In Ukraine, a study conducted in 2012 on the knowledge of prison staff about OAT and their stance towards its introduction in the penitentiary system revealed that an extremely negative disposition towards people who use drugs is common among prison staff and narcologists compared with the corresponding attitudes of narcologists in the community.[197] The study showed that prison staff was likely to be misinformed about the effectiveness of substitution therapy. In this study, prison staff named religion (17.7%) and incarceration (18.9%) as the most effective strategies for treating addiction; OAT was supported by 7.4%. Prison staff considered that the main obstacles to OAT implementation were insufficient funding and staff training, licensure procedures and prison corruption, while community narcologist named prison corruption, insufficient leadership, training and funding as the leading barriers. Further, 25% of community narcologists and 53% of prison staff thought that IDUs should blame themselves for their addiction.

197. Altice and Dvoryak (2012).

Chapter 5

Conclusions and recommendations

GENERAL CONCLUSIONS

Many of the places concerned by this study – the nine countries and Kosovo* – are in transition, and their financial and economic burdens are mirrored in prisons. Safety is the priority task of prisons, health issues are lower on the (political) agenda of ministries and prison administrations, and consequently of prison managers. This leads to the following points:

- Drug dependence is not considered as an illness but as an offence by most prison staff. This is the main obstacle to treating drug-dependent prisoners adequately with state-of-the-art interventions and treatments.
- The need for equivalence of health care is not being acknowledged in most of the prison systems studied, but it should be taken as a guiding principle in running prisons.
- The particular ethos of punishment and how to treat (especially drug-dependent) prisoners dominates the extent, size and quality of health services for prisoners.
- Hierarchical systems in prisons hinder the acceptance and quick transfer of evidence-based knowledge in health care and interventions. The management of prisons shows a clear lack of evidence-based/evidence-informed decision making.
- There are many threats to professional ethics and the independence of medical doctors: involvement in solitary confinement, collaboration with security forces, disclosure of data and information, etc.
- Definitions of terms used to assess, monitor and react to drug use in prisons are heterogeneous and often not comparable, because there is no common understanding of the subject (drugs), the substances, consumption patterns and risk, with a lack of monitoring tools (see Harm Reduction International 2016) and controlling structures and measures.
- Responsibility for health care in prisons varies between countries, from Ministry of Justice to Ministry of Health, and there are some gaps in communication and collaboration.
- Overcrowding as seen in some prisons is a very serious threat to any efforts to control diseases in prison settings.
- The legal environment is not supportive for the provision of some prevention material. The prison population is dominated by males and in most of the nine countries and Kosovo* "(contextual) homosexuality" and same sex in general are very dangerous for prisoners if disclosed. Male-to-male sex is extremely stigmatised.
- There is a need to strengthen health and social care in prisons and to create a comprehensive and sustainable model of health and social care.
- Almost all diseases are over-represented in prisons; the same is true for drug use and drug dependence. Drug use is perceived as one of the main problems faced by prison systems. It threatens security, dominates relationships between prisoners and staff, and leads to violence, bullying and mobbing for prisoners, and often for their spouses and friends in the community.

- The prevalence of infectious diseases (particularly HIV and Aids, hepatitis B and C, and TB) is often much higher in prisons than outside – apart from TB, these diseases are basically driven by injecting drug use. Estimates of HIV prevalence range from <1% to 20% – which is disproportionally higher than in the community.
- High rates of injecting drug use, if coupled with lack of access to evidence-based prevention measures, can result in a rapid spread of HIV and hepatitis B and C.
- High-risk behaviour is continuing in prisons: studies indicate that over half of the drug-injecting population report in-prison injection drug use, among whom the majority shared equipment with several prisoners.

In many places there is an almost complete unavailability of effective addiction treatment (e.g. OAT), or the potential of such treatment has not been exploited yet. Detoxification treatment alone, short-term continuation and interruption of treatment can all have negative effects on the health of drug-dependent persons.

INDEPENDENT STATUS OF HEALTH CARE IN PRISONS

Health workers need to be independent in their work, professional and humane. All three components are important, especially when simultaneously present, allowing the authors to assume that health care in prisons is established and organised, and produces expected results. Medical staff are potentially at risk. Their duty to care for their patients who are prisoners can often conflict with the work of prison management and security. This can lead to difficult ethical challenges. In order to guarantee their independence in matters of health care, it is important that medical staff act in accordance with health-care standards normal in the community. Whatever the formal position of the prison doctor, his/her medical decisions should be governed exclusively by medical criteria. The independence of the medical staff can be enhanced if the quality and efficiency of their work is assessed by the administration responsible for health care, the Ministry of Health, which should also be the institution that manages the available funds used for prison health.

A prison doctor should act as the patient's personal physician, or as a substitute for the chosen doctor in the community. Accordingly, in the interest of safeguarding the doctor–patient relationship, a prison doctor should not be required to perform physical searches or examinations requested by an authority, except in emergency cases when no other doctor is available. From the fact that prison doctors cannot choose their patients and prisoners usually have no alternative, it follows that prison doctors have a professional obligation to treat cases even where the patient violates medical rules or resorts to threats or violence.

SHIFT OF RESPONSIBILITY FOR PRISON HEALTH CARE

Drug-dependence services and measures to address infectious diseases in prisons should be equivalent to the services provided outside prison. This can best be achieved by close co-operation and communication between prisons and community services, and by integrating prison drug strategies on blood-borne viruses into national strategies. It has been noted that

- there is a huge gap between the size, accessibility and quality of health-care services in prison and those in the community;
- drug services in prisons are not equivalent to services provided outside;
- closer co-operation and communication between prisons and community services is needed.

Therefore international organisations have recommended that the prison health system should be integrated into the national health system and the responsibility for prison health should be transferred to the Ministry of Health.[198]

DECRIMINALISATION OF POSSESSION OF DRUGS FOR PERSONAL USE AND WITHOUT INTENT TO SELL THE DRUGS

Based on the Russian experience, penitentiary systems are often overwhelmed by the high number of prisoners, including many drug users and people with serious health problems, and the medical capacity cannot cope with the burden. The majority of people serving time in prisons are sentenced for minor drug offences. In order to unburden the prison system, legislative changes are needed, most of all decriminalisation of possession of drugs for personal use and without intent to sell the drugs.

Drug laws – often too rigid – are responsible for the high number of prisoners or the high number of drug users among prisoners. The opportunity of "therapy instead of punishment" (applied in most criminal justice systems of current EU member states) can reduce the number of people incarcerated for minor drug offences or for other crimes committed by dependent drug users simply to be able to afford the drugs they need to avoid withdrawal. Thus changes and amendments to drug legislation (criminal and administrative) in some of the places covered in this study might contribute to clear definitions in law on the quantity of drugs for personal use, possession and trafficking, and when a drug-dependent prisoner can leave prison, to undergo inpatient or outpatient treatment, or be sent for treatment instead of going to prison.

FUNDING

Since they gained independence, many of the places covered by this study have been in transition from their former Soviet-organised state structure to become democracies with market economies. Moreover, territorial wars (e.g. in the former Yugoslavia, Georgia and Ukraine) have increased the financial and economic burden of the places covered by this study.

Poor funding of prison sector remains a major concern for most of them, thus limiting the number and extent of interventions that can be implemented. In the situation of budget crisis, prison health funding should not be cut even more. Current conditions provide inadequate access to health services and medicines, with interruptions of HIV, tuberculosis and hepatitis treatment, and a general absence of HIV and HCV prevention, including harm-reduction programmes, condom distribution and peer education.

Especially in places where external funding will end soon, some way of continuing prison health funding will have to be found, again with the help of international donors.

In particular, the introduction and development of drug-dependence treatment needs adequate funding and staffing (including psychiatrists, psychologists, individual and group work, and pharmacological treatment).

POLICE REFORM

It is necessary to focus also on police reform in order to discourage the police from arresting people for minor drug crimes, planting evidence and blackmailing people with threats of prison to extort bribes. Drug users should not be easy targets for achieving police quotas or objectives.

198. WHO/UNODC 2013, available at www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/Good-governance-for-prison-health-in-the-21st-century.pdf, accessed 8 October 2016.

Wide implementation of OAT is urgently needed in the prison system, in police stations, arrest houses and SIZO as well as in regular prisons.

EQUIVALENCE OF CARE AND HUMAN RIGHTS

Human rights principles apply to people charged with crimes related to illicit substances. This includes the right of addicted patients in prison to receive the health care and treatment that are also guaranteed at treatment centres in the community. However, there is a lack of equivalence in access to health care, treatment and harm-reduction measures between drug users in the community and those in penitentiary institutions; the right to health care of prisoners is frequently disregarded.

The gap should be bridged between the care, treatment and prevention services available in community medicine and what is available in prisons. Drug use should be seen as a medical condition and drug users should be treated according to health-care system standards. Prison health care should be compatible with the national health policy, and all health programmes and services available in the community should become available in the prison system, based on the best current standards and national guidelines.

ACCESS TO INTEGRATED HEALTH CARE

Prisons are settings with high risks of communicable diseases like HIV or tuberculosis. Prisoners often come from socially disadvantaged segments of the community and carry a higher burden of diseases than the general population, but this study shows the lack of a comprehensive strategy to address HIV, TB, co-infections (hepatitis and STIs), drug abuse and other health disorders.

However, for many inmates, prison is their chance to get access to comprehensive health care that is impossible in the chaotic lifestyle of a drug user. Imprisonment may be seen as an opportunity to provide a complex of integrative services, including treatment of infectious diseases, addiction and mental disorders, which will lead to improved prisoner health and reduced risks to the community on their release. There should be comprehensive management of HIV/ Aids and co-infections (TB, hepatitis and STIs) and of drug and alcohol dependence in prisons, including pre-trial detention centres, based on national standards and protocols. As female prisoners carry an even heavier burden of HIV infection and other diseases, women entering prison should be offered HIV testing and counselling for hepatitis C and sexually transmitted infections, while paying special attention to the psychosocial and health problems associated with these infections.

IMPROVED TREATMENT OF DRUG DEPENDENCE AND CO-MORBIDITIES IN PRISONS

Provision of a comprehensive drug policy for prisoners combining evidence-based elements of medical detoxification, psychological support, substitution therapy and effective prevention measures is needed (see Comprehensive Package by UNODC and others).

Health care in prisons should include access to drug-treatment programmes, according to the best community health-care standards. A wide range of drug services should be available to prisoners, based on local and individual needs. Interdisciplinary staff and multiprofessional teams should offer psychosocial as well as pharmacological treatment, and stimulate and enhance prisoners' potential for self-help.

Prison drug strategies require action for individual behavioural change as well as on the structural level. Although it is important to target programmes at individual prisoners or groups of prisoners, there is also a need for more structurally oriented measures, running concurrently, to address comprehensively the need for improvements in prisoners' living conditions and the working conditions of prison staff.

In order to guarantee a clear, robust system of treatment, it is obvious that guidelines, detailed protocols, standard operating procedures (SOPs) and training manuals are needed if staff are to respond adequately to the needs of drug-dependent prisoners and their co-morbidities. Guidelines and detailed protocols are needed on how exactly certain treatment options can or must be implemented, to support prison doctors/ nurses and administrators in delivering adequate health care (for example, in substitution treatment for opiate-dependent prisoners).

Adequate monitoring of treatment requires the introduction of statistical record-keeping related to the outcome and results of treatment.

THERAPY INSTEAD OF PUNISHMENT

Drug-dependence treatment as alternative to imprisonment can relieve the burden of prison systems and has been shown to decrease the risks of drug-use relapse, HIV transmission and re-incidence of crime, with significant benefits for the individual and public health. Where possible, treatment should be offered as an alternative to incarceration.

However, we found almost no implementation of policies on "therapy instead of punishment" in the nine countries and in Kosovo*.

INTRODUCTION AND DEVELOPMENT OF OAT

Coverage of OAT is poor and patchy, where it exists. There is an urgent need to abolish the ban on substitution therapy in many countries. The ban in Russia prohibits the realisation of evidence-based treatment that among other benefits would provide for reduction of criminal activities among drug users. Repeal of this ban would allow people to be placed in treatment rather than in prison. It would also allow treatment of withdrawal syndrome to be provided in police and pre-trial detention.

In places where prisoners cannot initiate or continue long-term methadone maintenance therapy (MMT) while in prison, such maintenance programmes need to be established. One response to treatment needs might result in establishing a drug-treatment centre along with other behavioural components as an adjunct to pharmacological maintenance therapies.

INTRODUCTION OF HARM-REDUCTION MEASURES

Harm reduction is a difficult part of public health. However, there is an almost complete absence of harm-reduction measures in prisons in the places studied (except Moldova). The reasons for this are not only financial problems but also difficulties of an ideological nature. In most of the nine countries and Kosovo*, harm-reduction measures in prison are viewed as threats to security, and the authorities will agree only to abstinence-based interventions.

It is important to improve the scope and quality of prevention activities in prisons, using also NGOs' resources and available community services. Needles, syringes, condoms, lubricants and disinfectants should be available, with easy, equal, low-threshold access for all prisoners.

Relapses into drug use and fatal overdoses after release are widespread. These risks need to be addressed during the period of imprisonment. Harm-reduction measures should include overdose prevention after release (e.g. Naloxone), together with training and provision of the kit.

TREATMENT OF INFECTIOUS DISEASES (HIV/AIDS, TB AND HEPATITIS)

Hepatitis is a challenge completely underestimated, underdiagnosed and almost untreated. Furthermore, apart from general advice, there are almost no coherent prevention strategies.

With regard to ART, not all prisoners in need of this treatment received it; here an improvement is needed.

ACCESS TO PRISONS – INVOLVEMENT OF NGOS AND INTERNATIONAL ORGANISATIONS

In a few cases, access to prisons by international and non-governmental organisations is highly restricted. In order to protect the rights and health of drug users in prisons, it is crucial to provide more education to all involved in prisons, with particular focus on the special health needs of PWUD and people with HIV, hepatitis, tuberculosis and other communicable diseases.

IMPROVING RELEASE PREPARATION, PROVIDING THROUGH CARE AND CONTINUING TREATMENT

In many cases a failure could be observed to effectively organise continuity of care for prisoners on transfer. There are barriers to continuity of care, such as geographical isolation from the prisoner's home area; however, it is the gap between prison and community medicine, together with a formal approach to referral for those

entering prison or transferring back to the community, that leads to discontinuity of services even for those prisoners who have established a connection with the health-care system.

For those prisoners already in treatment before incarceration, medical treatment – especially pharmacological therapy (e.g. OAT) – should be continued when entering prison. The same should apply on release. Pre-release preparations to ensure continuity of care, and access to health and other services after release, must be a necessary part of the programmes preparing inmates for release.

Overall there is a lack of long-term treatment and pre-release programmes for prisoners with substance-use disorders. This lack of continuation of care is the major threat to long-term treatment stability. Continuity of services (community–prison–community) is often interrupted.

Pre-release programmes with a particular focus on prisoners with problems related to substance use might help to overcome interface problems.

An analysis of the complete social protection system in the field of post-penal protection is needed. Current policies need to be revised in order to establish a reformed system with a focus on the needs of prisoners who are being released.

CAPACITY BUILDING FOR PRISON STAFF

It became obvious that the capacities of prison staff in prevention, management and treatment of substance use and other drug-harm related problems need to be strengthened.

To successfully implement evidence-based treatment both within prisons and after release, not only the availability of services, but also education is needed, both for prisoners and prison staff, to improve understanding of drug dependence and drug-use-related morbidities.

In many prisons there is a lack of qualified staff in the prison health service and insufficient training of staff at different levels, especially regarding drug dependence, infectious diseases and post-release overdoses.

Therefore the prison health staff need specific training to help overcome their isolation from mainstream health-care practices in the community.

Prison health services should be integrated into the national health system, including the training and professional development of health-care staff. The prison staff should be educated and trained on harm reduction and OAT, and educated in destigmatisation and the human rights of the drug-using population. Prison staff should better understand the nature, goals and objectives of harm-reduction programmes and substitution therapy. Training is especially important to ensure consistency across staff members (not only medical staff,

but prison management and custodial staff) and should address the nature of addiction as a disease rather than an offence. It is necessary to raise awareness for evidence-based treatment of IDUs, especially OAT among management and other prison staff, in close co-operation with community services providing OAT.

Prison staff and also prisoners should learn more about drug-related health problems. Therefore the creation of a uniform system of training and education by a specific category of prison staff is needed, including curriculum development, training of trainers and development of a system of supervision of the complete process of education. Prison staff need to acquire further knowledge and skills in relation to the management of problems associated with substance-using prisoners.

An analysis is needed, followed by recommendations and the creation of a new process of training and education in correctional institutes. These efforts should aim at strengthening the capacity of prisoners in educational and correctional units and should be co-ordinated with existing labour market needs.

Finally, in the absence of other human resources, there is a necessity and a need to consider the use of peer-group support for prisoners with drug dependence.

GENDER ISSUES

Gender-specific responses for drug-using women, at both policy and practical levels, are not being developed or implemented with particular attention to their specific health-care needs. Women who use drugs require specialised treatment services that take into account their specific needs (even more pregnant women, women with children). Without treatment, imprisonment often becomes a revolving door for drug-using women (see UNODC/Eurasian Harm Reduction Network 2012).

LACK OF CONTINUITY OF CARE

Continuity of treatment for prisoners entering and leaving prison requires close co-operation between prisons and external agencies. However, in most of the places covered by the study there was no clearly defined link or referral system between the prison health system and health services outside the prison system. This makes it difficult to follow up ex-prisoners who are discharged while on treatment. It was also noted that some individuals coming into prisons sometimes do not have any documentation, including information about their health status.

CHALLENGES

The main challenges cited by the places studied in terms of provision of services for HIV, TB, hepatitis B and C and STIs are the following:

- Stigma and discrimination against drug users, MSM, HIV-infected prisoners, sex workers and other groups remain high, posing a significant challenge to interventions and delivery of friendly health services in prisons. Stigma and discrimination contribute to the spread of HIV infection and are a threat to the life of HIV-infected people.
- There is a strong need for confidentiality on all levels and in all areas.
- National and international networking and exchange of good-practice models seems to be a valuable method for all prison systems. In addition, international networks need to disseminate internationally available good-practice models and knowledge of evidence-based strategies in prison settings and/or on the level of prison administration.
- Drug services in prisons should be subject to monitoring and evaluation. Close monitoring of the situation related to substance use among inmates is a good preparation for timely introduction of harm-reduction interventions (for example, needle and syringe programmes) if/when the need is identified.
- There is a need to develop and introduce education modules for prison health personnel and custodial staff, aiming at timely identification and effective management of problems related to substance use by inmates. This would include early identification and management of abuse of prescription psychotropic medicines.

The general recommendation would be to support ongoing prison-based drug policy debates and introduce reforms that would refocus current drug-control regimes towards a more balanced approach. That would include amending existing drug legislation and making sure that prisons are not filled with people sentenced for drug use *per se* or for possession of small amounts for personal use.

References

AHPPN [African HIV in Prisons Partnership Network] (2009), African Declaration of Commitment for HIV and Aids Prevention Care, Treatment and Support in Prisons, available at www.unodc.org/documents/hiv-aids/publications/2009_Final_AHPPN_Declaration_EN.pdf, accessed 5 September 2016.

Altice F.L. and Dvoryak S. (2012), Attitudes and beliefs about drug use, HIV/Aids and substitution therapy among prison staff. Kyiv, 2 July 2012.

Altice F.L. and Dvoryak S. (2012), PUHLSE Survey Results (presentation).

Andrey Rylkov Foundation (2013), *Hepatitis C in Russia: an epidemic of negligence*. Available at: http://en.rylkov-fond.org/wp-content/uploads/2014/07/ARF-HCV-report-2013-final_eng.pdf, accessed 9 October 2016.

Arain A., Robaeys G. and Stöver H. (2014), Hepatitis C in European prisons: a call for an evidence-informed response, *BMC Infectious Diseases*, 14(Suppl6):S17 (19 September).

Azbel L. et al. (2013), "Burden of infectious diseases, substance use disorders and mental illness among Ukrainian prisoners", *PLoS One*, 8(3):e59643.

Balabanova Y. et al. (2005) "Analysis of risk factors of the occurrence of drug resistance in patients with tuberculosis from civil and penitentiary sectors in the Samara region", *Probl. Tuberk.*, 5:25-31 [in Russian].

Balakireva O.M. et al. (2012), "Monitoring of informational behavior and HIV spread among prisoners", Report, Kyiv.

Bobrik A. et al. (2005), "Prison health in Russia: the larger picture", *Journal of Public Health Policy*, 26:30-59.

Bögemann H., "Promoting health and managing stress among prison employees". In: WHO Europe (2007): Health in prisons. Copenhagen/Denmark. 171-180

Boys A. et. al. (2002), "Drug use and initiation in prison: results from a national prison study in England and Wales", *Addiction*, 2002, 97:1551–60.

Cook C. (2009), *Harm reduction policy and practice worldwide: an overview of national support for harm reduction and policy and practice*, London, International Harm Reduction Association, 2009.

Correctional Service of Canada (1999), *Evaluation of HIV/Aids harm reduction measures in the Correctional Service of Canada*. CSC, Ottawa.

Dolan K. et al. (2005), "Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection", *Addiction*, 100(6):820-8.

Dolan K., Wodak A. and Hall W. (1999), "HIV risk behaviour and prevention in prison: a bleach program for inmates in NSW", *Drug and Alcohol Review*, 18:139-43.

Drobniewski F.A. et al. (2005), "Tuberculosis, HIV seroprevalence and intravenous drug abuse in prisoners", *European Respiratory Journal*, 26(2):298-304.

EMCDDA (2011), *Annual report on the state of the drugs problem in Europe*, EMCDDA, Lisbon, available at www.emcdda.europa.eu/publications/country-overviews/, accessed 6 September 2016.

EMCDDA (2012a), *Drug use in prison: the problem and responses*, Special Issue, EMCDDA, Lisbon, available at www.emcdda.europa.eu/system/files/publications/747/TDSI12002ENC_399981.pdf.

EMCDDA (2012b), *Treatment demand indicator (TDI) standard protocol 3.0: Guidelines for reporting data on people entering drug treatment in European countries*, Lisbon, s.n.

EMCDDA (2013), *Country overview: the former Yugoslav Republic of Macedonia*, available at www.emcdda.europa.eu/countries/former-yugoslav-republic-of-macedonia, accessed 9 October 2016.

EMCDDA (2016), *2016 EU drug markets report: in-depth analysis*, Europol, Lisbon, available at www.emcdda.europa.eu/publications/eu-drug-markets/2016/in-depth-analysis, accessed 9 October 2016.

EMCDDA (n.d.), "Best practice in drug interventions", available at www.emcdda.europa.eu/best-practice#view-answer9, accessed 5 September 2016.

EMCDDA and Ukraine [Ukrainian Medical and Monitoring Centre of Alcohol and Drugs] (2011), *National report on the drug situation* [data 2010], available at www.damonitoring.net.ua/file/NATIONAL DRUG REPORT(eng-FIN).pdf, accessed 27 September 2012.

European Commission (2007), Report from the Commission to the European Parliament and the Council on the implementation of the Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence, Brussels, COM (2007) 199 final, available at http://eurlex.europa.eu/LexUriServ/site/en/com/2007/com2007_0199en01.pdf, accessed 30 November 2013.

Farrell M. and Marsden J. (2008), "Acute risk of drug-related death among newly released prisoners in England and Wales", *Addiction*, 103(2):251-5.

Fazel S., Bains P. and Doll H. (2006), "Substance abuse and dependence in prisoners: a systematic review", *Addiction*, 101(2):181-91.

Fotiadou M. et al. (2004), "Self-reported substance misuse in Greek male prisoners", *European Addiction Research*, 10(2):56-60.

Frolova O. et al. (2008), "HIV-infection in Russian Federation and its influence on the prevalence of tuberculosis" in M. I. Perlman and U. V. Mikhailova, eds, *Tuberculosis in Russian Federation, 2007: Analytical review of main statistical indicators on tuberculosis used in Russian Federation*, Ministry of Health, Moscow, pp. 87-97.

Frost L. and Tchertkov V. (2002), "Prisoner risk taking in the Russian Federation", *Aids Education and Prevention*, 14(suppl. B):7-23.

Golichenko M. and Sarang A. (2013), "Atmospheric pressure: Russian drug policy as a driver for violations of the UN Convention against Torture and the International Covenant on Economic, Social and Cultural Rights", *Health and Human Rights*, 15(1) [report first published by the Andrey Rylkov Foundation in 2012].

Goyer K. and Gow J. (2001), "Transmission of HIV in South African prisoners: risk variables", *Society in Transition*, 32(1):128-32.

Grinstead O. et al. (1999), "Reducing post-release HIV risk among male prison inmates: a peer-led intervention", *Criminal Justice and Behaviour*, 26:453-65.

Hedrich D. et al. (2012), "The effectiveness of opioid maintenance treatment in prison settings: a systematic review", *Addiction*, 107(3):501-15.

Heidari E. et al. (2007), "Oral health of remand prisoners in HMP Brixton, London", *British Dental Journal*, 202(2):E5.

Heimer R. et al. (2005), "Imprisonment as risk for HIV in the Russian Federation: evidence for change", Proceedings of the 16th International Conference on the Reduction of Drug Related Harm, Belfast, UK, 20-24 March 2005, Abstract 813.

Hiller, M.; Knight, K.; Simpson D. (1999): Prison-based substance abuse treatment,residential aftercare and recidivism. In: Addiction, 94 (6), 833-842

Hoover J. and Jürgens R. (2009), *Harm reduction in prison: the Moldova model*, s.l., s.n.

International Centre for Prison Studies (2013), *Ukraine*, World Prison Brief, available at www.prisonstudies.org/country/ukraine, accessed 9 September 2016.

International Centre for Prison Studies (2016), *Kosovo**, World Prison Brief, available at www.prisonstudies.org/country/Kosovo*kosova, accessed 9 October 2016.

International Treatment Preparedness Coalition (2015), *Access to medicines for treatment of hepatitis C in the Russian Federation in 2014* (in press), Andrey Rylkov Foundation, Moscow.

Ivanovo Aids Centre (2015), Conference on treatment of hepatitis C with linear interferons for infectious disease doctors, gastroenterologists and FPS doctors, available at http://ivspeedcentr.ru/about/news/33.html, accessed 9 October 2016.

Jürgens R., Ball A. and Verster A. (2009), "Interventions to reduce HIV transmission related to injecting drug use in prison", *Lancet Infectious Diseases*, 9(1):57-66, doi: 10.1016/S1473-3099(08)70305-0. Review. PubMed PMID: 19095196.

Jürgens R., Nowak M. and Day M. (2011), "HIV and incarceration: prisons and detention", *Journal of the International Aids Society*, 14(1):26.

Kalashnikov v. Russia, 47095/99, Council of Europe: European Court of Human Rights, 15 July 2002, available at: http://www.refworld.org/cases,ECHR,416bb0d44.html

Kerr T. et al. (2004), "Harm reduction in prisons: a rights based analysis", *Critical Public Health*, 14(4):345-60.

Koretskaya N. (2002), "Risk factors for tuberculosis, specific features of its detection and course", *Probl. Tuberk.*, 8:7-10 [in Russian].

Kosmak A. and Kopylova I. (2008), "Tuberculosis in a penitentiary somatic hospital", *Probl. Tuberk. Bolezn. Legk*, (2):1214. PMID: 18368772.

Kosovo*: Ministry of Health (2009), Kosovo* Strategic Plan on HIV/Aids 2009-13.

Kosovo*: Ministry of Internal Affairs (2013), *Police Inspectorate of Kosovo, Annual Report*, available at www.Kosovopolice.com/repository/docs/RAPORTI_ANGLISHT_2013.pdf, accessed 9 October 2016.

Kosovo*: Ministry of Justice (2011), "Hospital care in the high security prison in Dubrava, Kosovo", available at www.md-ks.org/?page=2,70, accessed 9 October 2016.

Kosovo*: Ministry of Justice (2016), *Probation Service*, available at www.md-ks.org/?page=2,31, accessed 9 October 2016.

Kosovo*: Ministry of Justice (n.d.), *The Ministry of Justice and its organization*, available at www.md-ks.org/repository/docs/Organogrami_2014_2.pdf, accessed 9 October 2016.

Kruglov Y. V. et al. (2008), "The most severe HIV epidemic in Europe: Ukraine's national HIV prevalence estimates for 2007", *Sexually Transmitted Infections*, 84(Suppl 1):i37-i41.

Leon G. (de) (2000), *The Therapeutic Community. Theory, Model, and Method*, Springer, New York.

Lines R. et al. (2006), *Prison needle exchange: a review of international evidence and experience*, 2nd edn, Canadian HIV/Aids Legal Network, Montreal.

Lobacheva T. et al. (2005), "Pulmonary tuberculosis in two remand prisons (SIZOs) in St. Petersburg, Russia", *Eurosurveillance*, 10(6):93-6.

Lobacheva T., Asikainen T. and Giesecke J. (2007), "Risk factors for developing tuberculosis in remand prisons in St. Petersburg, Russia – a casecontrol study", *European Journal of Epidemiology*, 22(2):1217.

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):117-24.

Mathers B. M. et al. (2008), "Reference Group to the UN on HIV and Injecting Drug Use Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review", *The Lancet*, 372(9651):1733-45.

Matic S. et al., eds (2008), "Progress on implementing the Dublin Declaration on Partnership to Fight HIV/Aids in Europe and Central Asia", Copenhagen, WHO Regional Office for Europe, available at www.euro.who.int/Document/SHA/Dublin_Dec_Report.pdf, accessed 30 November 2013.

Michel L. et al. (2015), "Insufficient access to harm reduction measures in prisons in 5 countries (PRIDE Europe): a shared European public health concern", *BMC Public Health* (27 Oct. 2015), 15:1093, doi: 10.1186/s12889-015-2421-y.

Mukadi Y. D., Maher D. and Harries A. (2001), "Tuberculosis case fatality rates in high HIV prevalence populations in Sub-Saharan Africa", *Aids*, 15(2):143-52.

Niveau G. and Ritter C. (2008), "Route of administration of illicit drugs among remand prison entrants", *European Addiction Research*, 14(2):92-8.

Nowak M. (2009), Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Human Rights Council, New York. 14 January, A/HRC/10/44.

Open Society Institute (2004): Skills training and capacity building in harm reduction; available at https://www.opensocietyfoundations.org/reports/skills-training-and-capacity-building-harm-reduction [accessed 5 April 2017]

Parfitt T. (2010), "Crime and unjust punishment in Russia", *The Lancet*, 376:1815-16.

Patel K. K. [The Patel Report] (2010), Reducing drug-related crime and rehabilitating offenders. Recovery and rehabilitation for drug users in prison and on release: recommendations for action. Prison Drug Treatment Strategy Review Group. Department of Health, London, available at www.gov.uk/government/publications/the-patel-report-reducing-drug-related-crime-and-rehabilitating-offenders, accessed 1 April 2016.

Pompidou Group/Council of Europe (2010), *National experiences with quasi-coerced treatment of drug dependent offenders*, Expert Forum on Criminal Justice, P-PG/CJ, Council of Europe, Strasbourg.

Pompidou Group/Council of Europe (2013), *Mental health and addiction in prisons*, available at www.coe.int/T/DG3/Pompidou/Source/Publications/MentalHealth-2013-dlv.pdf, accessed 10 October 2016.

Reiter S. (2011), *Russia's dead end prison system*, Open Democracy (3 June), available at: www.opendemocracy.net/od-russia/svetlana-reiter/russias-dead-end-prison-system, accessed 10 October 2016.

Rhodes T. et al. (2010), "Policy resistance to harm reduction for drug users and potential effect of change", *British Medical Journal*, 341:c3439.

Ritter C. et al. (2011), "Smoking in prisons: the need for effective and acceptable interventions", *Journal of Public Health Policy*, 32:32-45.

Ritter C., Broers B. and Elger B. S. (2013), "Cannabis use in a Swiss male prison: qualitative study exploring detainees' and staffs' perspectives", *International Journal of Drug Policy*, 24(6):573-8, available at http://dx.doi.org/10.1016/j.drugpo.2013.05.001, accessed 14 September 2016.

Russian Federation (1998), On approval of the List of narcotic and psychotropic substances and precursors controlled in the Russian Federation, Government of Russia, Moscow.

Russian Federation: Federal Penitentiary Service (2012), Press conference of the head of the medical department Sergey Baryshev, Report, available at www.fsin.su/news/index.php?ELEMENT_ID=37816, accessed 10 October 2016.

Russian Federation: Federal Penitentiary Service (2014), Protocol of the meeting of the FPS on the outcomes of the Service activities in 2013 and future plans.

Russian Federation: President's Office (2010), "Strategy for the implementation of the National Anti-Drug Policy of the Russian Federation in the period until 2020," adopted by Presidential Order No. 690 of 9 June 2010, para. 48.

Russian Harm Reduction Network (2008), *Prevalence of HIV and associated infections, population size estimate among injecting drug users in Ekaterinburg and Orel*, available [in Russian] at www.esvero.ru/files/Orel_E-burg.pdf, accessed 10 October 2016.

SADC [Southern African Development Community] (2011), Minimum standards for HIV and Aids, TB, Hepatitis B and C and STIs prevention, treatment, care and support in prisons in the SADC Region – Communicable Diseases Project/Directorate for Social and Human Development and Special Programmes, November 2011.

Sahajian F., Lamothe P. and Fabry J. (2006), "Psychoactive substance use among newly incarcerated prison inmates", *Santé Publique*, 18(2):223-34.

Sarang A. et al. (2006), "Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institutions," *Addiction*, 101:1787-96.

Sarang A. et al. (2010), Integration of medical services for patients with HIV, TB and drug dependency in the city of Kaliningrad. Report to the World Health Organization.

Scottish Prison Service (2008), Prisoner survey 2008, 11th survey bulletin, SPS, Edinburgh, available at www.sps. gov.uk/Publications/Publication75.aspx, accessed 30 November 2013.

Shaw J., Appleby L. and Baker D. (2003), *Safer prisons: a national study of prison suicides 1999–2000 by the national confidential inquiry into suicides and homicides by people with mental illness*, London, Department of Health.

Shewan D., Stöver H. and Dolan K. (2005), "Injecting in prisons", *Injecting illicit drugs*, ed. Pates R., McBride A. and Arnold K., Blackwell, Oxford, pp. 69-81.

Simooya O. O. et al. (2001), "'Behind walls': a study of HIV risk behaviours and seroprevalence in prisons in Zambia", *Aids*, 15(13):1741-4.

Sirbiladze T. and Tavzarashvili L. (2012), *Estimating the prevalence of injection drug use in Georgia*, Bemoni Public Union, Tbilisi.

Skala P. (2012), press conference, 21 May, available [in Russian] at www.yurincom.com/ru/legal_news/?id=11324, accessed 10 October 2016.

Socioconsulting (2007), *Monitoring of prisoner awareness and behaviour as a component of second generation HIV surveillance. Analytical report for International HIV/Aids Alliance in Ukraine*, ed. N. Kalashnik et al., available at http://sociocon.org/en/issledovaniya/monitoring/file26.html, accessed 8 September 2016.

Stewart D. (2009), "Drug use and perceived treatment need among newly sentenced prisoners in England and Wales", *Addiction*, 104(2):243-7.

Stöver H. (2014), "How to improve HIV/TB prevention, treatment and care in prisons", *GFO Newsletter* 254, Aidspan, Independent observer of the Global Fund, 30 October, available at http://aidspan.org/gfo_article/how-improve-hivtb-prevention-treatment-and-care-prisons, accessed 10 October 2016.

Stöver H. and Lines R. (2006), "Silence still = death: 25 years of HIV/ Aids in prisons", *HIV/Aids in Europe: moving from death sentence to chronic disease management*, ed. Matic S., Lazarus J. V. and Donoghoe M. C., WHO Europe, Copenhagen, pp. 67–86, available at www. euro.who.int/InformationSources/Publications/Catalogue/20051123_2, accessed 30 November 2013.

Stöver H. and Nelles J. (2003), "Ten years of experience with needle and syringe exchange programmes in European prisons", *International Journal of Drug Policy*, 14(5):437-44.

Stöver H. and Thane K. (2011), *Towards a continuum of care in the EU criminal justice system. A survey of prisoners' needs in four countries (Estonia, Hungary, Lithuania, Poland*), BIS-Verlag, Oldenburg.

Stöver H. and Trautmann F. (2001), *Risk reduction for drug users in European prisons*, Trimbos Institute, Utrecht.

Stöver H. et al. (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, Brussels (SANCO/2006/C4/02), available at http://ec.europa.eu/health/ph_determinants/life_style/drug/ documents/drug_frep1.pdf, accessed 30 November 2013.

Stöver H., Hennebel L. C. and Casselmann J. (2004), *Substitution treatment in European prisons. A study of policies and practices of substitution in prisons in 18 European countries*, European Network of Drug Services in Prison, London, 2004.

Stöver H., Knorr B. and Weilandt C. (2006), "Prison health is public health", *International Journal of Prisoner Health*, 2(2):151-2.

"The former Yugoslav Republic of Macedonia": Ministry of Justice [Directorate for Execution of Sanctions] (2014), *Crime against public health as of 31.12.2013*, Annual Report of the Directorate for Execution of Sanctions on the condition and operation of the Penitentiary and correctional institutions in Republic of Macedonia for 2013, MoJ, Skopje.

Todts S. et al. (2008), *Usage de drogues dans les prisons belges: monitoring des risques sanitaires*, Service Public Fédéral Justice, Brussels.

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

UK Department of Health *see* Patel K. K; Shaw, Appleby and Baker

UKHRA [United Kingdom Harm Reduction Alliance] (2014), website at: www.ukhra.org, accessed 20 January 2014.

UN (2011), *United Nations Rules for the treatment of women prisoners and non-custodial measures for women offenders* [the Bangkok Rules], available at www.unodc.org/documents/commissions/CCPCJ/Crime_Resolutions/2010-2019/2010/General_Assembly/A-RES-65-229.pdf, accessed 10 October 2016.

UN (2015), *United Nations Standard minimum rules for the treatment of prisoners* [the Mandela Rules], available at www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6_Rev1/ECN152015_L6Rev1_e_V1503585.pdf, accessed 10 October 2016.

UN [United Nations] (1990), *Basic principles for the treatment of prisoners*, UN, New York (A/ RES/45/111), available at www. un.org/documents/ga/res/45/a45r111.htm, accessed 20 January 2014.

UN Human Rights Committee (2015), *Concluding observations on the seventh periodic report of the Russian Federation*, available at http://ehrac.org.uk/resources/unhrc-concluding-observations-on-the-seventh-periodic-report-of-the-russian-federation/, accessed 10 October 2016.

UN Special Rapporteur on the Independence of Judges and Lawyers (2009), *Report of the mission to Russia*, UN Doc. A/HRC/11/41/Add.2, available at www.ohchr.org/EN/HRBodies/SP/Pages/CountryvisitsN-Z.aspx, accessed 10 October 2016.

UNAIDS (2009), *Comprehensive external evaluation of the national Aids response in Ukraine: consolidated report*, WHO Europe, Copenhagen, available at www.unaids.org.ua/hiv/response/programm/evaluation, accessed 26 September 2012.

UNAIDS (2014), *The gap report*, available at www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf, accessed 10 October 2016.

UNAIDS Programme Coordinating Board (2015): 37th meeting, 26-28 October 2015, agenda item: HIV in prisons and other closed settings, available at www.unaids.org/sites/default/files/media_asset/20151012_UNAIDS_PCB37_15-21_EN.pdf, accessed 5 September 2016.

UNDP (2013), *Assessment of implementation of the National Aids Programme in Ukraine for years 2009-13: synthesis report*, UNAIDS in Ukraine, Kyiv, available at www.ua.undp.org/content/ukraine/en/home/library/poverty/assessment-of-implementation-of-the-national-aids-programme-for-.html, accessed 10 October 2016.

UNODC (2014a), *The illicit drug trade through South-East Europe*, UNODC, Vienna, available at www.unodc.org/documents/data-and-analysis/Studies/Illicit_DT_through_SEE_REPORT_2014_web.pdf, accessed 10 October 2016.

UNODC (2014b), *HIV prevalence and risk behaviour among prisoners. Data brief of bio-behavioural surveys of 2009, 2011 and 2013*, UNODC in Ukraine, Kyiv.

UNODC [United Nations Office on Drugs and Crime], *see also* WHO; WHO/UNODC

UNODC [with UNAIDS and WHO] (2006), *Aids prevention, care, treatment and support in prison settings: a framework for an effective national response*, UNODC, Vienna, available at www.who.int/hiv/pub/prisons/prison_framework/en/, accessed 5 September 2016.

UNODC [with UNAIDS] (2007), *HIV and prisons in sub-Saharan Africa*, available at www.unodc.org/documents/hiv-aids/Africa%20HIV_Prison_Paper_Oct-23-07-en.pdf, accessed 5 September 2016.

UNODC/Eurasian Harm Reduction Network (2012), "Ensuring relevant authorities act to contain the HIV/TB/Hepatitis C epidemics among drug users and in prison settings in Albania, Serbia and 'the former Yugoslav Republic of Macedonia': Assessment of policy and training needs in Albania", Report prepared by Heino Stöver and Catherine Ritter.

UNODC/UISR [Ukrainian Institute of Social Research Olexander Yaremenko] (2012), *Analysis of HIV/Aids response in the penitentiary system of Ukraine*, Summary report on the comprehensive study, UISR/UNODC, Kyiv, available at www.unodc.org/documents/hiv-aids/Analysis_of_HIVAIDS_response_in_penitentiary_system_of_Ukraine.pdf, accessed 8 September 2016.

Van Meter J. (1996), *Adolescents in youth empowerment positions: special projects of national significance*, US Dept of Health and Human Services, Washington DC.

Vienna Declaration (2010), available at www.viennadeclaration.com/2010/06/thevienna-declaration-a-global-call-to-action-for-science-based-drug-policy, accessed 10 October 2016.

Vorobey S. (2014), "Tuberculosis, HIV-infection and co-infection in the institutions of the Penitentiary system of the Russian Federation", presentation at the "Tuberculosis and HIV-infection – a threat of the twin epidemic. Current issues in prevention, diagnostics and treatment" conference, 2-3 October 2014, Moscow.

WHO (1993), *WHO guidelines on HIV infection and Aids in prisons*, WHO, Geneva, available at http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-GuidelPrisons_en.pdf, accessed 29 November 2013.

WHO (2004a), *Substitution maintenance therapy in the management of opioid dependence and HIV/Aids prevention*, WHO/UNODC/UNAIDS position paper, Geneva, available at www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf, accessed 30 November 2013.

WHO (2009), *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*, Geneva, available at www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf, accessed 25 February 2014.

WHO (2010), *Prevention of acute drug-related mortality in prison populations during the immediate post-release period*, WHO, Copenhagen. available at www.euro.who.int/__data/assets/pdf_file/0020/114914/E93993.pdf, accessed 30 November 2013.

WHO (2013), *Global tuberculosis report 2013*, WHO, Copenhagen, available at http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf, accessed 10 October 2016.

WHO (2014a), *Prisons and health*, 2nd edition, WHO, Copenhagen, available at www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp, accessed 10 October 2016.

WHO (2014b), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (July 2014, updated 2016), WHO, Copenhagen, available at http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1, accessed 5 September 2016.

WHO [World Health Organization] *see also* UNODC; WHO Europe; WHO/UNODC

WHO Europe (2003), Declaration on prison health as part of public health, adopted at the joint WHO/Russian Federation International Meeting on Prison Health and Public Health, Moscow, 24 October 2003, available at: www.euro.who.int/__data/assets/pdf_file/0007/98971/E94242.pdf, accessed 5 September 2016.

WHO Europe (2005), *Status paper on prisons, drugs and harm reduction*, WHO, Copenhagen, available at www.euro.who.int/__data/assets/pdf_file/0006/78549/E85877.pdf, accessed 30 November 2013.

WHO Europe (2007), *Health in prisons: a WHO guide to the essentials in prison health*, WHO, Copenhagen, available at www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf, accessed 8 October 2015.

WHO Europe (2010b), *The Madrid recommendation: Health protection in prisons as an essential part of public health*, WHO, Copenhagen, available at: www.euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf, accessed 5 September 2016.

WHO Europe [with Prison Health Policy Unit] (2002), *Prisons, drugs and society. Consensus statement on principles, policies and practices*, Department of Health, London, available at www.euro.who.int/en/health-topics/disease-prevention/illicit-drugs/publications/pre-2013/prisons,-drugs-and-society-2001, accessed 14 September 2016.

WHO/Europe (2005): *Status Paper on Prisons, Drugs and Harm Reduction*. Copenhagen/Denmark

WHO/UNODC (2013), *Policy brief: good governance for prison health in the 21st century. A policy brief on the organization of prison health*, WHO, Geneva.

Wolfe D., Carrieri P. and Shepard D. (2010), "Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward", *The Lancet*, 376:355-66.

Zlobinets M. (2014), Narcopolicy Conference, 10-11 September 2014, Kyiv, available at www.dropbox.com/sh/cenzlvteklhitab/AAD1UlBWF7s5FASlLDvZdM-9a/Mikhail%20Zlobinets_ukr.pdf?dl=0, accessed 6 September 2016.

Zurhold H. and Stöver H. (2015), "Provision of harm reduction and drug treatment services in custodial settings – findings from the European ACCESS study", *Drugs: Education, Prevention* and Policy, 23(2).

Zurhold H., Haasen C. and Stöver H. (2005), Female drug users in European prisons, BIS-Verlag, Oldenburg.

Prisons reflect all aspects of society, including psychoactive substance and drug use. People in prison use, peddle and traffic drugs. Some already use or are addicted to drugs before admission; others start using in prison. Squalid living conditions or an impoverished social environment, together with the loss of autonomy and self-determination, are known contributory factors in the use of psychoactive substances.

The response to drug use in a custodial setting, just like in the outside world, can either help users or increase the risk of harm.

People in prison sometimes become heavy users. Some inject drugs, often sharing injection material – even crude, improvised, frighteningly inappropriate equipment – which is seldom sterilised and therefore transmits diseases. Prison disciplinary systems can discourage prisoners from seeking assistance for a fellow inmate overdosing on heroin, for example, if they fear disciplinary actions themselves – possibly entailing more time in prison – and a life that could have been saved is thus lost.

Conversely, experience shows that an approach to drugs in prison that puts a premium on harm reduction – without condoning drug use – can encourage safer practices or even facilitate moving towards moderate use, treatment and abstinence. This fits the human rights agenda.

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