TCJP

Training Criminal Justice Professionals
in Harm Reduction Services

Prison staff and harm reduction

A training manual

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Training Criminal Justice Professionals
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This manual has been developed within the scope of the project “Training Criminal Justice Professionals in Harm Reduction Services for Vulnerable Groups” (TCJP - contract number 2007 318), funded by the Public Health Programme of the European Commission.

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CCSA	Canadian Centre on Substance Abuse
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association
EATG	European AIDS Treatment Group
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
EU	European Union
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
ICD-10	International Classification of Diseases of the World Health Organization (WHO)
IDU	Injecting Drug User
NGO	Non-Governmental Organisation
OST	Opioid Substitution Treatment
PEP	Post-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
STI	Sexually Transmitted Infection
THC	Tetrahydrocannabinol
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Preface

This training manual was developed within the scope of the project “Training Criminal Justice Professionals in Harm Reduction Services for Vulnerable Groups” (TCJP) which has been funded by the Directorate General Health & Consumer Protection of the European Commission. The project began in December 2007 and lasted for three years.

The Scientific Institute of the Medical Association of German Doctors (WIAD gem. e. V.) has been the coordinator of the project. The TCJP project brought together a multi-disciplinary network representing a wide range of different professional groups and practitioners working inside and outside prisons. Partners of the project were the Association of Varna Organizations for Drug Prevention (AVODP), Varna, Bulgaria; the Birmingham City University (BCU), Birmingham, United Kingdom; Latvia's Association for Family Planning and Sexual Health “Papardes zieds”, Riga, Latvia and Promovarea Dreptului la Sanatate (Promoting the Right to Health (PDS)), Bucharest, Romania.

The project’s steering group and advisory board included representatives from the Osservatio Carcere, Padova, Italy, the WHO Regional Office for Europe and Collaborating Centre for Prisons and Health in London, the UNODC Project Office for the Baltic States, and representatives from different Ministries of Justice throughout Europe.

The main aim of the TCJP project has been to develop and improve training for professionals working in the criminal justice system on the front line with problem drug users with the prospect that a well trained workforce gives personnel extensive knowledge about drugs, problem drug use as well as related harm like infectious diseases. A well trained workforce reduces fear of the unknown and enables informed decision making and improved relationships between detainees and staff subsequently contributing to harm reduction.

The development of the training manual on harm reduction was based on the views and needs of prison staff, representatives from NGOs working in the field of prison and harm reduction as well as on those of problem drug users in prison. Within the scope of the three years of the project, qualitative interviews with professionals in the criminal justice system and focus groups with problem drug users in prison were conducted and quantitative questionnaires sent to educational and training institutions for staff working in the criminal justice system.

Based on the results of the research, the training manual was produced in collaboration with all partners. The draft version of the manual was piloted by the Bulgarian, Latvian and Romanian partners in their countries.

INTRODUCTION

1. Introduction

1.1 What is in this manual?

This manual is designed to assist in the process of training prison staff in harm reduction. This package will not teach you how to become a trainer, does not teach you how to conduct and deliver harm reduction nor does it contain all the information on each topic covered in the manual. The design of this package assumes that the person delivering the training will already be actively involved in training and have a good understanding of harm reduction and drug use. Depending on the specific situation in each prison, either single or mixed groups of professionals can be trained (e.g. a training session with security staff only, or a session including security staff, medical staff and social workers). What option you chose should depend on the respective prison setting. Training a single group of professionals will allow the trainer to respond to that group's level of knowledge and specific needs while including different professional groups might facilitate wider discussion by including different points of view. Before providing training for some professional groups (e.g. staff from the prison management), ensure that individual participants will not be inhibited or the group process impaired. Training on harm reduction should be an ongoing process and if possible be integrated in existing training activities and curricula.

This manual, all annexes and PowerPoint presentations are available as a free download on the website: www.tcjp.eu.

1.2 How to use the manual?

1.2.1 Structure of the training package

The training package is divided into different modules. It consists of an introductory section, a core module on harm reduction and ten additional modules.

This introduction will provide the facilitator of the training with basic information on how the manual should be used, and gives more detailed information on how the training can be conducted.

The core module provides an introduction and overview of the most important aspects of harm reduction, including an overview of drugs, risk behaviour and drug related harm, as well as harm reduction measures.

In addition to the core module, the ten additional modules give more detailed information on different aspects of harm reduction.

Each of the additional modules is designed to stand alone. Some aspects of the modules are similar. Repeating certain closely linked aspects of the training will allow the trainers to become more acquainted with the information and will reinforce participants' understanding.

The manual has a flexible structure and the additional modules can be used separately or in sequence according to the need of the professionals. **Each training programme should start with the core module.** After the core module, the other modules in the pack can be used in the most effective way to suit the needs of the group receiving the training. The additional modules do not have to be used in the sequence presented in the pack.

For each of the modules, PowerPoint presentations summarising the most important aspects are provided that should be used by trainers when delivering the training. Additionally, in the notes sections of the PowerPoint slides all further detailed information given in this manual is listed.
The additional modules on sexuality (3.8) and cooperation with NGOs (3.9) are on the whole interactive and therefore do not provide a PowerPoint presentation.

1.2.2 Structure of the modules

Each module begins with a specification of the target group, the time required for delivery of the module and a list of materials needed. The main objectives of the module and what you can hope to achieve are clearly outlined. Knowledge, skills and behaviours that trainees should acquire are listed in the targeted learning outcomes. Each module includes an introduction and a range of activities that can be used to achieve the respective objectives. To assist trainers, a step by step description is included. The time indicated for each activity is variable – please feel free to modify or amend the modules, e.g. by inviting a guest speaker or leaving certain parts out. Further, the modules contain references to additional resources, which give more detailed information on the respective topic. By the end of each module, all participants should fill out the evaluation form (Annex 1).

It is important to adapt the modules to the national context, e.g. add national resources, national statistics and provide national information material to be distributed to participants.

1.3 What is harm reduction?

The term harm reduction (HR) refers to a concept that aims to reduce the negative consequences of certain behaviours. In relation to injecting drug use, harm reduction aims at preventing the transmission of infectious diseases through, for example, sharing injection equipment. The term harm reduction can be used to refer either to the related set of general principles or to specific types of intervention such as opioid substitution treatment and needle exchange programmes. The term harm reduction has been defined as “policies, programmes, services and actions that work to reduce the health, social and economic harms to individuals, communities and society” (Newcombe, 1992).

Harm reduction recognises that some use of psychoactive substances is inevitable and that some level of substance use is expected in a society (CCSA, 1996). It accepts that many people continue using drugs because they are unwilling or unable to stop their use. Harm reduction focuses on the prevention of drug related harm without necessarily requiring abstinence by drug users. Harm reduction complements preventative measures for drug consumption and measures reducing the overall level of drug consumption, and assists those willing to stop using drugs. Harm reduction is non-judgemental and always respects the dignity and rights of the drug users. The concept of harm reduction can be broadened to include the prevention of harm from other risk behaviour like unprotected sexual contact, tattooing and piercing.

The International Harm Reduction Alliance (IHRA) provides a useful position statement on harm reduction that can be distributed as a handout to trainees (the position statement is accessible at: http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf).

1.4 Why do training on harm reduction?

In many countries there is clear evidence that prison authorities are facing increasing problems with illegal drug use and other risk behaviours that can be detrimental to prisoners' health (MacDonald, 2005; Lines, 2006). Those with problem drug use are over-represented in the prison population and in many countries these prisoners are marginalized, stigmatized and discriminated members of the society. There are related health problems caused by the continued and excessive use of drugs and alcohol, as well as the risks of contracting communicable diseases through injecting drug use. This reinforces the need for a harm reduction approach in prison and for a well trained workforce who are able to meet the needs of prisoners with problem drug use.

In most EU countries between 10 to 30% of all sentenced prisoners have been convicted for drug offences (Aebi & Delgrande, 2007). Other estimates indicate that the number of those with problem drug use in prison is much higher. Additionally, we do not know how many prisoners are convicted for property crime (robbery, burglary etc.) to support a drug dependence. Drug use continues in the prison setting despite strenuous efforts to control drugs from entering prisons. Although injecting drug users are less likely to inject while in prison, there is a higher risk of sharing of drug injecting equipment and sharing among a greater number of people as, in most prisons, it is not possible to access clean equipment (Lines et al, 2004). Tattooing is also a popular activity in prison and needles can be shared for the same reasons as for injecting drug use. The prevalence of sexual behaviour in prison, as a possible way of transmitting infectious diseases, is difficult to estimate, but several studies have shown that significant risky sexual behaviour does occur. The estimates of men who have sex with men range from between 2 to 65% (Okie, 2007; Krebs, 2006).

Harm reduction training benefits everyone in the prison environment including all prison staff with the reduction of the incidence of blood-borne diseases such as HIV and hepatitis C. A well trained workforce gives personnel extensive knowledge about HIV and transmission and protection, reduces fear of the unknown and enables informed decision making and improved relationships between prisoners and staff.

The rationale for providing harm reduction training

Harm reduction is a very politically sensitive area and prison administrations are often resistant to implementing harm reduction despite it being widely implemented in the community. The three key rationales for implementing a harm reduction approach in prison are the public health imperative, cost effectiveness and prisoners' human rights.

Public health imperative and cost effectiveness of harm reduction

The introduction of comprehensive harm reduction programmes have been shown to be effective in protecting both public and individual health. Comprehensive harm reduction programmes can halt HIV epidemics and other blood borne infections if injecting drug users (IDUs) are appropriately supported (i.e. by providing information; needle exchange programmes; condoms provided in prison). Scientific evidence shows that harm reduction strategies including needle and syringe exchange are cost-effective measure to prevent and control the transmission of infectious diseases. Through preventing new cases of HIV and HCV infections and saved lives, investments in harm reduction result in a higher return.

Prisoners' human rights

International conventions, declarations and humanitarian principles obligate states to respect, protect and fulfil, equitably and in a non-discriminatory manner, problem drug user's human rights. This includes the implementation of comprehensive harm reduction programmes as well as the provision of treatment, care and support. People in prison keep their fundamental rights and freedoms set out in the Universal Declaration of Human Rights (accessible at: http://www.un.org/en/documents/udhr/) and in other United Nations covenants.

A rights-based analysis of the HIV/AIDS situation in prisons indicates that governments have an obligation to honour the "principle of equivalence," which states that prisoners are entitled to the same level of health care that is provided in the community and are obligated to honour international human rights laws that require them to protect the health of prisoners.

Access to HIV prevention and harm reduction programmes is a right, given the evidence of their effectiveness in preventing harms associated with drug dependence and injection drug use. The failure to provide measures that repeatedly have been shown to reduce drug related harms, perpetuates the discrimination and stigmatization of a group of highly vulnerable members of society. Prisoners, even though they live behind the walls of a prison, are part of the broader community, and governments have a legal obligation to ensure that inmates have at least the same international standards of health and human rights applied to them as all other citizens within their country (Kerr & Jürgens, 2004).

1.5 How to conduct the training?

1.5.1 Prearrangements

Prearrangements are very important for the successful delivery of a training course. Trainers should contact potential participants in the training in good time.

When contacting prisons, you should first inform the management about your plans and then the staff you would like to involve in the training. In some countries, admission from prison authorities might be necessary before planning a training course.

If possible, talk personally to the staff you want to invite instead of informing them by fax, letter or e-mail. Ask the trainees you have already invited to inform other colleagues about the training.

Prepare a short presentation of the training material and keep the administration and the staff informed about all training details. By involving the trainees in the planning of the training, they will feel that they are actively participating in the process of planning and organization. You should always take into consideration trainees' expectations, recommendations, preferences and needs as regards the training.

1.5.2 Facilitator

When delivering the training on harm reduction, make sure you update your knowledge in harm reduction, drug use and infectious diseases and the various related challenges.

Be aware of your limitations and do not use activities that you feel uncomfortable with. Acceptance of training will be greater if trainers are confident about their knowledge and if trainees believe trainers are qualified in what they present.

For certain parts of the training, it might be useful to invite guest speakers such as ex- or current drug users, as this provides the prisoners' perspective. Including experts from different disciplines with specialised knowledge can further enhance the training.

Another possibility is to have the training package delivered by a mixed team of experts, including, for example, professional trainers, prison staff, social workers and psychiatrists. In general, it can be helpful to contact other trainers dealing with harm reduction to exchange experiences.

When delivering any kind of training, trainers should always adhere to some general principles. During the training session, a facilitator should respond to trainees' uncertainties and fears in an empathetic way. When interacting with participants, make sure to carefully listen and to read between the lines. Patience is important as well as flexibility in allocating time to certain tasks. Make sure to adjust the pace of the training according to the specific knowledge and understanding of the participants. Nevertheless, always ensure that the intended training outcomes are met.

A supportive and non-threatening atmosphere should be created as this will put trainees at ease and encourage them to raise questions. It is also important to respect the experiences and qualifications trainees have regarding the content of the training.

Tell the trainees that you wish the session to be as interactive as possible with your main role being to facilitate the discussion because:

- they are the experts in their own domain (i.e. prison environment),
- their opinions and comments are valuable and they should ask questions and make comments at any point during the session,
- the more they participate the better the session will be.

1.5.3 Training environment

The choice of venue for the training can depend on various factors including financial resources and accessibility. If the training consists of one or several short sessions, a central location that can be easily accessed by all participants might be the best choice. A training session over a few days can be held either in a central, well connected location or an alternative, residential venue. The first option allows the participants to return to their homes in the evening and makes the training course cheaper to run. Residential training can enable closer contact between participants and allow them to explore the subject matter in more depth. The flexible structure of the training manual allows different ways of delivering the training. The core module for example does not have to be delivered within one single day but can be split up into its different sessions and be delivered in three short evening sessions.

Make sure that the room where the training takes place is adequate in size and temperature and has enough light. Various seating arrangements can be used. For example, desks may be placed in rows facing forward or in a horseshoe shape for a lecture; participants may sit in a circle for group discussions. However, it is preferable that the setting should be informal in order to help participants feel at ease.

Provide water, tea, coffee, snacks, etc. and the training materials and make sure the technical equipment needed can be used on the premises. Before the training, you should make sure date, time and directions to the training venue are made clear to all participants. If training takes place inside prison, staff should be off duty and not on call. It might be helpful to the group dynamics and the success of the training if participants do not wear their uniforms.

1.5.4 Required material/ equipment

The training modules contain different materials such as PowerPoint presentations, background information for the trainer and handouts. The modules provide a selection of references to international resources on harm reduction. When preparing for the training, look for additional material in the national language of the participants. It can be helpful to contact the Ministry of Health (also the Ministries of Police, Narcotics, Justice, Public Security and Youth Affairs) in the country of delivery. The WHO, United Nations, as well as international and local NGOs should be contacted before the training to obtain any outreach materials about harm reduction that may be available, which can be distributed to the participants. Furthermore, it is good to provide participants with material they can distribute to prisoners. This helps to empower front-line staff in their role of supporting harm reduction. Try to ensure that also materials for illiterate prisoners (with pictograms) are available

When delivering the training, be sure to have the materials listed below with you. All further required material is listed in each training module.

- Agenda
- List of participants with address/ email of participants (in order to send follow-up forms etc.)/ sign-in sheets (template see Annex 2)
- Certificates of attendance (template see Annex 3)

- Participants' course evaluation sheet (Annex 1)
- All necessary technical equipment, including items such as flipcharts and markers, a beamer, a laptop or desktop computer and name tags.
- Other material required for individual modules (presentations, background information sheets etc.)

1.5.5 Setting the ground rules for the training

Before starting the training it is useful to define some general ground rules. When doing this, always take into account the specific background of the participants.

Encourage participants to express their opinion honestly. However, try to direct participants not to use pejorative expressions, e.g. using the expression "drug user" or "problem drug user" rather than "drug addict." In general, encourage the group to use non-judgemental language at all the times. The setting of the ground rules also can be used as an icebreaker by the very beginning of a training course (see below).

Confidentiality

The confidentially of training sessions, and the sharing of sensitive information by participants during sessions, should be treated with utmost importance. Any specific examples given of intravenous drug users (IDUs), drug injecting or drug hang-outs should not be shared with external colleagues or organisations outside of the training session. Failure to observe this protocol could result in fear or distrust, drive IDUs underground and compromise harm reduction strategies. If a training programme is to be delivered partly by IDUs, consideration will need to be given as to whether they may need specific preparation or training to aid their contributions (WHO, 2004).

1.5.6 Different methods of training

When conducting a training session, a variety of methods can be used. This section describes the methods that are recommended for the modules in this training package.

Large parts of the training are interactive to encourage participants to be actively involved. Interactive learning tends to have greater impact than more passive approaches to learning. It encourages participants to think and engage with the issue. It is, however, more demanding for the trainer as you will need to encourage discussion, participation and the sharing of thoughts and beliefs.

In particular, it is sometimes difficult to draw shy participants into discussions and various methods may be necessary to include them. One method of encouraging less forthcoming participants to take part more fully is to use **comment cards** on which participants who do not wish to say anything can write their thoughts and ideas. These can be handed in to the facilitator at any time during the training session and fed back to the group (anonymously) by the facilitator.

Icebreakers

It is useful to begin the training sessions with an icebreaker, as this helps participants feel at ease. Icebreakers do not have to be used before each module if there is more than one module to be conducted during a training session.

Examples of icebreakers include an exercise where you have one minute to talk to your neighbour, and then introduce them to the group, or the name game, where everyone introduces themselves, whilst repeating the names of other participants, until the last person in the group has to remember and repeat all participants' names.

Icebreakers are a good way to establish a good atmosphere at the start of the training session. It is important to put people at ease and help them to get to know each other and the trainer, especially if you expect participants to share their thoughts and concerns on delicate matters such as harm reduction and HIV.

The following are some activities and games that you can use at the beginning of the training session. What you choose to use is dependent on a range of factors: what activities will follow, who the participants are and how well the participants know you and each other.

a) Setting ground rules (15 minutes)

Purpose: To help those attending the training know what to expect on the course and what is expected of them. Setting ground rules will also help to create a safe environment where participants will feel able to talk about their ideas and feelings.

How to do it: Using a flipchart, ask participants for rules they would like to have listed. Any rules agreed by the group should be written on the flipchart. There will also be ground rules provided by the trainer. For example, confidentiality (what is said in the group stays in the group), respect (for one another and for others' opinions), language (non-racist, non-sexist), participation (individual choice to participate), smoking etc.

b) Introduce your neighbour (5 minutes plus 2 minutes per group member)

Purpose: For group members to get to know each other and the trainer.

How to do it: Ask group members to work in pairs. Give them 5 minutes to interview each other to learn as much as they can about each other. When the pairs have completed the task bring them back to the main group and ask each person to introduce to the group the partner they just interviewed.

c) Names story (2 minutes per group member)

Purpose: For group members to learn each others' names and to get to know one another.

How to do it: Put a piece of flipchart paper in the centre of the room and ask the group members to write their name and then tell the group a story about their name. They can tell the story about their first name, second name or a nickname (it can be about why they were given the name, who they were named after or why they like or dislike their name).

d) Fact and questions (2 minutes per group member)

Purpose: To share what group members know about the training subject and what they would like to know (about the training subject).

How to do it: Go round the group and ask each person to introduce themselves and then share two pieces of information:

- What they know about the training subject
- What they would like to know about the training subject

After the round the trainer can explain what items can be covered in the training, and any unrealistic expectations within the group can be challenged by the trainer. It is important to allocate sufficient time during the training session to cover the areas that group members identify as wanting to know more about.

e) Introduction based on assumptions (10 minutes plus 2 minutes per group member)

Purpose: To explore how we make assumptions and to get to know each other.

How to do it: Ask group members to work in pairs. Participants are allowed to tell each other their names and afterwards should not talk anymore to each other. Allow them five minutes to “assume” the answers to three questions about their partners. The questions are:

- What paper does your partner usually read?
- What is your partner’s favourite food?
- What is your partner’s favourite music?

After the pairs have done this, ask each group member to introduce their partner and give the answers to the three questions. The partner can then correct the mistaken assumptions that have been made.

Allow a few minutes after all group members have been introduced to discuss how and why the assumptions were made.

Energisers

Whilst icebreakers help participants to get to know each other, energisers are often helpful to motivate people after lunch breaks or whenever energy, attention and motivation of the participants seem to decrease. Energisers are small activities that can be physical but are not necessarily so.

If you conduct several modules one after the other, you can choose either icebreakers or energizers as a starting point. Icebreakers are more useful at the beginning of a training to get to know each other, to feel at ease and to become familiar with the topic. Energizers can be used when moving from one topic to another, to get relaxed, to release some tension if a controversial theme has been raised, and to raise energy.

Lectures

Lectures are the least engaging method, but a good opportunity to provide basic information to participants. A good lecture includes a clear structure, clear and comprehensible language, relevant content, examples and room for discussion.

A lecture is more effective if participants can contribute as well as listening. Questions should be used to break up the lecture and to encourage discussion. It is important to always involve participatory methods in training in order to challenge attitudes.

Brainstorming

Brainstorming is a method of generating and collecting ideas, opinions and information quickly. Introduce a particular topic and collect key words or phrases called out by participants by writing them down on a flipchart, or let participants write down on paper their associations. Everyone should be encouraged to participate without proceeding in any set order. After collecting the responses, encourage discussion on what was said.

Group discussion

When group discussions are taking place, participants should ideally be seated in a circle with the facilitators as part of the circle. This gives a non-verbal message that as facilitator, you are giving up your position of authority and encouraging honest discussion to take place. A group discussion is a good method of starting or concluding a specific topic raising questions that are not clear or controversial. You will have to guide the process, encourage expression of different thoughts and attitudes, make sure that different views are respected, move forward, summarise the results and draw conclusions. Don’t be afraid of conflicting views arising during discussions but be aware to manage intolerant or verbally aggressive behaviour.

Small-groups discussion

An effective way of encouraging participation in a larger group is to break it into smaller groups of between four and six people. One person can be assigned from each group to make notes of the most important outcomes in order to present these to the whole group afterwards. Not only is this a good way of stimulating discussion within the larger group, it also helps to ensure that participants are closely involved in the learning process. It can help participants to better understand the topic(s) of the training session and to tolerate different points of view.

Case studies

Case studies, where participants examine a story that involves real situations and people, can be a powerful tool in training. Real life situations, especially when personalised by participants can have a very strong impact on learning.

Guest speakers

It can be useful to invite guest speakers to a training course such as experts in the field of harm reduction or ex- or current drug users. When involving guest speakers, it is advisable to come to some sort of informal agreement with them regarding discussion of issues such as their right to disclose drug use, HIV status and the right to refuse to answer questions that they consider too personal. Make sure to inform the guest speaker clearly about the aim and objective as well as the philosophy behind the training and clearly agree the content of his/ her contribution.

1.6 Evaluation of the training

At the end of a training session, all participants should fill out an evaluation form (Annex 1) in order to help you assessing the participants' views on the effectiveness of the training. Evaluation forms should be used after *each module.* If a module is divided into different sessions you should not evaluate the participant's views until having finalised all sessions of the module. The forms should be carefully analysed to inform the preparation of future training courses.

1.7 Planning a course of training

The following are some points to consider when preparing and planning your training:

- Start on time with prearrangements for the training.
- Identify your audience and be aware of what they already know and what they expect to gain from the training.
- Set dates and times.
- Book a suitable room.
- Make sure the technical equipment can be used on the premises.
- Make sure directions are clear to everyone.
- Provide refreshments, snacks etc.
- Choose activities which are most suitable to the target audience.
- Read all materials thoroughly before the training session.
- Make sure that your knowledge is up to date. It may be useful to contact the Ministry of Health (also the Ministries of Police, Narcotics, Justice, Public Security and Youth Affairs) in the country of delivery, WHO, United Nations, as well as international and local NGOs to obtain any materials on harm reduction that may be available.
- Be aware of your limitations and do not use activities that you feel uncomfortable with.
- Make sure you have all equipment and materials with you (compare with respective checklist).

- Make sufficient copies of handouts that are used.
- Distribute comment cards and provide a box so that participants can leave their comments during breaks etc.
- Set the ground rules with the group regarding confidentiality.
- Arrive in the training room early to set the room up. Many of the activities in this package are best suited to individuals sitting in a circle or semi-circle as opposed to a more formal class room style.
- Relax and enjoy the training session.

Resources:

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CORE MODULE

2. CORE MODULE

Target audience:

10-12 prison staff

Total time required:

approx. 4 ½ hours

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart
- Markers in various colours
- Paper and pencils
- Small box
- Cards with true and false statements about drugs (compare to Annex 4)
- “True and false statements on drugs: Answer key for the facilitator” (Annex 4)
- “Common concerns about harm reduction” (Annex 5)
- PowerPoint presentations of sessions 1, 2, 3

Objectives:

- To provide participants with a broad overview on drugs, infectious diseases, risk behaviours and harm reduction.
- To challenge attitudes and understandings regarding drug use.
- To sensitize the participants to the different challenges related to drugs, risk behaviours and infectious diseases.

Learning outcomes:

This session will increase participant’s knowledge about

- different types of drugs and their effects,
- risk behaviour, infectious diseases and how these are related,
- the principle of harm reduction,
- the range of methods used to minimize drug related harms,
- the effectiveness of harm reduction tools in preventing adverse consequences of drug use.

By the end of the session, participants will have a clear understanding of the key issues related to problem drug use. Participants will be aware that drug related harms are preventable and that harm reduction methods prevent disease and reduce mortality.

Activities:

Icebreaker (20 minutes)

Session 1 Overview on drugs (60 minutes)

- Activity: True and false statements about drugs - 30 minutes
- Lecture on drugs - 30 minutes

Session 2 Risk behaviour and drug related harm (60 minutes)

- Activity: How does HIV spread in prison? How can we reduce harm from risk behaviours? (Part I)? - 30 minutes
- Lecture on drug related harm - 30 minutes

Session 3 Harm reduction (110 minutes)

- Activity: How does HIV spread in prison? How can we reduce harm from risk behaviours? (Part II)? – 30 minutes
- Lecture on harm reduction – 50 minutes
- Activity: Common concerns about harm reduction – 30 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

Introduction to core module

UNODC (2009). *Drug Dependence Treatment: Interventions for Drug Users in Prison.* Treatnet Publication. Retrieved September 9, 2009, from http://www.unodc.org/docs/treatment/111_PRISON.pdf

WHO, UNODC & UNAIDS (2004). *Substitution maintenance therapy in the management of opioid dependence and HIV/ AIDS prevention.* Geneva. Retrieved September 11, 2009, from http://www.unodc.org/docs/treatment/Brochure_E.pdf

Session 1

EMCDDA (2002). *Annual report on the state of the drugs problem in the European Union and Norway*. Chapter 3 on polydrug use. Retrieved October 16, 2009, from http://www.emcdda.europa.eu/html.cfm/index37266EN.html

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United Nations Economic and Social Commission for Asia and the Pacific (2003*). Life Skills Training Guide for Young People: HIV/AIDS and Substance Use Prevention*. Retrieved October 15, 2009, from http://www.unodc.org/pdf/youthnet/action/message/escap_peers_00.pdf

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Session 2

EMCDDA (2008).*The state of the drugs problem in Europe. Annual Report 2008*. Lisbon: EMCDDA. Retrieved October 15, 2009, from http://www.emcdda.europa.eu/publications/annual-report/2008

Farrell, M., & Marsden, J. (2008). Acute risk of drug related death among newly released prisoners in England and Wales. *Addiction 103*, 251-255.

Hunt, N. (2003). *A review of the evidence-base for harm reduction approaches to drug use*. London: Forward Thinking on Drugs. Retrieved October 15, 2009, from http://www.antidrug.health.am/eng/lib_eng/HR_Hunt.pdf

UNAIDS (2008). *Report on the global AIDS epidemic*. Geneva. Retrieved October 8, 2009, from http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

WHO (1993). *The ICD-10 Classification of Mental and Behavioural Disorders. Diagnostic criteria for research*. Geneva. Retrieved October, 21, 2009, from http://www.who.int/classifications/icd/en/GRNBOOK.pdf

WHO (2007). *ICD-10. Version 2007. International statistical classification of diseases and related health problems. 10th revision.* Retrieved October 29, 2009, from http://apps.who.int/classifications/apps/icd/icd10online/

WHO (2007). *Orientation on Harm Reduction.* Training Course: Trainer Manual. Retrieved October 16, 2009, from http://www.wpro.who.int/NR/rdonlyres/699B2B2B-381D-43E1-914B-FE997E116C24/0/TrainerManual2.pdf

WHO (2010). *Prevention of acute drug related mortality in prison populations during the immediate post-release period.* Retrieved June 10, 2010, from http://www.euro.who.int/__data/assets/pdf_file/0020/114914/E93993.pdf

Session 3

CCSA (1996). *Harm Reduction: Concepts and Practice: A Policy Discussion Paper*.. Retrieved October 13, 2009, from http://www.ccsa.ca/2005%20CCSA%20Documents/ccsa-003900-2005.pdf

Newcombe, R. (1992). The reduction of drug related harm: a conceptual framework for theory, practice and research. In: O'Hare et al (Eds.). *The reduction of drug related harm*. London: Routledge.

WHO (2005). *Status Paper on Prison, Drugs and Harm Reduction*. Retrieved October 8, 2009, from http://www.euro.who.int/document/e85877.pdf

Other helpful resources:

EMCDDA (2010). *Harm Reduction: evidence, impact and challenges*. EMCDDA Monographs. Publications Office of the European Union: Luxembourg.

UNODC (2009). *World Drug Report 2009*. Vienna: UNODC. Retrieved October 5, 2009, from http://www.unodc.org/unodc/en/data-and-analysis/WDR-2009.html

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WHO, (2007). *Health in prison. A who guideline to the essentials in prison health*. Copenhagen: WHO. Retrieved October 6, 2009, from http://www.euro.who.int/document/e90174.pdf

WHO (2010). *The Madrid Recommendation: Health protection in prison as an essential part of public health.* Retrieved June 10, 2010, from http://www.euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf

Other helpful training manuals on harm reduction:

Bulmistre, I., Bundule, L., Brokere, I., Dudareva, S., Karnīte, A., Lāss, I., et al. (2009). *Comprehensive Action on HIV/AIDS Prevention among IDUs and Bridging Population*. *A Manual for Harm Reduction Service Providers.* Retrieved August 21, 2010, from http://www.lic.gov.lv/docs/268//handbook_en_2009.pdf

WHO (2004).*Training Guide for HIV Prevention Outreach to Injecting* Drug Users. Workshop Manual. Retrieved September 24, 2009, from http://www.who.int/hiv/pub/prev_care/trainingguideweb.pdf

WHO (2007). *Orientation on Harm Reduction*. *Training Course.* Retrieved September 16, 2009, from http://www.wpro.who.int/publications/PUB_9789290613077.htm

Other helpful websites:

Publications on HIV and prison settings from UNODC. Retrieved June 16, 2010, from http://www.unodc.org/unodc/en/hiv-aids/publications.html?ref=menuside#prison

Introduction

☞ The following introduction to the module is meant for the trainer, giving general background information on the topic.

The number of problem drug users is comparatively higher in prison than in the outside community. Within the last years, a rise in the use of drugs is found in the outside community and subsequently in the prison setting.

WHO, UNAIDS and UNODC (2004) state that around three-quarters of prisoners have alcohol or drug related problems and around one third may be opioid dependent.

Upon release, opioid dependent prisoners have a disproportionally higher risk of fatal overdose and relapse. Rates of infectious diseases, such as HIV and hepatitis as well as mental health disorders, suicides or suicide attempts are much higher in prison than in the outside community, with drug use as one of the main contributors.

There are various explanations for drug use in prison:

- Drug dependence was developed before imprisonment
- Drug problems/ dependence developed in prison
- Criminal activity took place in order to fund drug use which led to imprisonment
- Drug use itself was the reason for imprisonment (in some countries, drug use per se is an illegal activity)
- Drug use began after criminal activity in order to cope with the consequences (UNODC, 2009)

Although prisons are secure environments, drugs are widely available to prisoners. Drugs can be smuggled into prison in various ways and it is unlikely that it will ever be possible to curtail this.

Around Europe, imprisoned drug users are under-served in terms of treatment and help. However, there is a tendency to view prisons as being completely separate from society at large. This is untrue on two counts: prisoners come from the community and go back to it after their release and prison staff, too, are in daily contact with prisoners during their working day and return home to the community after work. Addressing the problem of drug use and infectious diseases in prison is therefore essential as prisoners form part of our society. Prison health problems should be taken into account and adequate treatment measures implemented.

As drug dependence poses a risk factor to offending, adequately treating dependence and related health problems are a valid measure in reducing re-offending. Mere criminal justice interventions only show limited impact on drug-using behaviour and re-offending.

This core module is in three parts.

Session 1 provides an overview on drugs, amongst others covering the following:

- True and false statements about drugs
- What is a drug?
- How are drugs taken?
- Effects of a drug
- Drug dependence
- Different kinds of drugs and their effects

Session 2 addresses risk behaviour and drug related harm, covering:

- Different forms of risk behaviour
- Drug related harm
  - Infectious diseases
  - Overdose
  - Other health problems
  - Other drug related harm

Finally, in **session 3** the different aspects of harm reduction will be outlined, including:

- What is harm reduction?
- Principles of harm reduction
- Different kinds of harm reduction measures
- Common concerns about harm reduction

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Session 1: Overview on drugs

Total time required: 60 minutes

Objectives:

- To provide participants with a broad overview on drugs.
- To challenge attitudes and understandings regarding drug use.

Learning outcomes:

This session will increase participants' knowledge about different types of drugs and their effects.

Activities:

- Activity: True and false statements about drugs – 30 minutes
- Lecture on drugs – 30 minutes

Activity: True and false statements about drugs

30 minutes

➢ ***PowerPoint: Session 1 (slide 3)***

Materials needed:

Flipchart, markers, small box, true and false statements written on little cards, "True and false statements on drugs: Answer key for the facilitator" (Annex 4)

Method:

Split the participants up into two groups facing each other and arrange the chairs/tables accordingly. Put the cards with the statements in a box in between them.

Explain that each team will, alternately, draw one card with a true or false statement on drugs. The team whose turn it is, is allowed to discuss the statement for one or two minutes.
Each team that answers a statement correctly will get 5 points. If a team does not give the right answer it will get 0 points. If a team draws a statement card and does not want to answer, the other team

will get 10 extra points if it gives the right answer. If no team gives the right answer, provide them with the right one. During the game, keep the scores on a flipchart.

In order to encourage further discussion, ask the teams after each round why they chose their respective answer.

After the game, discuss with the group topics such as:

- Have they learned anything new/ what have they learned from the game?
- Have they learned anything surprising or striking?
- What kind of drugs do prisoners use in their prison?

Lecture on drugs

30 minutes

➢ ***Point: Session 1 (slides 4-25)***

☞ During the lecture, be as interactive as possible by asking questions frequently, e.g. start the lecture by asking participants to name any kind of drugs they can think of and write them down on a flipchart.

What is a drug?

The WHO defines drugs as:
"..any substance that, when taken into a living organism, may modify its perception, mood, cognition behaviour or motor function" (WHO, 1993, p.8).

This definition does not distinguish between legal and illegal drugs and includes alcohol, tobacco and solvents (e.g. from adhesives and thinners) and excludes medicinal, non-psychoactive substances.

Drug use is an ancient human activity that in some form is found in all societies. For example, the Sumerians, a civilization in Southern Iraq 5000 BC, were aware of the psychoactive effect of opium.

Why do people take drugs?

☞ Shortly ask participants to brainstorm on the different reasons, why people start taking drugs and write down their answers on a flipchart.

How are drugs taken?

Drugs can either be

- swallowed (e.g. in the form of pills or liquids like alcohol),
- inhaled (e.g. smoking tobacco or marihuana),
- snorted (e.g. cocaine),
- injected (e.g. heroin).

Effects of a drug

The effect a particular drug has on individuals depends on various factors including:

- What kind of drug is used
- The amount used
- The way the drug is used (e.g. taken orally, smoked etc.)
- Personal characteristics like sex, weight, age and psychological state
- The social setting in which the drugs are used
- Previous experience with the drug

Many people use drugs without becoming dependent on them.

Drug use *can* be experimental, when drugs are used only once or for a short time out of curiosity, or recreational or social, when drugs are used in order to enhance social situations (e.g. alcohol).
Drug use has many detrimental effects on mental and physical health. Drug use can lead to various negative side effects such as overdose and drug dependence.

Drug dependence

Symptoms of drug dependence can include the following aspects (according to ICD-10)

- People who are drug dependent feel a strong desire and a sense of compulsion to take the drug(s).
- Drug dependent persons have difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use.
- In a dependent person, withdrawal symptoms occur upon cessation of the intake of drugs and the subsequent use of the drug in order to avoid these symptoms occurs.
- Furthermore, a “tolerance” is developed, i.e. higher doses are required in order to achieve the effects of the drug (opioid dependent persons are sometimes used to doses that would kill non-tolerant users).
- The use of drugs takes over higher priority than other behaviours formerly of great value with an increased amount of time necessary to obtain or take the substance or to recover from its effects.
- Finally, the persistent use of the drug despite other harmful consequences (e.g. health problems) can be a sign of drug dependence.

Drug withdrawal

- When a person regularly takes a drug over a longer period of time, the brain and body need to adjust if usage is stopped suddenly.
- This can lead, depending on the type of drug used and the period of time this drug has been regularly used, to more or less severe physical and psychological withdrawal symptoms.
- Often medical assistance is needed to cope with withdrawal symptoms.
- Withdrawal from heroin, for example, resembles the symptoms of a severe influenza, including dilated pupils, chills, nausea, diarrhoea, muscle cramps and a strong desire to take the drug.

- Withdrawal from amphetamines results in symptoms including fatigue, irritability, mood swings and, in severe cases, psychoses.

Underlying factors of drug use

- Drug dependence is a complex behavioural disorder that is influenced by biological, psychological and sociological factors.
- Drug dependence is a medical condition and can be seen as a chronic relapsing disease.
- Psychiatric diseases often underlie drug use.
  - Over 50% of those with a substance use disorder (except for alcohol) are found to have a co-occurring mental disorder (Regier et al., 1990).

Different kind of drugs and their effects

☞ You can either present the information on all or some of the following drugs. Before presenting the information, ask the participants what they know about the respective drug. If you would like to include pictures of the different drugs outlined, you could use those from the *Drug Profiles* on the EMCDDA website (http://www.emcdda.europa.eu/publications/drug-profiles). The *Drug Profiles* provide further useful information for example on the current street names of the listed drugs.

Alcohol

- Alcohol is probably the most commonly used drug in the world.
- Compared to other drugs, alcohol has a lower potency and comparatively larger doses have to be consumed to provide its effects.
- Depending on the blood alcohol concentration, its consumption effects talkativeness, reduced inhibition, amnesia, semi- and unconsciousness, and can also lead to fatal overdoses.
- Alcohol is an irritant of the gastrointestinal tract (stomach and bowel) and chronic heavy consumption can lead to various negative and fatal health consequences like liver cirrhosis (a disease where the liver slowly deteriorates and malfunctions due to chronic injury).
- According to the WHO, critical consumption starts when men consume over a sustained period of time 40 grams of pure alcohol a day (that corresponds to one litre of beer), for women the threshold lies at 20 grams of pure alcohol (corresponding to half a litre of beer).
- In the media, it is often reported that low levels of alcohol use can have a protective effect on the heart. However, this is not finally proven and it always has to be considered that the consumption of alcohol means a higher risk of developing cancer and other detrimental health consequences. Studies have further identified that although low-level consumption of alcohol may have protective effects for some individuals, these findings cannot be translated to the population as a whole.

Tobacco

- Nicotine is one of the most widely used drugs in the world.
- Tobacco can be either smoked or chewed.
- Desired effects are increased arousal and attentiveness and suppressed appetite.
- Smoking tobacco is associated with a wide range of health problems such as respiratory diseases (diseases of the breathing system, like lungs and bronchi), heart diseases and cancer.

Cannabis

- Cannabis is the third most popular drug in developed countries (after alcohol and tobacco).
- It is usually smoked or taken orally.
- Cannabis is consumed in the form of marihuana (the dried leaves and flowers of the cannabis sativa plant) or in the form of hashish (the extracted resin of the plant that contains more THC [tetrahydrocannabinol]). THC is the substance responsible for its psychoactive effect.
- Possible effects are euphoria, relaxation, perceptual distortion, increased appetite and cognitive and psychomotor impairment, anxiety and paranoia.

Amphetamine and Methamphetamines

- Amphetamines and Methamphetamines are “psycho-stimulants” or “central nervous system stimulants”. They are better known by their “street” names including speed, crystal, meth and ice.
- (Meth)amphetamines speed up the messages going to and from the body to the brain.
- They can be orally ingested, snorted, smoked or injected.
- Symptoms include: increased breathing and heart rate, raised blood pressure, dilated pupils.
- Adverse effects are: irregular heartbeat, tremor, loss of coordination, collapse.

Ecstasy

- Ecstasy is an amphetamine derivate, falling under the category of amphetamine type stimulants.
- Ecstasy is usually orally ingested. In its powdered form it can be snorted, smoked or injected, although such use is rare.
- It acts as a “central nervous system stimulant” causing euphoria, increased sensory awareness and mild central stimulation.
- Adverse effects are similar to those of amphetamines and methamphetamines. A further common adverse effect is body overheating.

Cocaine

- Cocaine also belongs to the group of the “central nervous system stimulants”.
- Cocaine is usually snorted whereas crack, a highly potent derivate of cocaine, is smoked.
- Effects are severe mood swings including euphoria, dysphoria and, in extreme cases, cocaine psychosis and heart problems.
- Cocaine is a highly addictive drug.

LSD and other hallucinogens

- Hallucinogens either occur naturally for example magic mushrooms or in synthetic or semi-synthetic form such as LSD.
- Hallucinogens are usually taken orally and have mind altering and psychedelic effects.
- Desired effects are perceptual distortion of time and place, visual hallucinations and synaesthesia (sounds are seen, colours are heard).

- Adverse effects are dizziness, disorientation, anxiety, depression and flashbacks.
- Hallucinogens cause psychological rather than physical dependence.

Benzodiazepines

- Benzodiazepines are sedative-hypnotics that in low doses help against anxiety and in high doses effect sedation and sleep.
- Benzodiazepines are legal prescription drugs (e.g. Valium) but regularly appear on the illegal market.
- They are either swallowed or injected.
- Benzodiazepines are often used in combination with alcohol to increase their effect.
- Long-time use leads to physical dependence, has negative effects on the memory and concentration and can cause emotional blunting.

Heroin/ opioids

- Opium is naturally derived from the juice of the opium poppy; its main active constituent is morphine.
- Opioids are drugs with morphine-like effects, either semi-synthetic like heroin or synthetic such as methadone.
- Opioids depress the central nervous system and are therapeutically used as pain killer.
- Heroin is a relatively potent opioid, it is easily dissolved in water for injecting and quickly passes the blood-brain barrier.
- Heroin can either be injected, snorted or smoked.
- A typical symptom of opioid use is the so-called miosis (narrowed pupils of the user).
- Desired effects are drowsiness, euphoria, reduced anxiety and/ or pain.
- Adverse effects are lowered breathing, sedation, dependence and overdoses.
- Heroin is associated with far more accidental overdoses and fatal poisonings than any other scheduled substance.
- Heroin dependence is a chronic, relapsing disease; it is a dependence that is very difficult to resolve.
- Heroin dependent persons show strong psychic and physical withdrawal symptoms upon cessation.

Poly-drug use

- If a person uses more than one drug or type of drug at the same time or sequentially this is referred to as poly-drug use.
- Illegal drugs and alcohol and sometimes tobacco are included in poly-drug use.
- According to this definition, almost all illegal drug users can be defined as poly-drug users as they presumably use alcohol or tobacco at some time in their lives.
- Therefore, in poly-drug use it is important to take into account the different health risks that can be produced by different combinations of drugs. A combination of alcohol and tobacco can have comparably lower immediate health risk as for example a combination of benzodiazepines together with alcohol that can easily lead to fatal overdoses (EMCDDA 2002).

Session 2: Risk behaviour and drug related harm

Total time required: 60 minutes

Objectives:

- To provide participants with a broad overview on infectious diseases, risk behaviours and drug related harm

Learning outcomes:

This session will increase participant's knowledge about risk behaviour and related harm.

By the end of the session participants will have a clear understanding of the key issues related to problem drug use.

Activities:

- Activity: How does HIV spread in prison? How can we reduce harm from risk behaviours? (Part I)? – 30 minutes
- Lecture on drug related harm – 30 minutes

Activity: How does HIV spread in prison? How can we reduce harm from risk behaviours? (Part I)

30 minutes

➢ ***PowerPoint: Session 2 (slides 3-4)***

Materials needed:

Flipchart, markers, paper, pencils

Method:

Start this session with ***slide 3*** in order to give some information on the spread of HIV:

HIV/AIDS

- Problem drug use can be associated with a number of harmful consequences.
- Infectious diseases are among the most serious health consequences related to drugs.
- It is estimated that around 33 million people around the world currently live with HIV with 2,7 million new infections and 2 million AIDS related deaths in 2007.
- HIV prevalence is higher in prison than in the community (UNAIDS, 2008).

Split participants into small groups and ask them to write down on paper risk behaviours in the prison setting that can lead to the transmission of HIV. If necessary, provide an example. Ask the small groups to present their results.

Write down the answers on the left side of a flipchart. Respond to incorrect answers by stating the correct ways of HIV transmission. Respond to answers not relevant to the prison setting, but remind participants only to refer to risk behaviours within prison.

Risk behaviour that can lead to the spread of infectious diseases in prison includes:

- Sharing injection equipment
- Unprotected sexual activity
- Sharing tattooing needles
- Body piercing

Lecture on drug related harm

30 minutes

➢ ***PowerPoint: Session 2 (slides 5-12)***

☞ During the lecture be as interactive as possible by asking such questions as: “Does anyone know what HIV stands for?” etc.

Infectious diseases

HIV/AIDS

- An infection with HIV (Human Immunodeficiency Virus) leads, after a certain time (that can be up to several years or decades) to the immunodeficiency disease AIDS (Acquired Immunodeficiency Syndrome).
- HIV/ AIDS can be transmitted via blood, be sexually transmitted or be transmitted from mother to child.
- Despite better medication and success in therapy, AIDS is treatable but not curable. Therefore it is important to detect HIV/AIDS and start treatment at an early point.
- Injecting drug use contributes to the spread of HIV/AIDS.

Hepatitis C

- Viral hepatitis, especially hepatitis C is highly prevalent among injecting drug users across Europe.
- Hepatitis C is transmittable via blood e.g. by sharing injection equipment.
- In most European countries, over 40% (in some countries up to 90%) of injecting drug users are infected with hepatitis C.

- 50 to 90% of those infected develop a chronic hepatitis C infection.
- Chronic hepatitis C can lead to liver cirrhosis and liver cancer.

(all numbers taken from EMCDDA, 2008)

Hepatitis B

- Only around 5% of the hepatitis-B infected develop a chronic form of the disease (with comparably serious health consequences to a chronic hepatitis C infection).
- Many European countries report over 40% of injecting drug users with a history of hepatitis B infection.
- Hepatitis B is sexually transmittable and also can be transmitted via blood and other body fluids (e.g. saliva, breast milk).
- Unlike HIV and hepatitis C, there exists a vaccination against hepatitis B.

(all numbers taken from EMCDDA, 2008)

Other health problems

- Besides blood-borne viruses, poor hygiene when injecting drugs as well as the injection of contaminated drugs and using contaminated injecting equipment may lead to bacterial infections.
- Local infections like abscesses are common among injecting drug users.

Overdose

- In Europe, there are around 7.000 to 8.000 drug-induced deaths each year (this is only a minimum estimate due to known under reporting).
- Opioids are most often associated with drug related deaths but it also occurs with other drugs and alcohol.
- Consumption of drugs like amphetamines, methamphetamines, ecstasy and cocaine can lead to life threatening and serious emergencies.
- Newly released prisoners especially are at high and acute risk of drug related death (EMCDDA, 2008).
- A study carried out in the United Kingdom (Farrell & Marsden, 2008) reported that the risk of death for newly released prisoners was 10 times higher than normal.
- All female and 95% of male deaths that occurred during the first fortnight outside prison were drug related (overdose).
- Of 49.000 released prisoners 442 died within a period of 3-5 years; 59% of these deaths were drug related.
- In 95% of the drug related deaths, opioids were involved.

Other drug related harm

- Mental health problems
- Economic problems
- Social problems
- Family break-down
- Neglect of children
- Open drug scenes (i.e. public places where drug user congregate) affecting real and perceived safety of people
- Drug related crime
- Imprisonment

Session 3: Harm reduction

Total time required: 110 minutes

Objectives

- To explain the principles of harm reduction.
- To provide an overview of harm reduction measures.

Learning outcomes:

After completing this module, participants will have increased knowledge about

- a range of methods used to minimize drug related harms,
- the effectiveness of harm reduction tools in the prevention of adverse consequences arising from drug use.

By the end of this session participants will be aware that drug related harms are preventable and that harm reduction methods prevent disease and reduce mortality.

Activities

- Activity: How does HIV spread in prison? How can we reduce harm from risk behaviours? (Part II)? – 30 minutes
- Lecture on harm reduction – 50 minutes
- Activity: Common concerns about harm reduction – 30 minutes

Activity: How does HIV spread in prison? How can we reduce harm from risk behaviours? (Part II)

30 minutes

➢ ***PowerPoint: Session 3 (slide 3)***

Materials needed:

Flipchart, markers

Method:

After having outlined in the lecture what kinds of drug related harm exists, go back to the activity.

Ask participants to re-assemble in small groups, as in the first part of the exercise. On the flipchart, examples of risk behaviours in prison from Part I of the activity are listed. If necessary, adjust or amend this list according to the content of the lecture.

Now, ask participants how harm from these behaviours can be reduced. Write down the respective harm reduction measure(s) next to the respective risk behaviour.

Explain to participants that even though most of the mentioned risk behaviour is illegal in prison, some of it such as drug use in prison and sexual activity in prison will always take place.

Many participants might respond that stricter rules and more punitive measures will be needed to reduce drug use in prison and the related harms. Point out that there will always be ways of smuggling drugs into prison. Drug use has always been part of human society, will always take place in prison and requires harm reduction measures to respond to it.

Lecture: Harm reduction

50 minutes

➢ ***PowerPoint: Session 3 (slides 4-17)***

☞ With reference to the harm reduction measures listed by the participants during the activity, start the lecture by explaining the concept of harm reduction and give more details of each single harm reduction measure.

What is harm reduction?

The term harm reduction refers to a concept that aims at reducing the negative consequences of certain behaviours. In relation to injecting drug use, harm reduction aims at preventing the transmission of infectious diseases e.g. through sharing injection equipment.

Newcombe (1992) gives a good broad definition including the various aspects of harm reduction:
“Harm reduction is a term that defines policies, programmes, services and actions that work to reduce the health, social and economic harms to individuals, communities and society.”

Principles of harm reduction

- “Harm reduction accepts that some use of psychoactive substances is inevitable and that some level of substance use is expected in a society” (CCSA, 1996).
- It recognises that many people despite the strongest efforts continue using drugs because they are unwilling or unable to stop.
- Harm reduction focuses on the prevention of drug related harm without necessarily requiring abstinence by the drug users.
- Harm reduction complements preventative measures for drug consumption and measures reducing the overall level of drug consumption, and assists those willing to stop using drugs.
- Harm reduction is non-judgemental and always respects the dignity and rights of the drug users.
- The concept of harm reduction can be broadened to prevent harm from other risk behaviour like unprotected sexual contact, tattooing etc.

- The term harm reduction can be used to refer to the related set of general principles or to specific types of intervention such as methadone treatment and needle exchange programmes.

Why implement harm reduction?

- Harm reduction is effective in protecting public and individual health by halting the transmission of infectious diseases like HIV/AIDS and hepatitis B and C.
- Thereby, harm reduction is a cost-effective measure, i.e. the investments of comparably low cost harm reduction leads to a high impact on the health of a whole society.
- People in prison keep their fundamental rights and are entitled to the level of health care that is provided in the community.
- Governments are obligated to honour international human rights laws that require them to protect the health of prisoners.
- Addressing the problems of drug use and infectious diseases and implementing adequate harm reduction measures in prison is essential as prisoners form part of our society, living in the outside community prior to imprisonment and returning to it after release.

Different kind of harm reduction measures

Information, education and communication

- Providing information on drugs, infectious diseases and how they are transmitted is the most widespread method of harm reduction found in European prisons.
- Information can be provided by health and social services or trained inmates (so-called peer educators).
- Useful ways of distributing information can be individual and/ or group counselling, providing brochures, leaflets and posters, providing information about potential risks related to drug use and other risk behaviour.

Detoxification and opioid substitution treatment (OST) for opioid dependent persons

- Drug dependent prisoners should be encouraged to enrol in drug treatment programmes.
- Drug dependent prisoners often face serious withdrawal symptoms on admission to prison often leading to self-harm and violence.
- Opioid substitution treatment is a medically supervised treatment for opioid dependent persons with substitution drugs like methadone.
- As with other health conditions, the use of adequate medication and behavioural change can improve the condition of an opioid dependent person.
- Methadone can be used for detoxification (quickly reducing the dose with drug-abstinence as the goal) or for maintenance therapy.
- Relapse after detoxification is extremely common and taken as a measure on its own it rarely constitutes adequate treatment.
- By contrast, opioid substitution treatment (over a longer period of time)
  - improves the overall health status,
  - reduces criminal activity,
  - prevents overdoses and deaths,
  - reduces the transmission of infectious diseases,

  - improves the treatment of drug users living with HIV/AIDS,
  - reduces the use of illegal drugs,
  - stabilizes the drug users' lives,
  - improves the levels of social functioning and employment.

- WHO, UNODC and UNAIDS (2004) strongly recommend the implementation of opioid substitution treatment in communities at high risk of HIV.
- Treatment should always be accompanied by psycho-social support of the dependent person.
- Reasons for introducing opioid substitution treatment in prison include:
  - difficulties for staff arising during withdrawal periods of prisoners such as violence, drug smuggling,
  - higher rates of self-harm and suicide during periods of withdrawal,
  - the requirement to provide equal services in prison and communities.

Needle/syringe exchange

In Europe, HIV prevalence among prisoners is primarily related to the sharing of injecting equipment.

- Needle and syringe exchange programmes are widespread in the outside community in countries throughout Europe and encourage the return and safe disposal of syringes and needles in exchange for new sterile syringes.
- HIV is known to be able to survive in a needle for several days and hepatitis C even for several weeks (depending on conditions like temperature, humidity etc.).
- Accordingly, syringe exchange is a valid measure in reducing risk of HIV and hepatitis infection.
- Furthermore, syringe exchange links participants to drug treatment, medical care and other social services.
- When heroin or other injectable drugs are prepared for injecting use, they are mixed with water and cooked up in a "cooker" (usually a spoon); afterwards the solution is filtered through a piece of cotton or cigarette filter. As sharing of this equipment is also related to potential transmission of infectious diseases some needle and syringe programmes also provide sterile wipes, water, cookers and filters.
- Needle exchange programmes have been successfully introduced in prison in some European countries, e.g. in Spain needle exchange programmes have been initiated in all prisons.
- Vending machines have been used as a means to distribute syringes. Upon admission a prisoner is provided with a fake syringe. If necessary, the fake syringe can be deposited in the vending machine and replaced with a sterile one. After injecting, they can deposit the used syringe and obtain a new one.
- Sterile syringes can also be distributed by the medical service or peer educators.
- Studies show that after the implementation of needle exchange programmes in prison
  - neither drug use or injecting drug use increased,
  - syringes were not misused (e.g. as weapons),
  - the disposal of used syringes was uncomplicated,
  - even the reduction of drug use can result if needle exchange is embedded in an improved structure of drug counselling and treatment,
  - the spread of infectious is reduced.

☞ Most prison staff are afraid of needle stick injuries and the transmission of infectious diseases. Stress that none of the studies reported higher rates of needle sticks after the introduction of needle exchange programmes.

Bleach kits

- Nowadays, the disinfection of injecting equipment with bleach is a **second-line strategy only**.
- Thoroughly cleaning injecting equipment and tattooing needles with bleach (bleach kits containing bleach and instructions for cleaning equipment) can help prevent the transmission of some infectious diseases.
- **But:** bleach does not kill the pathogen that causes hepatitis and is also not totally effective in eliminating HIV.
- Furthermore, the disinfecting process is relatively time-consuming.
- Bleach can create a false sense of security for prisoners sharing injecting equipment.

Condom distribution

Unprotected sexual contact between prisoners poses a risk of the transmission of HIV, hepatitis and other sexually transmitted infections.

- Sexual activity occurs in prison, either consensually or non-consensually.
- Condoms are an effective measure in preventing the transmission of infectious diseases.
- Providing condoms in prison does not increase sexual activity.
- Condoms in prison can be provided in the form of a dispensing machine or they can be placed in boxes in common areas in the prison.

Voluntary HIV counselling and testing (VCT)

- Voluntary HIV testing helps prisoners learn their HIV status.
- Voluntary HIV counselling and testing should be offered to prisoners upon admission and at any time during imprisonment.
- VCT helps HIV positive prisoners benefit from antiretroviral treatment, care and support.

Activity: Common concerns about harm reduction

30 minutes

➢ ***PowerPoint: Session 3 (slide 18)***

Materials needed:

"Common concerns about harm reduction" (Annex 5)

Method:

Despite the evidence based effectiveness of harm reduction, many participants might still be sceptical about the concept.

Ask participants to sit in a circle in order to create the right atmosphere for the following group discussion. Discuss with participants their views and common concerns about harm reduction. With the help of the sheet "Common concerns about harm reduction", clear up fears and misconceptions that might still persist.

Conclusion (questions and comments)

Total time required: 10 minutes

Evaluation

Total time required: 10 minutes

ADDITIONAL MODULES

3. Additional Modules

3.1 CONCEPTS AND MODELS OF DRUG DEPENDENCE

Target audience:

10-12 prison staff

Total time required:

130 minutes

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart, flipchart paper, tape
- Markers in various colours
- Paper and pencils
- “Continuum of drug use – case studies” (Annex 6)
- PowerPoint presentations of sessions 1 and 2

Objectives:

- To develop a common understanding of drug dependence among the participants.

Learning outcomes:

This session will increase participants’ knowledge about

- the concept and patterns of drug dependence,
- models of drug dependence.

Activities:

Icebreaker (20 minutes)

Session 1 Concept of drug dependence (70 minutes)

- Activity: Brainstorming on the participants' view and perception of drug dependence – 20 minutes
- Activity: Symptoms of dependence - 20 minutes
- Lecture: Continuum of drug use – 10 minutes
- Activity: Continuum of drug use - case studies – 20 minutes

Session 2 Basic models of drug dependence (20 minutes)

- Lecture: Models of drug dependence – 20 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation and close (10 minutes)

Resources:

Adams, P. (2008). *Fragmented intimacy. Addiction in a social world*. New York: Springer Science and Business Media.

Bandura, A. (1977). *Social Learning Theory*. New York: General Learning Press.

Bandura, A. (1986). *Social Foundations of Thought and Action*. Englewood Cliffs: Prentice-Hall.

Blume, A. (2005). *Treating drug problems*. Hoboken: John Wiley & Sons.

Coombs, R. H. & Howatt, W. A. (2005). *The addiction counsellor's*. Desk reference. Hoboken: John Wiley & Sons.

Martin, P. R. & Weinberg, B. A. & Bealer, B. K. (2007). *Healing addiction.* Hoboken: John Wiley & Sons.

Introduction

☞ The following introduction to the module is meant for the trainer, giving general background information on the topic.

In these early years of the twenty-first century we find ourselves constantly immersed in talk about dependences. Newspapers and television regularly present disturbing items on the rising negative effects of dependence. When the country is not waging a “war on drugs” it is struggling with drunken driving, youth drug crime, increases in pathological gambling, alcohol destroying families, spates of internet addiction, and so forth.

The term “dependence” means slightly different things in different contexts. Some people refer, rather lightly, to dependence on chocolate or on golf; in other cases, dependence is referred to more seriously as the following common phrases show: “Dependencies are leading more and more people into crime”; “Dependence drives most of our corruption”. At still other times, dependence is referred to in a manner that is nuanced with menace and prejudice: “We must stamp out all dependencies”; “Dependent persons are weak and worthless people.” Dependencies are simply an increasing part of public consciousness.

Why is it important to learn about drug dependence?

Alcohol is commonly used in most parts of the world and many people also use other drugs. Whereas most of these people never become dependent, drug or alcohol dependence is a serious health disorder. Drug dependence not only affects the person using drugs but also relatives and friends. Considering this fact, group members should learn as much as they can about drug dependence in order to teach their children and other family members and help them if they show early signs of becoming dependent to alcohol or other drugs.

This training module provides an introduction to the concept, characteristics and models of drug dependence.

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Session 1: Concept of drug dependence

Total time required: 70 minutes

Activity: Brainstorming on the participant's view and perception of drug dependence

20 minutes

➢ ***PowerPoint: Slide 3***

Materials needed:

Flipchart, flipchart paper taped on the wall, tape, paper, pencils, markers

Method:

Start this session by asking the group members to name or describe what comes into their mind when they hear the words "drug dependent person" and "alcoholic". Encourage them to be honest and to talk frankly, as there are no good or bad associations. Associations can be words, things, objects, feelings etc.

Ask participants to write down on paper five words/ associations as quickly as possible. Time pressure usually makes associations more spontaneous and less censored.

When everybody has finished writing down their associations, ask the first participant to name the first word in his/ her list and write it on some flipchart paper that is taped on the wall around the room. If other participants have also written down this word ask them to delete it from their lists. Then move to the next participant, ask this person to read out his/ her first word, write it on the flipchart, and the others delete it. Go on with the next words on the list until all words have been read out by the participants. Write the words large enough on the flipchart paper that is taped on the walls around the room so that people can easily read them.

Ask participants to look at these words for a few moments, read them again and think about how they can be grouped.

☞ Try to challenge negative conceptions and stress that current research considers drug dependence to be a chronic relapsing disease.

Activity: Symptoms of dependence

20 minutes

➢ ***PowerPoint: Slides 4-5***

Materials needed:

Flipchart, markers, paper, pencils

Method:

Split up the participants into small groups. Provide each group with paper and pencils. Ask participants to discuss the following questions within the group: When do you think a person can be considered as drug dependent? What symptoms and behavioural patterns does this person show? Answers should not be reduced merely to the fact of being intoxicated. Ask each group to write down five statements on the paper. If necessary provide an example.

Ask each group to present their results and write their answers on the flipchart.

After having finished the activity, present the symptoms of dependence listed by ICD-10 to the participants:

Symptoms of dependence

According to the international classification of diseases, (ICD-10) a person is considered to be drug dependent if three or more of the following have been present together for at least one month at some time during the previous year:

- Compulsive use (powerful urge, attributed to internal feelings rather than external influences, to take the substance/s in question).
- High priority of drug use (progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects).
- Loss of control (an inability to modulate the amount and frequency of psychoactive substance use. Diminished ability of an individual to control his or her use of a psychoactive substance in terms of onset, level or termination).
- Continued use despite adverse consequences (continuing to drink/use drugs despite knowing one has a physical or psychological problem that is caused or made worse by drinking/using drugs).
- Tolerance (it takes more to produce the desired euphoric effect. Drug dependent person may increase their frequency, duration, and intensity of use and move to the next level of dependence).
- Withdrawal (physiological changes manifested by discomfort and pain accompanying interruption in the use of an addictive substance or in the practice of an addictive behaviour. The severity of withdrawal symptoms is correlated with the dose drug dependent person had been using and the duration of their use).

Lecture: Continuum of drug use and drug problems

10 minutes

➢ ***PowerPoint: Slides 6-7***

Drug problems can appear in various forms. Some people start using drugs recreationally and at some point in time get into trouble with that use. Furthermore, there are some people who can and do use drugs recreationally without any problems. Thus, using drugs does not automatically mean that a person will become dependent, nor does having a drug problem necessarily mean it will always get worse. Also those people who develop drug problems do not necessarily experience consistent problems over time whereas some people have continuous problems. Some people move in and out of problems, so that sometimes they seem dependent on drugs and other times they do not. Continuous or chronic drug problems often are described as dependence by treatment professionals, whereas the more transient or episodic problems are often referred to as misuse, although even this distinction is not always clear-cut.

☞ Draw a line on the flipchart and name it “continuum of drug use”. Label one end of the line “drug abstinence” the middle “recreational use” and the other end “drug problems”. Many people do not use drugs at all, followed by a minority who are recreational users, some who may have mild or occasional problems or none at all, and then a very small minority who has drug problems and who may require help. Drug use does not necessarily translate into drug problems, nor does drug use mean a person needs treatment.

Activity: Continuum of drug use - case studies

20 minutes

➢ ***PowerPoint: Slide 8***

Materials needed:

Flipchart, markers, Handouts of case studies to be distributed to participants (Annex 6)

Method:

Distribute the case studies to the participants and ask them where on the continuum of drug use they would place the described persons. Ask participants to mark the spot on the continuum on the flipchart and to explain their choice.

Session 2: Basic models of drug dependence

Total time required: 20 minutes

Lecture: Models of drug dependence

20 minutes

➢ ***PowerPoint: Slides 10-18***

A variety of different factors can predispose a person to becoming drug dependent. These factors can be:

- biological,
- psychological,
- social.

Drug dependence has biological, psychological and social roots and biological, psychological, and social/environmental factors are all important for understanding and adequately treating drug dependence.

Drug problems can have multiple causes. The most widely used explanation models of drug dependence are outlined below.

☞ Before starting to explain the different models of drug dependence, explain to the participants that there is no right or wrong model of underlying factors of drug dependence but that drug dependence is a complex phenomenon including a wide range of different aspects.

Models underlying drug dependence

Medical/disease model

In this model drug dependence is seen as a lifelong disease involving biologic and environmental sources of origin. *Disease is* defined as a severely harmful, potentially fatal condition that manifests itself in an irreversible loss of control over the use of psychoactive substances. Although the disease may go into remission, there is no known cure for it.

Social learning model

This model links drug use to social learning. According to this model, social reinforcement causes individuals to model the drug use behaviours of their parents, older siblings, and peers. Social learning theorist Albert Bandura (1977, 1986) indicates four stages of social learning:

- Attention: the individual makes a conscious cognitive choice to observe the desired behaviour (in our case drug use).

- Memory: the individual recalls what s/he has observed from the modelling.
- Imitation: the individual repeats the actions (the drug use) that s/he has observed.
- Motivation: the individual must have some internal motivation for wanting to carry out the modelled behaviour, i.e. drug use.

Genetic model

Research over the past 20 years has identified a genetic predisposition in some individuals to alcohol, tobacco, and other substances. Epidemiological studies indicate that 40 to 60% of an individual's risk for dependence to alcohol, opiates, or cocaine is genetic. A growing number of genetic researchers now believe different classes of substances may be connected to unique genetic structures explaining why some people get dependent on certain drugs.

Bio-psychosocial model of dependence

The bio-psychosocial model shifts our focus from the drug itself to understanding drug use as a dis-ease whose course depends on the interactions of the drug or compulsive behaviour, the biogenetic and psychological susceptibilities of the individual, and the social context in which drug use occurs.

Biological factors/brain chemistry

Psychoactive drugs influence the body in such a way as to stimulate the pleasure centre of the brain. In this way, drug problems are biologically based. The powerful favourable effects of drugs, especially the euphoria they produce, involve several chemical messengers (=neurotransmitter) in the brain. The prolonged drug use results in long-lasting changes in the brain structure.

Therapists and researchers have found that a family history of drug dependence may be a particularly potent risk factor for drug problems, and the risk seems even higher if a member of the nuclear family has a history of drug dependence.

Psychological factors

Psychological factors may include personal variables such as the way a person behaves, thinks, and feels. Specific psychological factors might predispose a person to become drug dependent, amongst these:

- Emotional problems: depression, anxiety, etc.
- Mental disorders: bipolar disorders, attention deficit/hyperactivity disorder, psychosis
- Psychological stress

Social (environmental) factors

"We influence the environment but it also influences us."
A variety of social factors can predispose someone to become dependent. Social factors often are related to personal interactions but also can be related to environmental factors:

- Peer pressure
- Poverty
- Social relationships
- Life changes and crises
- Traumatic events
- Cultural isolation

Social and psychological factors are very important to understand the development and persistence of drug dependence and related problems because these are the areas that we will most likely be able to intervene upon and possibly change. We have not determined how to change biology yet, although some progress has been made in pharmacotherapy.

Conclusion (questions and comments)

Total time required: 10 minutes

- Group members should learn as much as they can about drug dependence in order to understand and advise prisoners, their children and other family members and help them as soon as possible if they start to show early signs of becoming dependent on alcohol or other drugs.
- It is important to be sensitized to the different stages of dependence. If a person is still at an early stage of drug dependence, someone who knows about the stages and the process of drug dependence could initiate help from drug counselling services and other services at this early stage and prevent further harm.
- Drug dependence is a chronic relapsing disease and has biological, psychological and social roots and biology, psychology, and social/environmental factors are all important for understanding and treating a drug problem. There is no right or wrong model of underlying factors of drug dependence but drug dependence is a complex phenomenon including a wide range of different aspects.

Evaluation

Total time required: 10 minutes

3.2 INFECTIOUS DISEASES

Target audience:

10-12 prison staff

Total duration:

180 minutes

Necessary materials:

- Laptop or desktop computer
- Flipchart
- Marker pens in different colours
- Paper
- Pencils
- Small cards with letters X, P and O
- Small box
- True and false statements written on little cards (refer to Annex 7)
- “True and false statements on HIV transmission: Answer key for the facilitator” (Annex 7)
- “HIV Transmission” (Annex 8)
- PowerPoint presentation of the session

Objectives:

- To provide participants with detailed information about the infectious diseases HIV/AIDS, hepatitis B and C and how they are transmitted.
- To sensitize participants to the importance of preventative measures in limiting the impact of infectious diseases on individual and public health.

Learning outcomes

This session will increase the participants’ knowledge about

- infectious diseases, specifically those transmitted by unprotected sexual contact, sharing of injection equipment and other risk behaviour,
- ways of transmission,
- preventative measures.

Activities:

Icebreaker (20 minutes)

Session 1 HIV infection and AIDS (80 minutes)

- Activity: Information about HIV and AIDS - 20 minutes
- Activity: HIV transmission - 60 minutes

Session 2 Hepatitis B and C (60 minutes)

- Lecture: Hepatitis B and C - 30 minutes
- Activity: Hepatitis infection - 30 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation and close (10 minutes)

Resources:

Session 1

International Planned Parenthood Federation (2001). *Advocacy Guide for HIV/AIDS.* Retrieved October 2, 2009, from
http://www.aidsportal.org/store/1245.pdf

EngenderHealth (2004). *Reducing stigma and discrimination related to HIV and AIDS: training for health care workers.* New York: EngenderHealth.

UNAIDS (2003). *HIV/AIDS: It's your business*. Geneva: UNAIDS.

Helpful websites:

International HIV/AIDS Alliance, Retrieved October 22, 2009, from
www.aidsalliance.org

World Health Organisation - AIDS, Retrieved October 22, 2009, from
http://www.who.int/topics/hiv_aids/en/

Session 2

Weinbaum, C. M., Sabin, K. M. & Santibanez, S. S. (2005). Hepatitis B, hepatitis C, and HIV in correctional populations: a review of epidemiology and prevention. *AIDS 19*, 41-46.

Helpful websites:

World Health Organisation. *Hepatitis*, Retrieved October 22, 2009, from
http://www.who.int/topics/hepatitis/en/

Introduction

☞ The following introduction to the module is meant for the trainer and gives general background information on the topic.

Injecting drug use is a contributor to the spread of infectious diseases such as HIV/AIDS and hepatitis B and C. The proportion of people suffering from these diseases is significantly higher in prison than in the community. In Germany for example, numbers are 50 times higher for prisoners for Hepatitis C, for HIV numbers for prisoners are 70 times higher than in the general population.

Across Europe, imprisoned drug users are given less treatment and help than in the community. Addressing the problem of infectious diseases in prison is essential as prisoners form part of our society, living in the community prior to imprisonment and returning to it after release. Further, the community and prisons cannot be seen as separate, as prison staff are in daily contact with prisoners, returning home after work. Prison health problems should be taken account of and adequate treatment measures implemented.

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Session 1: HIV infection and AIDS

Total time required: 80 minutes

Lecture: Information about HIV and AIDS

20 minutes

➢ ***PowerPoint: Slides 3-13***

☞ During the lecture, be as interactive as possible by asking questions frequently, e.g. start the lecture by asking participants if they know what HIV and AIDS stand for.

What does HIV stand for?

The abbreviation HIV stands for “Human Immunodeficiency Virus”

- Human means that this is a form of a disease appearing in human beings.
- The term immunodeficiency refers to a decline in the ability of the immune system to protect the body against infections or other diseases.
- A virus is a microscopic organism that causes diseases.

What does AIDS stand for?

The abbreviation AIDS stands for “Acquired Immunodeficiency Syndrome”.

- Acquired means that the deficiency can be contracted at any point in life and is not congenital.
- The term immunodeficiency again refers to the decline in the ability of the immune system to protect the body against infections or other diseases.
- The term syndrome refers to a series of signs and symptoms of the disease.

What is the difference between HIV and AIDS?

An infection with the HI virus leads, after a certain time (that can be up to several years or decades) to the disease AIDS.

General information on HIV

- Injecting drug use is a contributor to the spread of HIV/AIDS.
- Rates for HIV/AIDS are significantly higher for prisoners.
- In Germany for example, numbers for HIV for prisoners are 70 times higher than in the general population.
- HIV can be transmitted via infected blood or sexual contact and from mother to child.
- Unlike infections such as hepatitis B and C, a comparably higher amount of viruses is needed for infection with the disease, i.e. a person must be exposed to a certain amount of viruses in order to get infected.
- The HI virus can only survive outside the human body for a limited period of time.
- There is no natural or acquired resistance against the HI virus: anyone can become infected. New-born children are more sensitive to the virus due to the lack of maturity of their immune system.
- Despite better medication and success in therapy, HIV/AIDS is treatable but not curable and an HIV-vaccine is still at a research level.

Course of the HIV/AIDS infection

- The HI virus enters the human body through a “gateway” and reaches the host’s blood where it can survive for a limited period of time.
- In order to survive, the virus must enter human cells, having a “preference” for the cells of the immune system which normally have the role of defending the body against germs and diseases.
- The virus attaches to the host cell and then passes through its membrane.
- Once inside the cell, the virus breaks open and releases a specific type of molecules (RNA) and an enzyme, which allows it to produce its viral genetic information (DNA).
- The viral DNA is then integrated into the core (nucleus) of the human cell where it starts to produce new viruses that are released from the cell and can infect other cells of the host body.

Primary HIV infection

- Following exposure and infection, patients can show signs of acute viral infection.
- The period between HIV infection and the start of symptoms ranges between 5 and 30 days.
- The symptoms vary from light fever to pharyngitis (inflammation, throat pain), to high fever, skin eruptions, weariness, headache, muscular pain, which appear in any viral infection. Other signs may include enlarged ganglions, drop in weight, diarrhoea, vomit, night sweating and ulcerations (wounds) in the mouth.
- During the first months after infection, the concentration of the virus in the blood (viraemia or viral load) is very high, even in people showing no signs of acute viral infection; the level of viraemia then drops and it settles to a constant level, within a period of approximately 12 months from infection.

"Immunologic window"

- An HIV test does not detect the actual virus but the antibodies the body produces.
- An HIV test during the first three (in rare cases up to six) months after infection is not reliable as the body starts to produce HIV antibodies only a few months after infection.
- As a result, people who are infected with HIV can have a negative test result if the test was conducted short time after infection. This period is also called "immunologic window".
- Critical is that during this first period after infection especially, the concentration of the virus is very high with a high risk of infecting other people.

Asymptomatic HIV infection

- After the primary HIV infection, most HIV infected people enter the asymptomatic stage (without signs of the disease), for a few months or years. The length of this period depends on the age of the infected person, the means of transmission and their previous state of health.
- Some individuals may progress rapidly, while others may remain apparently healthy for a prolonged period of time. Only an extremely small group of HIV-infected individuals have survived for more than 20 years in the absence of anti-retroviral therapy.
- The result of an HIV test performed during this period will be positive, indicating the fact that the person is infected (sero-positive). This is why this period is also called "sero-positive period".

HIV symptomatic infection

- Following the asymptomatic period, the infected person starts to show different unspecific symptoms that repeatedly occur and/ or are persistent.
- The presence of HIV in the body permanently activates the immune system, finally leading to its attrition. This is characterized by an increase in the concentration of the virus and by the first opportunistic infections that take advantage of the weakened immune system.
- During this phase, we talk about a minor immuno-depression, a stage that can last for two to three years in an adult person.
- This phase is characterized by unspecific symptoms such as: asthenia which limits regular activities and night sweating. Some patients present psychological manifestations with depression and anxiety (exacerbated also by finding out the results of HIV tests), chronic diarrhoea (repeatedly and lasting), herpes zoster, repeated fungal infections.
- The aggravation of the immune deficiency finally develops into the disease AIDS.

AIDS

- The disease AIDS is defined through the presence of opportunistic infections.
- Bacteria, fungal infections and viruses, that in a healthy person rarely cause diseases, can easily spread in the body of an HIV infected person due to the weakened immune system.
- At this stage, patients may develop a wide range of opportunistic infections, like tuberculosis, bacterial pneumonia, and also HIV related cancers e.g. lymphomas and cerebral damage.
- The development of the HIV infection to the disease AIDS nowadays can be effectively delayed if therapy with anti-retroviral medications is started at an early stage after infection. This underlines the importance of regular HIV tests.

Activity: HIV transmission

60 minutes

➢ ***PowerPoint: Slides 14-18***

Part I: Exercise

Materials needed:

Cards for each participant - 3 of them marked with a small "X" on their back, one with the letter "P" and one with the letter "O", the rest of the cards blank; pencils

Method:

Provide each of the participants with a card and a pencil, without giving any further details.

Provide the participant that was given the card with the letter "O" with a little note saying "Do not shake hands with anyone". (Discretely) communicate with that participant that s/he should avoid by all means shaking hands with other people.

Ask the participants to take their cards and pencils and to move around the room and shake hands with at least three different people. Every time a participant shakes hands with someone, s/he will ask that person to sign on his/her card and they will sign in turn on theirs, without seeing what is written on the back. After some minutes, ask participants to go back to their seats.

Now ask those participants who had the "X"-marked cards, to stand up. Explain that the three of them symbolize someone that is HIV infected. Ask all those people who have shaken hands with these three (and have their signature on their cards) to stand up as well. Finally, ask all the people sitting on their chairs who have the signatures of those standing up to stand up as well. At the end of the exercise most participants will be most likely standing up.

Tell the participants that the handshake symbolized unprotected sexual contact. Ask who has the "P"-marked card. Explain that that person was not at risk of getting infected with HIV because s/he had used protection, so invite this person to sit down. All those who are standing up may be infected with HIV.

State that there was a person in the group who did NOT shake hands with anyone and tell them that anyone had the right to refuse doing that, even if they were not instructed to do that.
Ask all participants to sit down again. Emphasize that it was only an exercise, that in fact no one is exposed to the risk of being infected with HIV and specify that HIV infection is not transmitted by shaking hands.

Now, ask participants to reflect on the exercise and pose the following questions. Try to direct participants towards the answers given below.

What conclusions can be drawn from this exercise?

- The HIV virus can be easily transmitted.
- One cannot tell whether a person is HIV-infected or not just by the way they look.
- The use of a condom during sexual contact may cut down the risk of HIV infection.
- Sexual contact with only one person poses an equal risk of contracting HIV as it would by having sexual contact with all that person's previous partners ("when you sleep with one person, it is as if you were sleeping with all the partners they had before you").

How could the risk of HIV infection have been prevented?

- Participants could have refused to shake hands with the others (abstinence).
- Participants could ask to see what was written on the card of those they had shaken hands with in order to check if they had a "clean" card (HIV test).
- Participants could have shaken hands with only one person (fidelity).

Part II: HIV transmission

Materials needed:

Flipchart, marker

Method:

Divide a flipchart paper into two parts by drawing a horizontal line on the flipchart. Now, ask the participants through which body fluids they think HIV can be transmitted. Write on the top part of the flipchart right answers given by the participants (blood, sperm, vaginal secretions, breast milk, mother-to-child before and during birth).

If incorrect answers are given (for instance: saliva, tears, urine, stool) explain that the virus cannot be transmitted through those fluids as the concentration of the virus is not high enough.

It is important to know that the virus is present significantly in circulating blood and in the secretions of the genitals (sperm and vaginal secretions).

Go on by explaining that there is a need for a "gateway" through which the virus can enter the body.

Ask participants to name possible gateways for HIV to enter the body and write down the correct answers on the bottom part of the flipchart.

Possible gateways:

- Open wounds – only new wounds and ulcerating wounds pose a risk: wounds that have already closed and minor scratches do not pose a risk of infection.

- Mucous membranes of the penis, vagina, anus, mouth – the mucous membranes of the vagina and the anus are especially sensitive and often show small almost non-remarkable lesions. Possible gateways in the mouth can be inflammations or infections in the mouth. Small lesions, e.g. from brushing teeth do not play a significant role.

Explain to participants that there are factors that enhance the possibility of a transmission:

- High virus concentration (the virus concentration depends on the stage of infection and/or if medical treatment is undergone)
- Rubbing the infectious fluid into wounds or mucous membranes
- The infectious fluid staying for a long time at the gateway
- Having sexual contact during menstruation

Emphasize that sexually transmitted diseases enhance the risk of HIV transmission, especially those infections that cause lesions on the genitals, which open a gateway for HIV.

Part III: True and false statements on HIV transmission

Materials needed:

Flipchart, markers, small box, true and false statements written on little cards, “True and false statements on HIV transmission: Answer key for the facilitator” (Annex 7), “HIV Transmission” (Annex 8)

Method:

Split the participants up into two groups facing each other and arrange the chairs/tables accordingly. Put the cards with the statements in a box in between them.

Explain that each team will draw one card with a true or false statement on HIV transmission alternately. The team whose turn it is, is allowed to discuss the statement for one to two minutes.

Each team that answers a statement correctly will receive 5 points. If a team does not answer correctly, it will get 0 points. If a team draws a statement card and does not want to answer, the other team will get 10 extra points (if it answers correctly). If no team answers correctly, provide them with the correct answer. Keep the scores on a flipchart.

In order to encourage further discussion, ask the teams after each round why they chose the respective answer.

After the activity, distribute the sheet “HIV Transmission” (Annex 8) to the participants.

Session 2: Hepatitis B and C

Total time required: 60 minutes

Lecture: Hepatitis B and C

30 minutes

➢ ***PowerPoint: Slides 20-30***

☞ During the lecture be as interactive as possible by asking questions frequently, e.g. start the lecture by asking participants what they know about the disease hepatitis.

What is hepatitis?

- Hepatitis is a general term meaning inflammation of the liver.
- In most cases, it is a viral infection that attacks the liver.
- Viral hepatitis can be caused by a variety of different viruses such as hepatitis A, B, C, D and E.
- Each type of hepatitis is transmitted and treated differently.
- Hepatitis affects the liver and negatively influences its function with sometimes serious health consequences such as liver cirrhosis and liver cancer.
- A common symptom of liver diseases is when the skin turns yellow and the whites of the eyes become bright yellow-orange (jaundice).

Hepatitis B and C

- Viral hepatitis B and C are highly prevalent among injecting drug users across Europe.
- The prevalence of both diseases is significantly higher for prisoners.
- In Germany for example, rates of Hepatitis C for prisoners are 50 times higher than in the general population.
- Hepatitis B and C are mainly transmitted via blood (e.g. by sharing injection equipment) or by unprotected sexual contact.

Hepatitis can be both acute and chronic:

- Acute means that the disease starts suddenly, showing symptoms and sometimes disappears after this stage.
- Chronic means that the disease (sometimes after an acute stage) lasts over a long period of time and gradually worsens.

Acute and chronic hepatitis display the following characteristics:

- 50 to 90% of hepatitis C infected people develop a chronic hepatitis C infection.
- Chronic hepatitis C can lead to liver cirrhosis and liver cancer.

- Hepatitis B is generally an acute disease.
- Only around 5% of the hepatitis-B infected develop a chronic form of the disease (with comparably serious health consequences to a chronic hepatitis C infection).

The first symptoms of a hepatitis B infection are usually more intense than those of a hepatitis C infection. Unspecific symptoms such as an altered general state, weariness, muscle and joint pain, low fever, nausea, lack of appetite, the whites of the eyes turn yellow (jaundice), light colour stools and/or dark coloured urine may occur.
Many HCV-infected persons do not show any specific symptoms after infection. Most infected persons suffer from unspecific symptoms similar to that of a minor flu-like infection.

Transmission

- Hepatitis B and C are transmitted via contact with blood and other body fluids.
- Hepatitis B and C are highly infectious, i.e. only a small amount of infected blood or other infected body fluids needs to come into contact with cuts or other breaks in the skin or the mucous membrane in order to transmit the disease.
- The risk of transmission via sexual contact is especially high for hepatitis B whereas the risk for hepatitis C in this case is lower.
- Whereas the hepatitis C virus is mainly found in the blood of an infected person, hepatitis B viruses are also found in the saliva, semen, vaginal secretion and breast milk.
- The hepatitis B and C viruses can survive outside the body for several days. During that time, the virus can still cause infection if it enters the body of a person who is not infected.

The most common ways in which hepatitis is transmitted are as follows:

- Unprotected sexual contact
- Sharing of injecting equipment by drug users
- Sharing tattooing/piercing equipment
- Using contaminated and non-sterilized medical instruments
- Sharing objects used for personal hygiene, like razors, nail files, but also toothbrushes that might be infected with blood from small wounds in the mouth

Transmission during pregnancy to the foetus does not occur. Mother-to-baby transmission during birth is uncommon for hepatitis C, but very common for hepatitis B. Vaccinating a new born child of a hepatitis B-positive mother within the first 12 hours after birth can reduce the risk of an infection by 95%.

Activities without risk of transmission of the infection include:

- Use of toilets
- Coughing
- Sneezing
- Hugging
- Sharing eating utensils or drinking glasses
- Shaking hands

- Caresses
- There is a small risk of transmission of hepatitis B by kissing

Diagnosis and testing

- The symptoms of hepatitis are similar to those of other diseases; as a consequence, the presence or absence of symptoms is not an indicator for an infection.
- Only a medical test can diagnose infection with hepatitis.
- At present, a simple blood test is used to detect a hepatitis infection.
- The test identifies hepatitis antibodies (the special cells produced by the body's defence system) in the blood.
- The test will show if the person:
  - is infected at the time,
  - was infected in the past and was cured,
  - is immune to the virus at the time (due to vaccination or prior exposure),
  - suffers from a chronic form of the disease.

Treatment

- Prevention is the most efficient way of not becoming infected with hepatitis.
- There is only symptomatic treatment of nausea, vomiting, and other symptoms for acute hepatitis B infection.
- For the chronic form of hepatitis B and C an interferon therapy may be indicated.
- Alcohol consumption should be avoided because it aggravates hepatitis and increases the risk of liver cirrhosis.

Vaccination

- A vaccination is an injection that helps a person's immune system fight a certain infection or disease.
- There only exist vaccinations for certain diseases.
- The vaccine increases resistance of the person to a certain disease for a number of years or for life.

At present there is no vaccination to ensure protection against hepatitis C. However, there is a vaccination against hepatitis B which

- prevents the transmission of the virus of hepatitis B,
- protects against an infection with hepatitis B,
- offers immunity for at least 12 years.

☞ Emphasize that even for people who are vaccinated it is important to use protective measures, as hepatitis B is just one of the parenterally and sexually transmitted infections.

Activity: Hepatitis infection

30 minutes

➢ ***PowerPoint: Slide 31***

Materials needed:

Flipchart, flipchart paper, markers, paper, pencils

Method:

Provide each participant with paper and pencils. Ask participants to write down one or more situations where they were at risk of getting infected with hepatitis B and/or C inside as well as outside prison.

Ask participants to read out what they have written down. Take notes on the flipchart and discuss with the group on the different situations that are listed, Ask participants to range the different situations from high risk to low risk.

Conclusion (questions and comments)

Total time required: 10 minutes

- Injecting drug use is a major contributor to the spread of infectious diseases such as HIV/AIDS and hepatitis B and C.
- The proportion of people suffering from these diseases is significantly higher in prison than in the community.
- Addressing the problem of infectious diseases in prison is essential as prisoners form part of our society, living in the community prior to imprisonment and returning to it after release

Evaluation

Total time required: 10 minutes

3.3 MENTAL HEALTH AND DRUG USE

Target audience:

10-12 prison staff

Total time required:

110 minutes

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart
- Markers in various colours
- Handout: “Definitions of mental health” (Annex 9)
- PowerPoint presentation of the session

Objectives:

- To provide participants with detailed information on the relation between mental health and substance use.

Learning outcomes:

This session will increase participant’s knowledge about

- different mental health disorders,
- how mental health problems and substance use interact,

the epidemiology of co-morbidity.

By the end of the session, participants will be aware of the close link between mental health and substance use disorders. Participants will be aware of the importance of adequate treatment of substance use disorders as well as (co-occurring) mental health disorders in order to prevent further harm.

Activities:

Icebreaker (20 minutes)

Mental health and drug dependence (70 minutes)

- Activity: What is mental health? What does it mean? - 20 minutes
- Lecture: Mental health, mental diseases and drug use - 50 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders – DSM-IV-TR* (4th edition, Text Revision). Washington, DC: American Psychiatric Association.

EMCDDA (2009). *Addiction neurobiology: Ethical and social implications*. Lisbon: EMSDDA Monographs. Retrieved September 18, 2009, from http://www.emcdda.europa.eu/publications/monographs/neurobiology

Fazel, S. & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. *Lancet 360*, 572-573.

Foster, T. (2001). Dying for a drink. *British Medical Journal 323*, 817-818. Retrieved September, 11, 2009, from http://www.bmj.com/cgi/content/short/323/7317/817

Preuss, et al. (2003). Predictors ad Correlates of Suicide attempts over 5 Years in 1,237 Alcohol-Dependent Men and Women. *American Journal of Psychiatry 160,* 56-63.

Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, B.J., Judd, L.L., & Godwin, F.K. (1990). Comorbidity of mental health disorders with alcohol and other drug abuse. *Journal of the American Medical Association 264*, 2511-2518.

UNODC (2009). *Drug Dependence Treatment*. *Training Package.* Retrieved September 18, 2009, from http://www.uclaisap.org/internationalprojects/html/unodc/training-package-materials.html

Warner, L.A., Kessler, R.C., Hughes, M., Anthony, J.C. & Nelson, B. (1995). Prevalence and ocrrelates of drug use and dependence in the United States: Results from the National Comorbidity Survey. *Archives in General Psychiatry 52*, 219-229.

WHO, UNODC & UNAIDS (2004). *Substitution maintenance therapy in the management of opioid dependence and HIV/ AIDS prevention.* Geneva. Retrieved September 11, 2009, from http://www.unodc.org/docs/treatment/Brochure_E.pdf

WHO (2007). *Health in prisons. A WHO guide to the essentials in prison health. WHO Regional Office for Europe.* Retrieved July, 12, 2010, from http://www.who.int/hiv/topics/idu/prisons/e90174.pdf

WHO (2007). *ICD-10. Version 2007. International statistical classification of diseases and related health problems. 10th revision.* Retrieved October 29, 2009, from http://apps.who.int/classifications/apps/icd/icd10online/

Introduction

☞ The following introduction to the module is meant for the trainer, giving a short overview on general background information on the topic.

Substance use and mental health problems are disproportionally found in the prison population. Many mental health problems or substance use problems are not adequately diagnosed, if at all. It is estimated that 65% of prisoners have at least one or several mental health disorders (Fazel & Danesh, 2002). WHO, UNAIDS and UNODC (2004) state that around three-quarters of prisoners have alcohol or drug related problems and around one third may be opioid dependent.

In the following session, participants will learn about the close correlation between mental health disorders and substance use disorders.

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Mental health and drug dependence

70 minutes

Activity: What is mental health? What does it mean?

20 minutes

➢ ***PowerPoint: Slide 3***

Materials needed:

Flipchart, flipchart paper, markers, handout: “Definitions of mental health” (Annex 9)

Method:

Split participants up into small groups. Provide each group with a sheet of flipchart paper. Ask participants what they think mental health is, what does it mean exactly? Let the small groups discuss these questions for 10 minutes and ask them to write down their main responses on the flipchart paper. Tape each group’s flipchart paper on the wall and ask the group to present their results.

Explain to participants that

- There is no health without mental health
- Mental health is more than the absence of mental disorders
- Mental health is determined by socio-economic and environmental factors

After the activity, distribute the handouts with the definitions of mental health to the participants.

Lecture: Mental health, mental diseases and drug use

50 minutes

➢ ***PowerPoint: Slides 4-20***

☞ Throughout the session, stress that current research considers substance use disorders to be a chronic relapsing disease.
Throughout the lecture always refer to the answers given by the participants and be as interactive as possible by asking questions frequently and involving the participants.

What are mental health problems?

Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions. Mental health problems are usually defined and classified to enable professionals to refer people for appropriate care and treatment. Mental health problems result from a complex interaction of biological, social and psychological factors, but are still usually discussed in medical terms.

Most mental health symptoms have traditionally been divided into groups called either "**neurotic**" or "**psychotic**" symptoms. "Neurotic" covers those symptoms which can be regarded as severe forms of "normal" emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as "neuroses" are now more frequently called "common mental health problems".

Less common are "psychotic" symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no-one else can. Some mental health problems feature both neurotic and psychotic symptoms.

As well as distinguishing between neurotic and psychotic symptoms, psychiatrists sub-divide different kinds of mental health disorders according to:

- **Organic** (identifiable brain malfunction) versus **functional** (not due to simple structural abnormalities of the brain).

What is mental illness?

When someone experiences severe and/or enduring mental health problems, they are sometimes described as "mentally ill". This term is difficult since:

- There is no universally agreed cut-off point between normal behaviour and behaviour associated with mental illness. What is considered abnormal behaviour differs between cultures, social groups within the same culture, and even different social situations.
- The term "mental illness" can misleadingly imply that all mental health problems are solely caused by medical or biological factors. In fact, most mental health problems result from a complex interaction of biological and social/psychological factors.

The World Health Organization developed the ICD-10 (International Classification of Mental and Behavioural Disorders), which lists major groups of disorders as follows:

- F00-F09 Organic, including symptomatic, mental disorders (different kinds of dementia)
- F10-F19 Mental and behavioural disorders due to psychoactive substance use (alcohol, tobacco, all kinds of drugs)
- F20-F29 Schizophrenia, schizotypal and delusional disorders (psychotic disorders)
- F30-F39 Mood (affective) disorders (manic, depressive or manic-depressive disorders)
- F40-F48 Neurotic, stress-related and somatoform disorders (like anxiety disorders, obsessional thoughts or compulsive acts, reactions to severe stress, psychosomatic disorders)
- F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors (like eating disorders, nonorganic sleep disorders, sexual dysfunction)
- F60-F69 Disorders of adult personality and behaviour
- F70-F79 Mental retardation
- F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (like disturbance of activity and attention, conduct disorders, tic disorders)

Interactions between mental health and drug use

As people with substance use disorders often suffer from other mental health disorders at the same time, careful diagnosis and adequate treatment of both disorders is crucial. There are several interactions possible between mental health problems and drug use. Sometimes the mental problem occurs first. This can lead people to use alcohol or drugs that make them feel better temporarily. Sometimes the substance use occurs first. Over time, that can lead to emotional and mental problems.

Drug use can be a kind of “self-medication” used by a person with mental health problems, which have not been diagnosed and/or treated properly. Mental health disorders are often inadequately diagnosed and thus not treated appropriately.

Mental health problems/disorders can be:

- a direct result of the substance use of a person, in which no psychiatric disorder was pre-existing (so-called drug induced mental health disorders, e.g. psychotic disorders can be the result of psychoactive substance use).
- pre-existing to harmful substance use,
- a result of substance use by a person in which the symptoms of mental disorders have pre-existed.

Drugs causing psychic and/ or physical dependence

☞ Ask participants what kind of drugs they think can cause psychic and/ or physical dependence. Write down the answers on a flipchart.
Explain to participants that all drugs listed below can lead to substance use disorders.

- Alcohol
- Opiates
- Cannabis
- Cocaine
- Amphetamines
- Sedatives (e.g. Benzodiazepines)
- Hallucinogens (e.g. LSD)
- Volatile substances (thinners, adhesives)
- Prescription medicine

Dual diagnosis and co-morbidity

The term “dual diagnosis” or co-morbidity refers to co-occuring of mental health disorders and substance use disorders (alcohol and/or drug dependence or abuse). Dual diagnosis means that someone has both a mental disorder and an alcohol or drug problem. To get better, someone with a dual diagnosis must treat both conditions. First, the person must go for a period of time without using alcohol or drugs. This is called detoxification. The next step is rehabilitation for the substance problem and treatment for the mental disorder. This step might include medicines, support groups and talk therapy. In particular, alcohol and drug problems tend to occur with

- Personality disorders
- Depression
- Anxiety disorders
- Schizophrenia

Personality disorders are long-term patterns of thoughts and behaviours that cause serious problems with relationships and work. People with personality disorders have difficulty dealing with everyday stresses and problems. They often have stormy relationships with other people. The cause of personality disorders is unknown. However, genes and childhood experiences may play a role. Symptoms vary widely depending on the specific type of personality disorder (compare to: Medline plus http://www.nlm.nih.gov/medlineplus/personalitydisorders.html).

According to the Diagnostic and Statistical Manual (DSM-IV-TR), there are ten different personality disorders categorized into three main groups:

- Odd or eccentric behaviours
- Dramatic, emotional, or erratic behaviour
- Anxious, fearful behaviour

Depression is a serious medical illness that involves the brain. It is more than just a feeling of being "down in the dumps" or "blue" for a few days. If you are one of the millions of people who have depression, the feelings do not go away. They persist and interfere with your everyday life. Symptoms can include

- Sadness
- Loss of interest or pleasure in activities you used to enjoy
- Change in weight
- Difficulty sleeping or oversleeping
- Energy loss
- Feelings of worthlessness
- Thoughts of death or suicide

Depression can run in families, and usually starts between the ages of 15 and 30. It is much more common in women (compare to: Medline plus http://www.nlm.nih.gov/medlineplus/depression.html).

Anxiety disorders: Fear and anxiety are part of life. You may feel anxious before you take a test or walk down a dark street. This kind of anxiety is useful - it can make you more alert or careful. It usually ends soon after you are out of the situation that caused it. But for millions of people, the anxiety does not go away, and gets worse over time. They may have chest pains or nightmares. They may even be afraid to leave home. These people have anxiety disorders. Types include

- Panic disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Phobias
- Generalized anxiety disorder

(compare to : Medline plus http://www.nlm.nih.gov/medlineplus/anxiety.html)

Schizophrenia is a severe, lifelong brain disorder. People who have it may hear voices, see things that aren't there or believe that others are reading or controlling their minds. In men, symptoms usually start in the late teens and early 20s. They include hallucinations, or seeing things, and delusions such as hearing voices. For women, they start in the mid-20s to early 30s. Other symptoms include

- Unusual thoughts or perceptions
- Disorders of movement
- Difficulty speaking and expressing emotion
- Problems with attention, memory and organization

No one is sure what causes schizophrenia, but the genetic makeup and brain chemistry probably play a role. Medicines can relieve many of the symptoms, but it can take several tries before you find the right drug. With treatment, many people improve enough to lead satisfying lives (compare to: Medline plus http://www.nlm.nih.gov/medlineplus/schizophrenia.html).

Studies show that:

- Approximately half of the persons with a lifetime mental disorder also have a history of harmful alcohol or drug use or dependence (Warner et al., 1995)

- Over 50% of those with a substance use disorder (except for alcohol) are found to have a co-occurring mental health disorder, of these have
  - 26% an affective disorder like depression or manic depression (4,7 times higher),
  - 28% an anxiety disorder (2,5 times higher),
  - 17,8% an antisocial personality disorder (13,4 time higher),
  - and 6,8% schizophrenia (6,2 times higher).

(Regier et al., 1990)

Co-morbidity is associated with higher rates of:

- Relapse
- Hospitalization
- Violence
- Incarceration
- Homelessness
- Infectious diseases (HIV/AIDS, Hepatitis B and C)

Suicides and substance use

A high proportion of people with a substance use disorder has been or is suicidal.

- The likelihood of suicide attempts among people with an alcohol use disorders is six to 10 times higher than among persons without such dependence (Preuss et al., 2003).
- 40 to 60% of the suicides in Europe and the USA are alcohol/ drug affected (Foster, 2001).

Likelihood of suicide attempts

- Cocaine use: 62 times more likely
- Major depression: 41 times more likely
- Separation or divorce: 11 times more likely
- Alcohol use: 8 times more likely

(UNODC, 2009)

It is crucial to provide adequate treatment for drug dependent prisoners, taking into account co-occurring mental health disorders.

Suicidal risk can be managed in substance use disorder treatment. The risk of suicide declines in treatment above all by reducing withdrawal symptoms.

Conclusion (questions and comments)

Total time required: 10 minutes

- Drug dependence is disproportionally high in persons that are suffering from mental health disorders.
- Drug dependence itself can be seen as a mental health disorder.
- As people with substance use disorders often suffer from other mental health disorders at the same time, adequate treatment of both disorders is crucial.
- Suicidal risk can be managed in substance use disorder treatment taking into account co-occurring mental health disorders.

Evaluation

Total time required: 10 minutes

3.4 YOUNG PEOPLE AND DRUG USE

Target audience:

10-12 prison staff

Total time required:

120 minutes

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart, flipchart paper, tape
- Markers in various colours
- Paper, pencils
- “Blank forms: risk and protective factors regarding drug use” (Annex 10)
- “Possible risk and protective factors regarding drug use” (Annex 11)
- PowerPoint presentation of the session

Objectives:

- To provide the participants with basic knowledge on the effective actions for reducing the vulnerability of young people to psychoactive substance use and related harm.

Learning outcomes:

This session will increase participant’s knowledge about

- the reasons why young people may use drugs,
- the patterns and indicators for drug use among young people,
- the factors that can increase the risk of substance use among young people,
- factors that can protect young people from substance use.

Activities:

Icebreaker (20 minutes)

Young people and drug use (80 minutes)

- Activity: Creating a profile of a young person – 20 minutes
- Lecture: Young people and drug use – 30 minutes
- Activity: Protective and risk factors for drug use in young people – 30 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

United Nations Economic and Social Commission for Asia and the Pacific (2003*). Life Skills Training Guide for Young People: HIV/AIDS and Substance Use Prevention*. Retrieved October 15, 2009, from http://www.unodc.org/pdf/youthnet/action/message/escap_peers_00.pdf

WHO (2000). *Primary prevention of substance abuse. A Workbook for project operators.* Retrieved September 9, 2009, from http://www.who.int/substance_abuse/activities/global_initiative/en/primary_prevention_17.pdf

Introduction

☞ The following introduction to the module is meant for the trainer, giving a short overview on general background information on the topic.

Young people are, in general, considered to be vulnerable to drug use because they are in a period of life when patterns of behaviour are being formed and when they are most likely to be influenced by peers and role models who may be involved in drug use. While young people are under the influence of drugs, they may be more vulnerable to violence and exploitation. They may also be more likely to engage in sexual activities that put them at risk to sexually transmissible infections, including HIV.

This is an important period in a young person's life and equipping them with information relating to drug use can encourage them to make informed choices about their long-term health. Providing relevant information to young people, and others who are significant in their lives, can have positive benefits for both the individual and the wider community.

In most cultures, there is a history of drug use of some form, which has continued over generations. However, drug use has increased in recent years, particularly among specific groups including women and young people and these groups can be more susceptible to the adverse consequences of such behaviour.

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Young people and drug use

Total time required: 80 minutes

Activity: Creating a profile of a young person

20 minutes

➢ ***PowerPoint: Slide 3***

Materials needed:

Flipchart, flipchart paper, tape, paper, pencils, markers

Method:

Draw a large figure of a person on the flipchart preferably gender neutral.

Distribute paper and pencils to each participant and ask them to also draw a figure of a person on their paper. Ask participants to imagine an average young person in a period of transition from childhood to adulthood. Ask participants to think about several questions.

- What does this young person think? *(Write this question near the head of the figure)*
- How does this young person feel? *(Write this question near the heart of the figure)*
- What are the needs of this young person? *(Write this question near the stomach of the figure)*
- What does this young person do? *(Write this question between the hands or legs of the figure)*

Ask participants to write down one sentence answering each question. Allow them a few minutes to do so.

Now, ask participants for their answers and write down keywords at the above specified parts of the figure. Tape additional flipchart paper around the figure to create further space for answers if necessary.

You can finish the exercise by summarizing the profile you have created together with the participants or, you can ask somebody from the group to do so.

Lecture: Young people and drug use

30 minutes

➢ ***PowerPoint: Slides 4-12***

☞ Throughout the lecture always refer to the answers given by the participants and be as interactive as possible by asking questions frequently and involving the participants.

Current research considers drug dependence to be a chronic relapsing disease. The younger a person is when starting substance use, the more likely they are to experience negative health outcomes. Young people have particular characteristics that make them especially vulnerable to substance use. Physical and psychological development occurs during adolescence. The physical and social transitions that occur have a major influence on how behaviour patterns develop. Most of the risk-related characteristics have to do with identity seeking. As young people mature, they enter into new social roles. There is pressure to establish their new social identity, to seek new role models and not to miss out on opportunities. Shaping of the personality occurs, and young people are driven to seek a new self/ body image, as they strive to attain socially defined roles. Their identification with certain role models, in particular, may directly or indirectly lead to problems relating to substance use. They are highly prone to peer pressure and often disregard parental guidance. Their larger social and environmental context is also an important factor. Studies have shown that involvement with psychoactive substances during the period of adolescence is associated with other risk behaviours such as unprotected sexual contacts.

Other risk related characteristics include:

- **Experimentation**

  Young people go through a period of development that involves experimentation, exploration, curiosity and identity search. Part of such a quest usually involves risk taking, which can include experimenting with drugs. Young people are curious about drugs and want to experience new feelings and sensations. Nevertheless, it is important to note that, following some experimentation, most young people stop using drugs.

- **Independence and rebelliousness**

  Young people want to establish independence and separation from family, gain a sense of self-determination, choose an occupation and develop their own personal values. In the attempt to achieve all of these, they can become rebellious and experience low self-esteem. Turning to substance use may be a way of coping with these challenges.

- **Acceptance**

  Young people are constantly striving to be accepted by others. Use of substances may be a way of showing that they are mature (becoming a man or woman). For example, in some cultures, drinking and smoking is a way of showing that one is grown up. Young people may also use substances to show that they are not afraid to be a member of a group.

- **Boredom**

  Young people get bored easily, especially when they have nothing to do. Being out of school and bored can be a risk factor. On the other hand, for those in school, feelings of inadequacy or anticipation of failing in school might lead to use of substances as a way of coping.

Effects of a drug

There are many reasons why young people may use drugs. The effects drugs have on individuals depend on at least three things: the individual, the substance, and the environment (the "context of use").

- **The individual(s)**

  The knowledge and attitude the individual may have about substances and their effects, as well as curiosity can influence drug use. The individual's coping skills with respect to specific problems and peer pressure may also influence their decision to use substances.

- **The substance(s)**

  The existence of a substance is a separate risk factor. The composition and nature of the substance can influence its use. The percentage of ethanol in alcoholic drinks and their cost, for example, can influence the decision as to whether or not to use the substance.

- **The environment (context)**

  Within the environment, a variety of factors may influence substance use. These include: existing cultural norms, general and peer-group attitudes about substance use, behaviours of parents, peers and role models, rebelliousness, marketing strategies used for the promotion of the substances, laws, policies and regulations that limit the availability and accessibility of substances, possibilities (and perceived possibilities) for livelihood and personal development.

While young people are under the influence of drugs, they may be more vulnerable to violence and exploitation. They may also be more likely to engage in sexual activities that put them at risk for sexually transmissible infections, including HIV and hepatitis.

Patterns of drug use among young people

- **Experimental use**

  Young people are often curious about drugs and want to experience new feelings and sensations. Nevertheless, following some experimentation, most young people stop using drugs.

- **Functional use**

  For the majority of young people, drug use is not mindless or pathological, but functional. Drugs have a specific purpose in their lives, such as recreation, providing relief from anxiety or boredom, to keep awake or to get to sleep, to relieve hunger and pain, to feel good and to dream. Such use is often controlled and limited to specific circumstances and situations. Young people may vary the type of drug they use, depending on the situation, to achieve the

desired effect. If their drug use is not causing serious problems, there is little motivation for functional users to stop using drugs.

- **Dysfunctional use**

  Dysfunctional use is drug use that leads to impaired psychological or social functioning. Typically, such use affects personal relationships. As a result of their drug use, some young people become argumentative or even physically violent with family members or others. It may interfere with the young person's education or work. The routine tasks of the young person might be impaired. This behaviour may cause further alienation, including rejection by other members of the peer group or family. Because of these increasing difficulties, there may be a first motivation to think about quitting drugs. However, the benefits the dysfunctional user perceives in using drugs might make it difficult to stop their use.

- **Harmful use**

  In harmful use, drugs cause damage to the physical or mental health of a person. Physical harms can include injuries from overdose, accidents and violence. Other harms can result from the way in which the drug is used. Injecting drugs is particularly dangerous because of the risk of contracting hepatitis, HIV and other infectious diseases from contaminated needles and syringes. Furthermore, injecting drug use can lead to collapsed veins and is often associated with overdose. Smoking drugs can result in disorders of the respiratory system and burns. Although health damage is more likely to occur in individuals who use drugs regularly and in high amounts, it can also occur in experimental and occasional use, usually as a result of intoxication. Alcohol-related liver disease or smoking-related lung cancer, which tend to occur late in life are less likely to be found in young people.

- **Dependent use**

  Users who are dependent on drugs often have poor control over their intake. They continue to use drugs despite very serious consequences. In addition, they may spend more and more of their day on activities related to drugs: earning money for drugs (this can mean trading sex for drugs), purchasing drugs, using drugs, recovering from drug intake, and planning to get more drugs.

  Dependent users develop a tolerance for certain drugs, i.e. their bodies adjust to the drugs so that they have to increase the amount of a particular drug to produce the same desired effect. Dependent users also experience withdrawal symptoms, if they go too long without the drugs.

☞ Point out that patterns of drug use vary greatly among young people, and may change over time. Some develop a regular pattern of use while others may be quite haphazard and opportunistic. Just because a young person starts to use one drug does not mean that he or she will automatically progress to using other drugs or to more intensive use.

Indicators for drug use

- Personality changes

  Changes in personality and character can be an indicator that a person is using drugs. For example, a placid and soft-spoken person might suddenly become noisy and abusive or an outgoing and talkative person might become silent and withdrawn. These changes may be gradual and hard to detect.

- Extreme mood swings

  In drug users, mood may suddenly swing from depression to elation and vice versa, seemingly, without reason. Extreme behaviour may also be precipitated by the most innocuous events or statements.

- Possible change in physical appearance or wellbeing

  Changes in the physical appearance or in the general wellbeing of a person may occur due to drug use either suddenly or gradually. Changes in weight, changes in sleep patterns, slurred speech, staggering gait, sluggish reactions, pinpoint or dilated pupils, sweating, talkativeness, euphoria, nausea and vomiting are possible physical symptoms caused by drug use.

- Change in school/ job performance

  A significant deterioration in a student's performance (especially when they used to be diligent) may be an indicator of drug use. Equally, a rapid change from poor performance to a significantly enhanced performance at school or in the work place may also be an indicator of drug use.

- Changes in general "lifestyle"

  Changes in the general lifestyle of a young person as regards the peer group, a change in the daily habits, a change in clothing etc. can be an indicator for drug use.

- Seeking money, or increase in money supply if dealing

  Buying drugs is expensive and, with the progression of dependence, the amount of money required to support the habit increases. However, young people do not only use money to purchase drugs. For example, baseball caps, sport shoes and sexual activities are commonly traded for alcohol and other drugs.

☞ Explain to the participants that the above are just indicators of drug use. Some of these might just be typical adolescent behaviour. Drug use should not be presumed unless confirmed otherwise. The symptoms are indicative of drug use and may not always be related to drug dependence.

Activity: Protective and risk factors for drug use in young people

30 minutes

➢ ***PowerPoint: Slide 13***

Materials needed:

"Blank forms: risk and protective factors regarding drug use" (Annex 10), "Possible risk and protective factors regarding drug use" (Annex 11), paper, pencils

Method:

Factors that increase the individual risk for substance use are known as *risk factors* and those that decrease the risk are called *protective factors*. Risk factors have a tendency to push an individual toward using substances while protective factors do the opposite.

Ask participants to split up into small groups and elect a representative. When the groups have formed, distribute the empty risk and protective factor tables. Ask the groups to discuss possible risks and possible protective factors for substance use and to write them into the tables. If necessary provide an example. After 15 minutes, ask the representative from each group to present the results. Write these down on a flipchart.

Point out that identifying risk and protective factors for substance use is an important step in determining how one can respond to the problem. Although various studies have identified specific individual and environmental factors that usually have a risk and protective influence, these are not exhaustive or absolute. What may be a risk for one young person may not be a risk for another.

Conclusion (questions and comments)

Total time required: 10 minutes.

- Young people are in a stage of life that involves making choices about various lifestyle alternatives which involves the consolidation of health impacting behaviour.
- There are several indicators of drug use in a young person. However, some of these might just be typical adolescent behaviour. Drug use should not be presumed unless confirmed otherwise.
- Different aspects of the individual and the broader environment can either make people more vulnerable to substance use or protect them.

Evaluation

Total time required: 10 minutes

3.5 WOMEN PRISONERS

Target audience:

10-12 prison staff

Total time required:

170 minutes

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart, flipchart paper, tape
- Markers in various colours
- Paper and pencils
- “Statements on condom negotiation” (Annex 12)
- Case study 1 (Annex 13)
- Case Study 2 (Annex 14)
- PowerPoint presentation of the session

Objectives:

- To increase the understanding about issues for women prisoners with problem drug use.
- To increase the knowledge and understanding of the specific needs of women prisoners and those with problem drug use.

Learning outcomes:

This session will provide participants with a clear understanding of the particular needs of women prisoners and those with problem drug use in prison.

Activities:

Icebreaker (20 minutes)

Session 1: Women in prison (30 minutes)

- Lecture: Some facts on women prisoners – 10 minutes
- Activity: Brainstorming: Why does the number of women receiving custodial sentences increase? – 20 minutes

Session 2: Problem drug use and special issues faced by women in prison (100 minutes)

- Activity: Special issues and problems faced by women in prison – 60 minutes
- Activity: Case Studies – 20 minutes
- Activity: Negotiation skills for condom use – 20 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

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Browne, A., Miller, B. & E. Maguin (1999). Prevalence and severity of lifetime physical and sexual victimisation among incarcerated women. *International Journal of Law and Psychiatry 22*, 301-322.

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McClelland, G.T. & Newell, R. (2008). A qualitative study of the experiences of mothers involved in street-based prostitution and problematic substance use. *Journal of Research in Nursing* 13(5), 437-447.

Open Society Institute (2007). *Women, Harm Reduction and HIV*. New York: International Harm Reduction Development Program. Retrieved October 8, 2009, from http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/women_20070920/women_20070920.pdf

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http://www.unodc.org/docs/treatment/Case_Studies_E.pdf

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http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf

Wechsberg, W.M. et al. (2009). Substance abuse, treatment needs and access among female sex workers and non-sex workers in Pretoria, South Africa. *Substance Abuse Treatment and Prevention Policy*, 274, 11.

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http://www.who.int/hiv/idu/OMS_E4Acomprehensive_WEB.pdf

WHO (2007). *Health in prisons*. *A WHO guide to the essentials in prison health.* Copenhagen: WHO Retrieved September 8, 2009, from
http://www.euro.who.int/document/e90174.pdf

WHO (2009). *Women's health in* prison. *Correcting gender inequity in prison health.* Copenhagen: WHO. Retrieved, October 12, 2009, from
http://www.euro.who.int/Document/HIPP/UNODC_Decl_pres_Apr_2009.pdf

Zurhold, H., Stöver, H.,Haasen,C. (2004). *Female drug users in European prisons – best practice for relapse prevention and reintegration.* Final Report and Recommendations. Oldenburg: BIS-Verlag.

Introduction

☞ The following introduction to the module is meant for the trainer and provides a short overview on general background information on the topic.

Although women make up a small percentage of prison populations, the number of women in prison is increasing at a faster rate than that of men. Most women serve short sentences and are mostly imprisoned for non-violent offences such as property or drug related offences (WHO, 2009).

Prison authorities around the world pay very little attention to women prisoners' needs. To protect them from physical and emotional abuse, there is a need to overhaul the criminal justice system and train the staff in gender-sensitivity, says a World Health Organisation editorial. Therefore, it is important that you and the trainees are aware of the rights and needs of women prisoners and do not ignore them.

The module will explore issues that are specific to women, such as their role in the family, motherhood and the fact that many women are imprisoned far from home and their communities. There will be a focus on the growing use of drugs amongst women prisoners and how to address this issue in a sensitive way. The module also encourages participants to share their own experiences of working with women prisoners in their own contexts and to discuss ways in which more effective approaches may be taken.

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Session 1: Women in prison

Total time required: 30 minutes

Lecture: Some facts about women prisoners

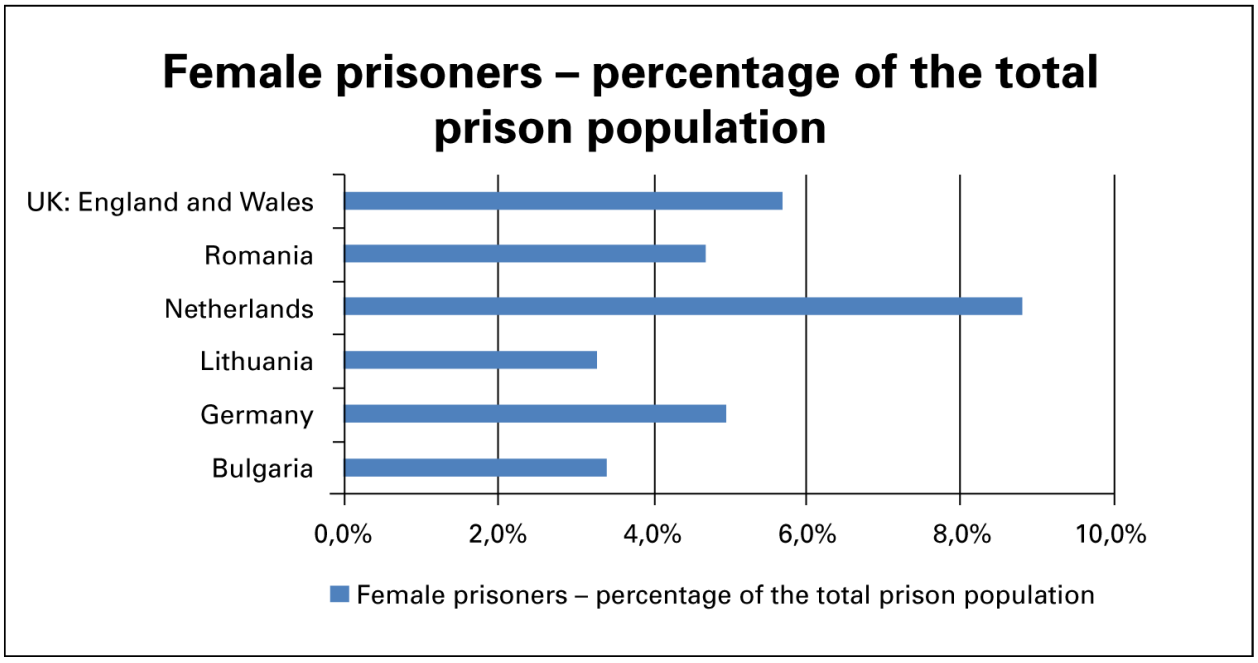
10 minutes

➢ ***PowerPoint: Slides 3-6***

☞ During the lecture be as interactive as possible by asking questions frequently and actively involving the participants.

Women make up a small minority of the population in prison systems throughout the world (see table 1 for the percentage of female prisoners in selected European countries). Within the last years, the number of women in prison is increasing at a much greater rate than the number of men in prison. Most women serve short sentences and are mostly imprisoned for non-violent offences such as property or drug related offences (WHO, 2009).

Table 1: Percentage of female prisoners in selected European countries



(Source: World Female Imprisonment List
http://www.unodc.org/pdf/india/womens_corner/women_prison_list_2006.pdf)

There are specific issues that women experience when they are imprisoned. In most societies, women have the major responsibility for childcare and related issues which has particular consequences for other members of her family. Women prisoners are a particularly vulnerable group and are often subject to stigma and gender discrimination both in prison and also in the community. Therefore, it is important to be are aware of the rights and needs of women and not to ignore them.

Problem drug use

There are many challenges facing women who use drugs. In many countries of the world, drug services and treatment in the community and in prison are not tailored to meet their needs (Open Society, 2007).

It is difficult to get exact data about the number of women with problem drug use. It is estimated that at least 75% of women in prison have had some sort of drug- or alcohol-related problem at the time of arrest.

In addition, drug use amongst women is increasing and there is a rapid increase amongst women injecting drug users (IDUs) sharing injecting equipment. This increase in problem drug use amongst women means that some of these women will end up in the prison populations. Once there, they will need access to services to reduce drug related harm, including the spread of infectious diseases through contaminated injection equipment and high risk sexual behaviour associated with drug use (WHO, 2009).

Activity: Brainstorming: Why does the number of women receiving custodial sentences increase?

20 minutes

➢ ***PowerPoint: Slide 7***

Materials needed:

Flipchart, paper, pencils, markers

Method:

Ask participants to split up into small groups and appoint a representative. When groups have been formed, distribute paper and pencils. Ask the groups to discuss why they think that an increasing number of women are receiving custodial sentences and if this is happening in their own prison systems. Ask the group to write down possible explanations. If necessary, provide an example; some are listed below. After 10 minutes, request the representative to present the groups' results. Write these down on a flipchart.

Possible reasons:

- Courts are being more punitive
- Less tolerance towards women who commit crime
- Lack of alternatives to prison
- High numbers of problem drug using women with offences related to drug use

Session 2: Problem drug use and special issues women face in prison

Total time required: 100 minutes

Activity: Special issues and problems women face in prison

60 minutes

➢ ***PowerPoint: Slides 9-22***

Materials needed:

Flipchart, flipchart paper, markers, paper, pencils

Method:

Ask participants to split up into small groups. When groups have been formed, distribute paper and pencils. Ask the groups to write down as many of the special issues and problems that they think women may face in prison. Ask them to also think about the specific problems women with problem drug use may face during custody.
Allow 10 minutes for this and then ask each group to present their results. Write down the answers on flipchart paper that is taped on the wall around the room. Allow enough time to discuss each group's list and provide examples and further detailed information as outlined below.

Special issues and problems women face in prison

☞ The following is a list of the key issues that impact on women prisoners that you need to make sure are raised by the trainees. You can either use the slides or take the following examples as background information during the discussions. There are some questions in the list below to stimulate discussion. It will not be possible to use all of them so choose the ones that match the interests of the group.

Women's role in the family

In the community, women usually play a key role in the family where they have responsibility for children and other family members. Imprisonment impacts on women emotionally both on her and on her family.

Accommodation far from home

Prisons, on the whole, are designed for male prisoners and locating women prisoners can be problematic as the number of prisoners coming from the same area or city is often too small to warrant a dedicated prison building. As a result, women are frequently housed in annexes of male prisons. Alternatively, they are sent to special women's prisons and, as a result, might be located significant distances away from their homes and families. This makes it difficult and expensive for family and children to visit her on a regular basis.

☞ Ask participants what they think can be done to overcome this problem in their prison? (e.g. can arrangements be made to compensate for this, by allowing prisoners' families and children to visit for a whole day or a whole weekend?).

Pregnancy and being a mother

Women prisoners are often mothers. Research in the United Kingdom indicates that 55% of women prisoners have at least one child below 16 years of age and 34% are single parents.[1] It is possible in some countries for women prisoners to keep their young children in prison with them, usually in special mother and baby sections. There is debate as to whether this is a good policy or not. Some professionals argue that when young children are separated from their mothers, their development and mental health may be damaged; on the other hand some professionals argue that raising children in a prison environment is potentially harmful and therefore not ideal.

☞ Ask participants to say what, in their own prison systems, the maximum age is at which children are allowed to stay in prison with their mothers. Do they think this age should be raised or lowered?

Women prisoners who are pregnant should have access to the same standard of care that is available in the community. Where possible, babies should be born in a hospital in the community. How long a prisoner can keep her baby in prison varies in different countries from nine months to three years. Ideally a pregnant or nursing mother should have the possibility of an alternative to custody sanction.

Mother-to-child transmission of HIV

Women drug users who are also pregnant are particularly vulnerable both in the community and in the prison environment. Often they receive little or no accurate information about drug use during pregnancy or prevention of mother-to-child transmission of HIV. The virus that causes AIDS can be transmitted from an infected mother to her newborn child but in reality, advances in HIV treatment have reduced the rate of mother-to-child transmission of HIV significantly. Studies indicate that if the mother takes appropriate medical precautions, including taking HIV drugs, the rate of transmission can be reduced from about 25% to below 2% (The Well Project, 2009).

[1] Submission by Friends World Committee for Consultation (Quakers) to the Committee on the Rights of theChild, Day of Discussion 2005, Children Deprived of Parental Care, Quaker United Nations Office, 2005, p. 2

Infection can occur any time during pregnancy but usually occurs at birth. During delivery, the newborn baby is exposed to the mother's blood and therefore, the baby is more likely to be infected when the delivery takes a long time (AIDS InfoNet, 2010).

Infection of newborn babies is more likely (up to 35% of babies of infected mothers) when antiretroviral treatment is not taken and if mothers breastfeed for 18 to 24 months. Drinking breast milk from an infected woman is one of the ways that babies are infected, although some research indicates that the picture may be more complex. It nevertheless is still recommended that mothers who are HIV-infected should generally not breast-feed their babies.

Pregnant women drug users

It is not recommended that pregnant women should be advised to quit heroin (i.e., go "cold turkey"). Methadone is the treatment of choice at this time. The dose can be reduced slowly during the second trimester of pregnancy. It is good practice to use methadone treatment as part of a holistic approach that includes other treatment such as psychosocial, obstetric, paediatric and drug services.

Many women with problem drug use are often concerned that they will lose parental rights or be coerced into having their child adopted or taken into state care. However, women with problem drug use who are also pregnant are often more motivated to change their drug use and risk behaviour. Often pregnant women will reduce the level of drug use to protect their baby. This is also a time when some pregnant women are more receptive to offers of treatment. It is important to offer pregnant women with problem drug use ongoing care or maintenance treatment as stopping the use of drugs rapidly (with resulting withdrawal) may well pose a significant risk to the foetus.

Harm reduction

There is a lack of harm reduction tools in prisons let alone those designed specifically for women.
Women prisoners should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to infant, or through sexual intercourse. Since women prisoners may engage in sexual intercourse during detention or release on parole, they should have access to information and services that assist in protecting them from infectious diseases. The condom is the most effective method of preventing infection with HIV, hepatitis and other STIs, because of the physical barrier it provides (WHO, 2007). Provision of condoms is one of the interventions required by the UNODC and UNAIDS. For women, one of the most difficult issues is how to persuade partners, or clients if engaged in sex work, to use condoms. It is important that condoms are provided in prison and skills developed to negotiate safer sex.

Sex workers

Prisons contain an overrepresentation of people from the most marginalised groups and these include sex workers. Research shows that sex work, sexual abuse and problem drug use are often linked. Drug dependence often pushes women into sex work. Additionally, sex workers with children often fear having them removed by social services (McClelland and Newell, 2008).
Women sex workers with problem drug use who need and want harm reduction and drug treatment often have difficulty in accessing services (Wechsberg et al., 2009). Providing harm reduction for sex

workers who use drugs is problematic as the motivation to earn money, especially for drugs, can override the fear of violence and the reality of risks (Sanders, 2007).

Suitable accommodation is essential for sex workers who wish to make a fresh start after imprisonment. It is important that they remove themselves from the temptations of street culture and the habits associated with their previous life and networks.

Experience of abuse

Imprisoned women are significantly more likely to have been physically or sexually abused than men. Up to 70% of female prisoners have experienced severe physical violence by a parent. Additionally, 59% of female prisoners have experienced sexual abuse as children (Browne et al., 1999).

Experienced abuse and resulting trauma are directly linked to female pathways of crime. Additionally, such experiences might contribute to marginalisation and problem drug use, with the latter possibly resulting in criminal behaviour. Abuse experienced in an intimate partnership can also be linked to engagement in criminal activities; this can often take the form of women being forced by their partners to participate in the sex industry.

Prison authorities throughout Europe pay very little attention to women prisoners' specific needs despite the high numbers who have experienced abuse and its related negative outcomes. There is a high demand for capacity building in the criminal justice system throughout Europe, in particular within the prison system, which addresses the needs of this specific group.

Hygiene and health care

Women prisoners have specific health and hygiene needs that prison authorities need to meet. If it is possible, women prisoners should have access to a woman doctor and to specialists in women's health, for example, for reproductive care. Women prisoners require access to sanitary towels and tampons and safe disposal arrangements for bloodstained articles.

While in the community, women prisoners are likely to have had poor preventive health care (WHO, 2009; Zurhold, 2004). Alarmingly high rates of mental health problems such as PTSD (post-traumatic stress disorder), depression or anxiety are found among the women prison population as well as a tendency to self-harm and suicide. Furthermore, high prevalence of alcohol and drug dependence is found among the female prison population. In England and Wales for example, 90% of women prisoners are reported to have either a mental health disorder, problem drug use or both.

Preparation for release

As women represent a small percentage of prison populations, they tend to have less access to education and training compared to male prisoners. Often the work they can engage in is limited and includes activities such as cleaning and sewing. There is often limited access to vocational training. It can be beneficial to prison administrations to involve NGOs to augment women's access to training and education both in prison and on release.

☞ Often women prisoners have limited access to educational and leisure activities – ask participants how this could be improved. What activities could be introduced?

Women prisoners are likely to face stigma when they return to the community and other difficulties such as negotiating the return of their children. As a result, they will require support at this time. Women with problem drug use will also need services to help protect themselves after release. Post-release services should include such measures as information relating to community needle exchange, access to drug treatment, referral to sexual and reproductive health services, housing and child support. Such services will also need to address issues including loneliness, low self-esteem or perceptions of self-efficacy, guilt, depression and difficulties in social and family relationships (including children).

Activity: Case studies

20 minutes

➢ ***PowerPoint: Slide 23***

Materials needed:

Handouts of case study 1 and 2 to be distributed to participants (Annex 12 and 13)

Method:

Choose either one of the following case studies and ask the group how they would react in this situation; alternatively, divide the group into two and give each group one of the case studies. Ask for the main points to be put onto a flipchart to aid feedback.

Case study 1 (Annex 12)

Janis is a 19-year-old shop worker. At arrival at the prison she requests testing for hepatitis C. In a discussion of risk factors, she admits to occasionally using heroin and thinks that she might be pregnant.

Case Study 2 (Annex 13)

Children can remain with their mothers in prison up until they are three years old. After the age of six months, children have to be in the nursery during the day while their mothers are at work. This can be distressing for some mothers. What can be done to reassure the mothers and reduce their distress?

Activity: Negotiation skills for condom use

20 minutes

➢ ***PowerPoint: Slide 24***

Women are particularly vulnerable to contracting HIV through sexual transmission because of a number of different physiological, psychological and social factors. It is essential that women, especially women prisoners, are equipped with information and skills that enable them to protect themselves. Using a condom is the only method that prevents unintended pregnancy and the transmission of infectious diseases at the same time. Despite this, there are often negative attitudes or misconceptions about condom use. This exercise will help to explore personal attitudes, clear myths and assist in the process of helping women in prison confront barriers to condom use. The exercise may then be used by professionals within a prison setting to assist women in developing negotiation skills.

Materials needed:

Small cards with statements on condom negotiation (Annex 14)

Method:

Ask participants to split into two groups. Give each group half of the small cards that have the statements of condom negotiation written on them. Ask the participants from one group to read out loud one of the statements, starting the sentence with "My partner says…". The task of the other group will be to provide an answer to the statement using the form: "But you can answer…". Allow some time for the answering group to discuss their ideas for a minute. Conclude with a short discussion on the main reasons why women do not negotiate for condom use and what skills they need to be able to protect themselves.

Conclusion (questions and comments)

Total time required: 10 minutes

- Women prisoners have a wide range of distinct needs, which are often neglected in both general health care and in harm reduction services. The situation is not helped by the difficulties women in prison encounter when attempting to access appropriate harm reduction measures. Women have the same concerns about engaging with drug treatment and harm reduction both inside and outside the prison environment.
- The special needs of women are often overlooked and neglected by prison authorities in their policies which, in the main, are designed for male prisoners.
- Standards of care within the prison system, including the provision of harm reduction, should not be any different from those accessible to men and women outside the prison system.

Evaluation

Total time required: 10 minutes

3.6 FOREIGN PRISONERS

Target audience:

10-12 prison staff

Total time required:

130 minutes

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart, flipchart paper, tape
- Markers in various colours
- Paper and pencils
- PowerPoint presentation of the session

Objectives:

- To inform participants on the specific problems and needs of foreign national prisoners in general and in relation to problem drug use.

Learning outcomes:

This session will increase participants' knowledge of

- the special needs of foreign national prisoners,
- approaches to overcome specific problems.

By the end of the session, participants should be aware of the specific needs and problems of foreign national prisoners and be sensitised to policies and strategies.

Activities:

Icebreaker (20 minutes)

Foreign nationals in prison (90 minutes)

- Lecture: Foreign prisoners; definition and facts – 15 minutes
- Activity: Brainstorming on problems foreign nationals may encounter in prison – 15 minutes
- Lecture: Special needs of foreign prisoners – 30 minutes
- Activity: The specific situation in the prison and possible approaches to overcome problems – 30 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

UNODC (2009). *Handbook on Prisoners with special needs*. Criminal Justice Handbook Series. Vienna: UNODC. Retrieved October 8, 2009, from http://www.unodc.org/documents/justice-and-prison-reform/Prisoners-with-special-needs.pdf

Helpful website:

World Prison Brief. Retrieved October 15, 2009, from www.kcl.ac.uk/depsta/rel/icps/worldbrief/world_brief.html

Introduction

☞ The following introduction to the module is meant for the trainer, giving a short overview on general background information on the topic.

The number of prisoners who are foreign nationals is rising throughout Europe. Many are imprisoned for drug related offences, with some having substance use problem that are in need of treatment. Isolation, language barriers, cultural differences and possible deportation are just some of the main problems facing foreign national prisoners. As most prison staff might lack detailed information on the specific needs of foreign prisoners, this module focuses on general issues/ problems facing this group. The module also addresses problems that might be encountered as a result of problem drug use.

It might be helpful for this session to invite a former foreign national prisoner, who can contribute by talking about his/ her time in prison.

This module is very similar to the module on ethnic minority prisoners. It is advisable to choose the module that best fits the specific situation in the prison/ country where the training is taking place.

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Foreign nationals in prison

Total time required: 90 minutes

Lecture: Foreign prisoners – definition and facts

15 minutes

➢ ***PowerPoint: Slides 3-7***

☞ During the lecture be as interactive as possible by asking questions frequently and actively involving the participants. For example, start the lecture by asking participants to identify the different nationalities of prisoners in their own prisons and write them down on a flipchart.

How do we define foreign prisoners?

Foreign national prisoners are prisoners who do not carry the passport of the country in which they are imprisoned, including

- those having lived for a longer period of time in the country of imprisonment without having been naturalised,
- as well as prisoners who have stayed for a short period of time in the country of imprisonment.

Foreign prisoners constitute a heterogeneous group with a wide range of national, cultural and religious backgrounds; this combination makes it difficult to adequately respond to their specific needs. Nevertheless, it is crucial to implement culturally specific measures, in particular adequate health prevention services and harm reduction measures.

Foreign prisoners – facts and figures

- Due to globalisation, migration, trafficking and transnational crime, the number of foreign prisoners is rising in Europe and throughout the world.
- Around 21% of the prison population in Europe comprises foreign nationals (corresponding to a total number of 103.000 in 2006) (UNODC 2009).
- The above numbers are presumably higher if prisoners with a migration background holding the citizenship of the country of imprisonment are taken into account.
- The number of foreign national prisoners is increasing in Europe both in absolute and relative terms.

- Depending on the country, rates vary up to 40-70% (e.g. in Switzerland where 71% of the prison population is made up of foreign nationals) (compare http://www.nationmaster.com/graph/cri_pri_for_pri-crime-prisoners-foreign).
- In some countries, those violating immigration laws are imprisoned; this might account for the high percentage of foreign prisoners in the overall prison population.
- Foreign prisoners are often socio-economically disadvantaged, having already faced inadequate health care and limited access to drug treatment before entering prison.

Especially high numbers of foreign prisoners are found in countries with a large migrant labour force. With the toughening of sentences for property crime and drug offences in many European countries, not only has the prison population increased, but socially and economically disadvantaged people from minority groups and foreign nationals have suffered particularly.

Implications for prison policy

It is crucial to develop and implement specific strategies in prisons aligned to foreign prisoners and their special needs. By tackling the specific needs of foreign prisoners, tension in the prison can be reduced and prison management be improved. From the perspective of foreign prisoners, such strategies lead to a better integration into prison services and improve their health status due to specific services being offered, e.g. for foreigners with problem drug use and/or mental health problems.

Activity: Brainstorming on problems foreign nationals may encounter in prison

15 minutes

➢ ***PowerPoint: Slide 8***

Materials needed:

Flipchart, flipchart paper taped on the wall, tape, paper, pencils, markers

Method:

Start the session by distributing paper and pencils and ask the participants what they think are the main problems foreign nationals might encounter in prison. If necessary, provide an example.

Ask participants to write down on paper five words/ associations as quickly as possible. Time pressure usually makes associations more spontaneous and less censored.

When everybody has finished writing down their associations, ask the first participant to name the first word in his/ her list and write it on flipchart paper that is taped on the wall around the room. If other participants have also written down this word ask them to delete it from their lists. Then move to the next participant, ask for the first word, write it on the flipchart, and ask the other participants to delete it if applicable. Continue until all words have been read out by the participants. When writing the words on the flipchart paper, make sure that participants can read them easily.

Ask participants to look at these words a few moments, read them again and think about how they can be grouped.

Lecture: Special needs of foreign prisoners

30 minutes

➢ ***PowerPoint: Slides 9-19***

☞ Throughout the lecture always refer to the answers given by the participants during the activity. Be as interactive as possible by asking questions frequently and involving the participants.

Foreign national prisoners have needs that are distinct from other prisoners and, as a result, can suffer from isolation. It is important to note that female foreign prisoners form a particularly vulnerable group due to high rates of problem drug use, isolation and separation from families and the community, pregnancy, childbirth and motherhood.

Access to justice

Foreign national prisoners may lack understanding of the operation of the legal system in the country of imprisonment due to cultural reasons and language barriers. Language barriers, a lack of awareness of their legal rights and a lack of social networks also make it difficult to find adequate legal counsel. The situation is further complicated in countries where detainees have to sign confessions during interrogations, which they might not understand.

Isolation

Prisoners who are not resident in the country of imprisonment, or who have recently arrived, might lack contact with their families and communities, i.e. support that is necessary for successful social reintegration. Foreign national prisoners often lack the knowledge of their right to contact the diplomatic representative of their country of origin. Nevertheless, this contact is not an adequate substitute for the support of families and friends.

A high proportion of foreign national prisoners are imprisoned for drug crimes. The proportion is particularly high for women. In the United Kingdom, 20% of the female prison population is of foreign nationality and 80% of these are convicted for drug offences. Many of these women are also mothers and isolation is aggravated not only by separation from the wider family and community but also from their children.

Language barriers

Language barriers are a contributory factor to the isolation experienced by many foreign national prisoners.

☞ Ask participants what language barrier problems they might have encountered with foreign national prisoners.

Due to language barriers, foreign national prisoners may face the following:

- Impaired communication with other prisoners and prison staff
- Exclusion from many of the prison activities
- A lack of understanding of prison rules – leading to a lack of understanding of their rights and obligations and to a possible unintended breaking of rules
- Exclusion from certain services, as requests often have to be made in writing (e.g. to see a doctor or the director, to participate in drug treatment programmes etc.)
- Dependence on interpreters (sometimes interpretation is provided by other prisoners, raising the issue of confidentiality when it is about medical or psychological treatment)

All of the above mentioned factors might contribute to isolation and a fear of breaking rules. Frustration, resulting from an inability to communicate, might also lead to aggressive behaviour.

Immigration status

Foreign national prisoners might lose their legal permit to reside in the country of imprisonment. In some countries, even long-term foreign residents may be deported to their country of origin after having served the sentence. In some cases, these people lack the ties in their country of origin or do not have the ability to speak the respective language due to their long-time stay in the country of imprisonment.
In general, prisoners often lack knowledge of immigration laws and do not know about their rights and duties. Cooperation between immigration authorities and prison administrations is mostly non-existent.

Discrimination

Foreign national prisoners may be subject to disadvantages and discrimination in the prison. Discrimination can be visible in verbal and physical abuse or more subtle and reflected by

- the security level they are allocated,
- the accommodation they are given,
- the number of disciplinary punishments they are given,
- searching procedures and methods,
- the type of work they are given (if given any at all).

Language barriers may further hinder the prisoners' ability to take part in prisoner programmes. These might include not only vocational training and education programmes but also programmes on drug prevention, harm reduction programmes etc.

Foreign national prisoners are often not considered for home leave or day paroles as it is feared that they might flee the country. Prisoners who do not have a secure address or are going to be expelled after having served the sentence are mostly excluded from day paroles or home leaves. Sometimes, they are indirectly discriminated against as they are unable to take part in the requisite number of prisoners' programmes that make them eligible for parole.

Furthermore, foreign national prisoners are often not considered for non-custodial measures as it is feared that they might flee the country. In general, alternatives to prison, like therapeutic treatment for drug dependent persons, are less likely to be applied.

Health

Foreign national prisoners exhibit high rates of mental health problems, which might result from or lead to (problem) drug use. Mental health care or drug treatments that take cultural differences into account are very rare in European prisons.

Some foreign national groups are at higher risk of contracting infectious diseases and health problems due to substance misuse. Foreign national prisoners might have special health care needs due to their socio-economic marginalization in society. Those who also have problem drug use might have experienced poor preventive health and inadequate medical care and little or no treatment for their dependence prior to imprisonment. Women form an especially disadvantaged group due to a lack of gender specific treatment.

Culture and religion

Foreign national prisoners might have special needs relating to:

- Facilities for worship
- Special diets
- Hygiene requirements

Psychological support, e.g. for drug dependent foreign national prisoners is likely to be inadequate due to cultural differences. This might include, for example, concepts of drug dependence.

Release

Foreign prisoners are likely to be ill-prepared for release due to their inability to take part in special preparatory release programmes and their lack of contact and ties with family and community. Additionally, foreign prisoners may not be eligible for welfare after release.
If a prisoner is deported after release, there is often little time to inform families and communities in their country of origin. Preparation for post-release measures in the country of origin or any kind of cooperation between the country of imprisonment and the country of origin regarding post-release support is usually non-existent.

Activity:	The specific situation in the prison and possible approaches to overcome problems

30 minutes

➢ ***PowerPoint: Slide 20***

Method:

Arrange chairs so that participants sit in a circle. Ask participants how the above issues are reflected in their own prisons. Ask them if there are specific strategies tailored to meet the needs of foreign prisoners, both in general and in relation to harm reduction, and what they think can be done to improve the situation.

What can be done? Examples of policies and strategies:

- Where the number of foreign national prisoners is comparably high, a foreign national advisor should be appointed in prisons.
- Foreign national support groups could be formed enabling peer support – e.g. helping with requests for services.
- Information about legal rights of prisoners should be provided in different languages.
- Information and contact details of relevant NGOs helping foreign prisoners should be available.
- Prisoners should be informed of their right to contact diplomatic representatives.
- Interpretation should be provided.
- Prison rules and regulations should be made available in different languages.
- Each prisoner should be provided with a copy of these rules upon admission.
- Additionally, rules and regulations should be thoroughly explained to the prisoner in his/ her respective language.
- Language courses should be offered to prisoners.
- Information material on the transmission of HIV/AIDS and other infectious diseases should be provided in different languages.
- Specified drug counselling services/ NGOs sensitive in migration and drug use should be offered.
- Prisoners should be given access to ministers of their own religion.
- Dietary requirements should be taken into account.
- Equal access should be given to education and vocational training and other training programmes, involving interpreters if needed.
- Equal access to work places should be provided.
- Alternatives to prison for foreign prisoners who are problem drug users should be made available.
- Health care professionals in prison settings have to consider patients' ideas about their health problems and incorporate relevant traditional practices (if possible) into treatment programmes.

Conclusion (questions and comments)

Total time required: 10 minutes

- Due to globalisation, migration, trafficking and transnational crime, the number of foreign national prisoners is rising in Europe and throughout the world.
- Foreign national prisoners are often socio-economically disadvantaged; they might have experienced inadequate health care and limited access to drug treatment already before entering prison.
- Foreign national prisoners have needs that are distinct from others in the prison population and often suffer from isolation.
- A wide range of policies and strategies exist that correspond to the specific needs of foreign national prisoners.

Evaluation

Total time required: 10 minutes

3.7 ETHNIC MINORITY PRISONERS

Target audience:

10-12 prison staff

Total time required:

130 minutes

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart, flipchart paper, tape
- Markers in various colours
- Paper and pencils
- PowerPoint presentation of the session

Objectives:

- To inform participants about the specific problems and needs of ethnic minority prisoners in general and in relation to problem drug use.

Learning outcomes:

This session will increase participants' knowledge of

- the special needs of ethnic minority prisoners,
- approaches to overcome specific problems.

By the end of the session, participants should be aware of the specific needs and problems of ethnic minority prisoners and be sensitised to respective policies and strategies.

Activities:

Icebreaker (20 minutes)

Ethnic minorities in prison (90 minutes)

- Lecture: Ethnic minority prisoners; definition and facts – 15 minutes
- Activity: Brainstorming on problems ethnic minorities might encounter in prison – 15 minutes
- Lecture: Special needs of ethnic minority prisoners – 30 minutes
- Activity: The specific situation in the prison and possible approaches to overcome problems - 30 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

UNODC (2009). *Handbook on Prisoners with special needs*. Criminal Justice Handbook Series. Vienna: UNODC. Retrieved October 8, 2009, from http://www.unodc.org/documents/justice-and-prison-reform/Prisoners-with-special-needs.pdf

Helpful website:

World Prison Brief. Retrieved October 15, 2009, from www.kcl.ac.uk/depsta/rel/icps/worldbrief/world_brief.html

Introduction

☞ The following introduction to the module is meant for the trainer, giving a short overview on general background information on the topic.

A large proportion of prisoners in European prisons are from ethnic minorities. In each country of Europe, this may mean very different ethnic groups. In many cases, being from an ethnic minority brings with it not only a wide range of cultural and religious values that may differ from those of the majority but often also feelings of exclusion as a result of many years of racial prejudice and in some cases segregation.

The number of ethnic minority prisoners is rising in prisons throughout Europe. Many prisoners from ethnic minorities are imprisoned for drug related offences, with some of them having substance use problems that are in need of treatment. Discrimination, health problems and cultural differences are just some of the main problems ethnic minority prisoners might face in prison. As most prison staff might lack detailed information about the specific needs of ethnic minority prisoners, this module focuses on the general issues and problems facing ethnic minorities in prison with additional reference to problems encountered through problem drug use.

It might be helpful for this session to invite a former ethnic minority prisoner, who can contribute by talking about his/ her time in prison.

This module is very similar to the module on foreign national prisoners. It is advisable to choose the module that best fits the specific situation in the prison/ country where the training is taking place.

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Ethnic minority prisoners

Total time required: 90 minutes

Lecture: Ethnic minority prisoners – definition and facts

15 minutes

➢ ***PowerPoint: Slides 3-7***

☞ During the lecture be as interactive as possible by asking questions frequently and actively involving the participants. For example, start the lecture by asking participants to identify the different national ethnic backgrounds of prisoners in their own prisons and write them down on a flipchart.

How do we define ethnic minority prisoners?

The term “ethnic minorities” is broad and includes people who are from ethnic groups that are different from the majority group. The term “ethnic group” has been used to describe “a group of individuals who share a set of norms, values, beliefs and practices and who are usually also bound by common descent”. An example of an ethnic minority are Black Americans in the USA.

Every country in Europe has its own ethnic minorities, each with its own distinct characteristics. Indeed, people from each European country will have different concepts of an “ethnic minority”.
In some countries, the biggest or most prominent ethnic minorities are indigenous, such as Germans in the Baltic States or Hungarians in Romania. In other countries, the biggest ethnic minorities have migrant origins, such as the Afro-Caribbean and Asian communities in the UK or the Turkish community in Germany.

The term “ethnic minority” can refer to a minority group with a different ethnic origin or persons with an immigrant background (either recent immigrants and/ or second- and third-generations). Most countries do not provide data on prisoners by ethnicity and we can only rely on estimations.

The following are some facts about ethnic minority prisoners:

- Ethnic minority groups tend to be amongst the poorest and most marginalised groups in society.

- A large proportion of the prison population is made up of people from ethnic minority backgrounds (for example, in the UK, this is approximately a quarter of the prison population).
- Minority ethnic groups form a rapidly growing proportion of prison populations in Europe.
- Ethnic minorities have often experienced inadequate health care and limited access to drug treatment already before entering prison.
- People from specific ethnic minority groups might show a higher concentration of problem drug use (e.g. Spätausiedler, i.e. ethnic Germans from Russia now living in Germany) whereas other minority groups tend to abstain from drugs.

The toughening of sentences for property crime and drug offences in many European countries has not only increased the prison population, but has also impacted significantly on socially and economically disadvantaged people from minority groups.
Ethnic minority prisoners constitute a heterogeneous group with a wide range of national, cultural and religious backgrounds; this combination makes it difficult to adequately respond to their specific needs. Nevertheless, it is crucial to implement culturally specific measures, in particular adequate health prevention services and harm reduction measures.

Implications for prison policy

It is crucial to develop and implement specific strategies in prisons aligned to the special needs of ethnic minority prisoners. By tackling the specific needs of ethnic minority prisoners, tension in the prison can be reduced and prison management improved. From the perspective of ethnic minority prisoners, such strategies lead to a better integration into prison services and improve their health status.

Through imprisonment disadvantaged members of ethnic minorities are further marginalised possibly leading to a cycle of incarceration. Incarceration might lead to the perpetuation of stereotypes and discrimination against ethnic minorities.

Activity: Brainstorming on problems ethnic minorities might encounter in prison

15 minutes

➢ ***PowerPoint: Slide 8***

Materials needed:

Flipchart, flipchart paper taped on the wall, tape, paper, pencils, markers

Method:

Start the session by distributing paper and pencils and ask the participants what they think are the main problems ethnic minorities encounter in prison. If necessary, provide an example.

Ask participants to write down on paper five words/ associations as quickly as possible. Time pressure usually makes associations more spontaneous and less censored.

When everybody has finished writing down their associations, ask the first participant to name the first word in his/ her list and write it on flipchart paper that is taped on the wall around the room. When writing the words on the flipchart paper, make sure that participants can read them easily. If other participants have also written down this word ask them to delete it from their lists. Then move to the next participant, ask for the first word, write it on the flipchart, and ask the other participants to delete it if applicable. Continue until all words have been read out by the participants.

Ask participants to look at these words a few moments, read them again and think about how they can be grouped.

Lecture: Special needs of ethnic minority prisoners

30 minutes

➢ ***PowerPoint: Slides 9-17***

☞ Throughout the lecture always refer to the answers given by the participants during the activity. Be as interactive as possible by asking questions frequently and involving the participants.

Ethic minority prisoners are an especially vulnerable group in the prison system. They have needs that are distinct from other prisoners depending on their respective cultural background, including tradition, religion and language. It is important to note that female ethnic minority prisoners form a particularly vulnerable group due to high rates of problem drug use, and separation from families and the community, pregnancy, childbirth and motherhood.

Access to justice

Prisoners from ethnic minorities might have had previous poor experience of the criminal justice system resulting from prejudice by the authorities from the majority community. There might also be an expectation of poor treatment owing to a perception of prejudice. For example, people from ethnic minorities are more likely than people from the majority to be victims of crime; they are also likely to receive much harsher penalties than their counterparts; in terms of employment the legal establishment is almost uniformly from the ethnic majority and ethnic minorities are under-represented in both the prison and police services.

Discrimination

Ethnic minority prisoners might be subject to disadvantages and discrimination in the prison. Discrimination can be visible in verbal and physical abuse or more subtle reflected by:

- the security level they are allocated,
- the accommodation they are given,
- the number of disciplinary punishments they are given,
- searching procedures and methods,
- the type of work they are given (if given any at all).

The access of ethnic minorities to education, health care and prisoner programmes might be impaired resulting in a higher rate of reoffending and problems in social reintegration of prisoners after release. Language barriers might further hinder the prisoners' ability to take part in prisoner programmes. These might include not only vocational training, education programmes but also programmes on drug prevention, harm reduction programmes etc.

Ethnic minority prisoners are often not considered for home leave or day parole due to a higher number of disciplinary punishments or because they are unable to take part in the requisite number of prisoner programmes that make them eligible for parole.

Family and community links

For some ethnic minority groups, separation from their family and community can have especially detrimental effects. The family to some ethnic groups is central to the functioning of communities and the well-being of individuals. On the other hand, existing links to family and community can help in social reintegration and reducing the harmful effects of imprisonment.

Language barriers

Due to language barriers, ethnic minority prisoners might face the following:

- Impaired communication with other prisoners and prison staff
- Exclusion from many of the prison activities
- A lack of understanding of prison rules – leadind to a lack of understanding of their rights and obligations and possible unintended breaking of the rules
- Exclusion from certain services, as requests often have to be made in writing (e.g. to see a doctor or the director, to participate in drug treatment programmes etc.)
- Dependence on interpreters (sometimes interpretation is provided by other prisoners, raising the issue of confidentiality when it is about medical or psychological treatment)

All of the above mentioned factors might contribute to isolation and a fear of breaking rules. Frustration, resulting from an inability to communicate, might also lead to aggressive behaviour.

Culture and religion

Prisoners from ethnic minorities might have special needs relating to:

- Facilities for worship
- Special diets
- Hygiene requirements

Psychological support, e.g. for drug dependent inmates is likely to be inadequate due to cultural differences. This might include, for example, concepts of drug dependence.

Health

Ethnic minority background of prisoners is often associated with increased rates of a range of physical and mental disorders. In the United Kingdom, for example, individuals from Caribbean, Irish and Pakistani communities have significantly increased rates of deliberate self-harm while those of Egyptian and Asian origin have increased rates of bulimia and anorexia nervosa. Mental health care treatments that take cultural differences into account are very rare in European prisons.

High rates of mental health problems amongst prisoners from ethnic minorities might result from, or lead to (problem) drug use. Substance use, drug related problems and the responses required to treat them could also differ in different societies and cultures. "Culture" often determines which substances are used and how they are used in many societies. Within ethnic minority groups, patterns of use of specific substances might mirror those from their culture of origin. Drug treatments that take cultural differences into account are very rare in European prisons. Women again form an especially disadvantaged group due to a lack of gender specific treatment.

Release

Prisoners from ethnic minorities might face inadequate preparation for release even though they often require more assistance due to their socio-economic marginalisation. Support services might not take into account the specific cultural background and discriminatory attitudes might be found in probation services, welfare services, accommodation services etc. The stigma of imprisonment poses particular problems for women from ethnic minorities. They might not be accepted by their communities which could lead to them re-offending.

Activity: The specific situation in the prison and possible approaches to overcome problems

30 minutes

➢ ***PowerPoint: Slide 19***

Method:

Arrange chairs so that participants sit in a circle. Ask participants how the above issues are reflected in their own prisons. Ask them if there are specific strategies tailored to meet the needs of ethnic minority prisoners, both in general and in relation to harm reduction, and what they think can be done to improve the situation.

What can be done? Examples of policies and strategies:

- Prison rules and regulations should be made available in different languages.
- Each prisoner should be provided with a copy of these rules upon admission.
- Additionally, rules and regulations should be thoroughly explained to the prisoner in his/her respective language.
- Interpretation should be provided.

- Language courses should be offered to prisoners.
- Information material on the transmission of HIV/AIDS and other infectious diseases should be provided in different languages.
- Specified drug counselling services/ NGOs sensitive in the needs of ethnic minorities and drug use should be offered.
- Prisoners should be given access to ministers of their own religion.
- Dietary requirements should be taken into account.
- Equal access should be given to education and vocational training and other training programmes, involving interpreters if needed.
- Equal access to work places should be provided.
- Health care professionals in prison settings have to consider patients' ideas about their health problems and incorporate relevant traditional practices (if possible) into treatment programmes.

Conclusion (questions and comments)

Total time required: 10 minutes

- Ethnic minority groups form a rapidly growing proportion of prison populations in Europe.
- Prisoners from ethnic minorities have needs that are distinct from others in the prison population.
- Prisoners from ethnic minorities are often socio-economically disadvantaged; they might have experienced inadequate health care and limited access to drug treatment before entering prison.
- A wide range of policies and strategies exist that correspond to the specific needs of ethnic minority prisoners.
- There exist a wide range of policies and strategies in order to correspond to the specific needs of ethnic minority prisoners.

Evaluation

Total time required: 10 minutes

3.8 SEXUALITY

Target audience:

10-12 prison staff

Total time required:

210 minutes

Materials needed:

- Paper and pencils
- Flipchart, flipchart paper, tape
- Markers in various colours
- “Key concepts of sexuality” (Annex 15)
- “World Association of Sexology Declaration of Sexual Rights” (Annex 16)
- “Common views on sensitive sexual issues” (Annex 17)
- “Vocabulary on sexuality” (Annex 18)

For this module, no PowerPoint presentation is needed.

Objectives:

- To increase the level of comfort in addressing sensitive issues related to sexuality.
- To develop a good general understanding about the broad concept of sexuality.
- To explore and challenge participants’ values, beliefs and attitudes.
- To enable staff to adopt a more positive approach towards sexuality in the prison setting.

Learning outcomes:

This session will increase participants’ knowledge about

- the concept of sexuality,
- sexual health and rights,
- sexual behaviours in relation to harm reduction and the prison setting.

Participants will develop skills and understanding on how to integrate sexuality issues in the broader context of harm reduction measures in prison. Activities in this session will help participants to recognise personal beliefs and attitudes about sexuality. Participants will also be more aware of how their personal beliefs influence professional decisions.

Activities:

Icebreaker (20 minutes)

- Activity: Expertise scale – 10 minutes
- Why do we have to talk about sexuality in prison? – 10 minutes

Session 1 Sexuality (90 minutes)

- Activity: Brainstorming on sexuality – 20 minutes
- Activity: Puzzle on sexuality terms – 30 minutes
- Activity: Puzzle on sexuality in prison – 40 minutes

Session 2 Sexual behaviours and attitudes (80 minutes)

- Activity: What is your opinion? – 25 minutes
- Activity: Vocabulary on sexuality – 25 minutes
- Activity: Condoms in prison – 30 minutes

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

EngenderHealth (2002). *Integration of HIV and STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling: A Training Manual.* Working draft. New York, NY: Engenderhealth. Retrieved October 5, 2009, from http://www.engenderhealth.org/pubs/hiv-aids-sti/integration-of-hiv-fp.php

EngenderHealth and International Community of Women Living with HIV/AIDS (ICW) (2006). *Sexual and reproductive health for HIV-positive women and adolescent girls: Manual for trainers and programme managers*. New York and London: JC Publishing. Retrieved October 14, 2009, from http://www.engenderhealth.org/pubs/hiv-aids-sti/srh-hiv-positive-women-girls.php

The Global Network of People Living With HIV/AIDS (GNP+) (2009). *Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV: A Guidance Package.* Amsterdam: The Global Network of People Living With HIV/AIDS (GNP+). Retrieved October 15, 2009, from http://www.who.int/reproductivehealth/topics/linkages/guidance_package.pdf

UNODC (2008). *HIV and AIDS in places of detention. A toolkit for policy makers, programme managers, prison officers and health care staff in prison settings.* New York, NY: United Nations. Retrieved October 14, 2009, from http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

WHO (2000). Effectiveness of male latex condoms in protecting against pregnancy and sexually transmitted infections. *Fact sheet N°243.* June 2000.

WHO, UNODC & UNAIDS (2007). *Interventions to address HIV in prisons Prevention of sexual transmission.* Evidence for Action Technical Papers. Geneva: WHO. Retrieved October 19, 2009, from http://www.who.int/hiv/idu/oms_ea_sexual_transmission_df.pdf

Wilkinson D. Condom effectiveness in reducing heterosexual HIV transmission: RHL commentary (last revised: 11 November 2002). *The WHO Reproductive Health Library.* Geneva: WHO. Retrieved October 15, 2009, from http://apps.who.int/rhl/hiv_aids/dwcom/en/index.html

Helpful websites:

Daniel H. Harris: *Prison Sexuality*. Prison writing program of the Pen American Centre. Retrieved September 29, 2009, from http://www.pen.org/viewmedia.php/prmMID/231

International Planned Parenthood Federation (IPPF). Retrieved September 24, 2009, from http://www.ippf.org/en

International Women's Health Coalition. Retrieved September 16, 2009, from http://www.iwhc.org/

United Nations Population Fund (UNFPA). Retrieved July 9, 2010, from http://www.unfpa.org/

WHO. Sexual and Reproductive Health. Retrieved September 22, 2009, from http://www.who.int/reproductivehealth/en/

Insert link(s) to national family planning association(s)
……..

Introduction

☞ The following introduction to the module is meant for the trainer, giving general background information on the topic.

Sexuality is a basic aspect of human beings. Sexuality begins before birth and lasts throughout life. It affects all aspects of our being in the world – physically, psychologically and socially. Sexuality is a way in which people express themselves – how they move, how they dress, how they behave. Through sexuality, people fulfil their needs for intimacy, closeness, tenderness and care. Sexuality is also a tool to express power, control, violence and manipulation. Sex can be a form of love or a form of payment. All these aspects of sexuality are sensitive and in the prison setting it can take even more extreme forms of expression.

You can take away someone's freedom in prison but it does not mean the person stops being sexual. You can never take away sexuality. Sexuality is important even in prison, because the majority of people in prison are in the sexually active age group.

Sexuality is a natural need. If many sexually frustrated individuals are in close everyday contact, staff have to be ready to pay attention to this issue. However, sexuality is also a taboo topic – especially in such an environment as prison. If there is no way to express sexuality in an acceptable way there is much more potential for it to be expressed in deviant ways. Sexuality is important not only as a basic human facet. Sexuality, and resulting sexual relationships, cannot be ignored because they are significant as a means of spreading diseases such as HIV/AIDS Therefore, we cannot ignore this topic when dealing with harm reduction.

Including the topic of sexuality in the training of harm reduction helps the development of a more holistic view of the prisoner as a person with a range of sexual needs and problems. It also helps to develop the professionals' competence in addressing issues surrounding the sexual transmission of HIV/AIDS. Through the training, professionals will become more aware of their own views and possibly prejudices about sex and sexuality.

In the first session, an overview on concepts shall be given covering the following topics:

- What is sex?
- What is sexuality?
- What are sexual and reproductive health and rights?

Session 2 addresses sexual behaviours and attitudes, covering:

- Attitudes towards sensitive issues
- Sexual orientation
- Condoms in prison

This module is on the whole interactive. It does not include a PowerPoint presentation nor does it contain lectures. The module has a flexible structure - you can choose to either conduct the whole module or you can choose one or two exercises focussing on specific issues.

Icebreaker

Total time required: 20 minutes

☞ In order to make participants feel at ease – start the session with the following icebreakers.

Icebreaker 1: Expertise scale

10 minutes

Method:

Ask participants to think about their knowledge, experience and skills in matters to do with sexuality, personally and professionally. Everyone has to score themselves on a scale of 1-10, where "10" means "an expert", but "1" means "know nothing".

Ask each participant "What is your score?" and "Why did you give yourself this evaluation?"

The facilitator summarises the answers by emphasizing that being familiar and comfortable with the topic of sexuality can help prison professionals in their harm reduction work.

Icebreaker 2: Why do we have to talk about sexuality in prison?

10 minutes

Method:

Ask the participants to introduce themselves answering the question „Why do you think, why do we need to talk about issues relating to sexuality in prison?"

When everybody has expressed their ideas, the facilitator can summarize these by emphasizing the need to identify and integrate sexuality in harm reduction activities.

Session 1: Sexuality

Total time required: 90 minutes

Activity: Brainstorming on sexuality

20 minutes

Materials needed:

Paper, pencils, flipchart papers, markers, tape

Method:

Ask participants to think of any associations when they hear the word “sexuality”. What comes to mind in connection with this word? Encourage them to be honest and to talk frankly, as there are no good or bad associations. Associations can be either words, things, objects, feelings etc.

Ask participants to write down on paper 10 words/ associations as quickly as possible. Time pressure usually makes associations more spontaneous and less censored.

When everybody has finished writing down their associations, ask the first participant to name the first word in his/ her list and write it on flipchart paper that is taped on the wall around the room. If other participants have also written down this word ask them to delete it from their lists. Then move to the next participant, ask for the first word, write it on the flipchart, and ask the other participants to delete it if applicable. Go on with the next words on the list until all words have been read out by the participants. When writing the words on the flipchart paper, make sure that participants can read them easily.

Ask participants to look at these words for a few moments, read them again and think about how they can be grouped. Usually words represent emotions, body parts, gender roles, clothes, situations, health issues, violence, etc. The discussion can lead to the conclusion that sexuality can be expressed in many ways and in many environments including prisons.

You can read all the words out aloud or ask one or more of the participants to do so. Participants might find this activity amusing and it will help to release some of the tension linked with the subject and help them to start speaking more freely about sexuality.

Activity: Puzzle on sexuality terms

30 minutes

Materials needed:

Flipchart papers, markers, tape, four terms written on small cards, “Key concepts of sexuality” (Annex 15)

Method:

(Adapted from the training materials of the Engenderhealth training manual, 2006)

Introduce the activity by telling participants that they will be doing a puzzle together. Divide participants into four small groups and give each group a flipchart and markers. Explain that each group will work separately but their combined efforts will create a comprehensive whole.

Each group is given a card with a word they have to define, the words are: “sex”, “sexuality”, “sexual health” and “reproductive health”. Encourage participants to define the term in a way that expresses their understanding of it, maybe even different aspects of it. Give enough time for the groups to complete the exercise and to write it down on flipchart paper (approximately 10 minutes).

When the definitions are finished, ask the groups to present their results. Start with the group defining the term “sex”. Ask the group members to tape their flipchart to the wall and to explain their definition. The other groups can ask questions, comment or add something to the definition. Go on with the term “sexuality”, then “reproductive health” and “sexual health”. Tape the flipcharts on the wall together as pieces of a puzzle.

Proceed with a discussion by asking participants about similarities and differences between “sex” and “sexuality”, then between “sexual health” and “reproductive health”.

☞ During the discussion, fill the gaps in knowledge and understanding (refer to descriptions of key concepts of sexuality in Annex 15).

Activity: Puzzle on sexuality in prison

40 minutes

Materials needed:

Flipchart, markers, tape, 4 terms written on small cards, “World Association of Sexology Declaration of Sexual Rights” (Annex 16)

Method:

After having completed defining the terms, ask participants to return to their small groups. Provide each group with flipchart paper and markers and again one of the terms - “sex”, “sexuality”, “sexual health” and “reproductive health.

You can use the “World Association of Sexology Declaration of Sexual Rights” as background information for the puzzle on sexuality in prisons or distribute the declaration to the participants for their group work.

Allocate one of the following issues to each group:

- Sex *in prison*
- Sexuality *in prison*
- Sexual health *in prison*
- Reproductive health *in prison*

Ask participants to brainstorm on their issue. Encourage participants to discuss all aspects that come to their mind and to write the key points on the flipchart paper. Allow enough time to complete the discussion.

Ask the first group to tape their flipchart paper to the wall and explain the key points of their discussion. Then, the other groups can ask questions and share their own experiences.

The exercise can be concluded by a discussion analysing aspects of sexual expressions, behaviours, customs, health and rights in their workplace. Ask them to share ideas about how they can promote understanding and respect for sexual and reproductive rights in their work setting.

Session 2: Sexual behaviours and attitudes

Total time required: 80 minutes

Activity: What is your opinion?

25 minutes

Materials needed:

“Common views on sensitive sexual issues” (Annex 17) (you can use the given examples and add new statements based on the local needs), two sheets of paper with signs “Agree”, ”Disagree”, tape

Method:

Prepare signs “Agree” and ”Disagree” and post them on the opposite sides of the room.

Explain that you will be reading statements that can help the group to think of their personal viewpoints on sensitive questions.

Read out loud the first statement and ask the participants to take a decision and move to the wall with the sign “Agree” or ”Disagree”. You can also leave the middle for those who cannot decide.

Depending on the group size and other factors, ask all participants or only a few from each group to explain why they have chosen this opinion and to justify it. Acknowledge that some participants might have strong feelings and attitudes about sexual orientation. Emphasize that it is important to be aware of personal attitudes because these can influence our attitude and behaviour towards prisoners.

If participants make very discriminative or aggressive statements, acknowledge that everyone can have their own opinions, but expressing them this way can be offensive to others and even unprofessional. If this occurs, the facilitator needs to be ready to respond sensitively with explanations of why such views are problematic.

After having discussed the chosen statements, participants can return to their seats and the facilitator can close the exercise with a group discussion on the most controversial points, how to explain one‘s own opinions, how acceptable the arguments of others are and how personal beliefs influence professional roles.

Activity: Vocabulary on sexuality

25 minutes

Materials needed:

Flipchart, marker, “Vocabulary on sexuality” (Annex 18), small cards with sexuality terms

Method:

Prepare small cards with the specific vocabulary and distribute them among the participants. Add further terms if needed.

Allow a few minutes for the participants to prepare their own definition of the term.

Read the terms out loud one after the other, and ask participants about their definitions. Add information or explain where necessary to fill gaps in understanding. Respond to discriminative comments appropriately.

Activity: Condoms in prison

30 minutes

Materials needed:

Flipchart, marker

Method:

Ask the participants to think about the term ”safer sex“ and encourage a group discussion. Write down on a flipchart the main points. You need to keep in mind that the main idea is to encourage condom distribution in prison – so emphasize participants' points that focus on the idea that safer sex protects from the spread of infectious diseases. Also emphasise where participants mention protection from unwanted pregnancy, safety from violence or other associations with safer sex. All of these can be used for further discussion regarding sex in prisons.

Next, divide the participants into two groups. Provide each group with a flipchart and markers. Ask the first group to brainstorm on the question:

“Why do people use condoms – positive aspects“

the second group should do the same with the question:

”Why do people not use condoms – negative aspects“.

Ask the groups to present their results.

After having presented the results, ask the first group to brainstorm on the question *”Why should condoms be distributed in prison? What could be the benefits? In which way could condoms be distributed?“*

and ask the second group:

”Why should condoms not be distributed in prisons? What could be the threats?“

A concluding discussion can help participants to understand personal and professional attitudes about condoms and the possibilities of introducing them in harm reduction measures in their workplaces.

Conclusion (questions and comments)

Total time required: 10 minutes

Evaluation

Total time required: 10 minutes

3.9 COOPERATION WITH NGOs

Target audience:

10-12 prison staff (multidisciplinary team: treatment staff and key security staff)

Total time required:

100 minutes

Materials needed:

- Flipchart
- Markers in various colours
- List of local NGOs (or local branches of national or international NGOs) working in the areas: HIV/AIDS, drugs, human rights, probation etc.

For this module, no PowerPoint presentation is needed.

Objectives:

- To raise awareness of prison staff on civil society, its organization and benefits of cooperation with them.
- To develop cooperation skills to allow prison staff to involve civil society organizations in harm reduction work.
- To identify areas of common interest for prison staff and NGOs.

Learning outcomes:

By the end of this session, participants will

- recognize non-governmental organisations,
- be able to identify areas of possible cooperation with NGOs in reaching common goals,
- be aware of benefits and challenges of this cooperation.

Participants will be aware that cooperation with NGOs is possible and can contribute to harm reduction related to drug use in prison.

Activities:

Icebreaker (20 minutes)

Structured discussion on cooperation with NGOs (60 minutes)

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

Hoover, J. & Jurgens R. (2009). *Harm reduction in prison: the Moldova Model*. New York: Open Society Institute. Retrieved September 9, 2009, from http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/moldova_20090720

WHO (2006). *Report of the WHO European Region Planning and Technical Consultation on working with civil society to scale up access to HIV prevention, treatment and care.* Report on meeting held in Berlin, Germany, 5-7 October 2005. Copenhagen: WHO Regional Office for Europe. Retrieved September 1, 2009, from http://test.cp.euro.who.int/Document/E88049.pdf

Introduction

☞ The following introduction to the module is meant for the trainer, giving a short overview on general background information on the topic.

Non-governmental organisations play an important role in harm reduction work in prison. NGOs identify problems, raise the issue on the political agenda and provide services and advocate, facilitate, initiate and implement many different changes. In most cases, NGOs work in rather narrow, focussed areas. This facilitates reaching individuals at a grass-roots level.

Cooperation with NGOs in the prison setting is challenging as it combines two totally different systems: the prison – a closed, restrictive system and NGOs - with a rather flexible, open, informal type of organisational structure.

Due to legal and cultural differences, current cooperation between NGOs and prisons differs from country to country. In each country the extent and kind of cooperation possible needs to be assessed. The NGOs vary in terms of their mission, strategies of reaching their goals, their size, area of work, number of employees, professional experience etc. Therefore, each prison should establish a framework for cooperation, which can take advantage of the opportunities provided by NGOs in tackling problems.

During the session, the main topics to be discussed are:

- The nature of an NGO
- What NGOs should know about the prison system to cooperate successfully
- How the prison system can develop cooperation with NGOs

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease

Structured discussion on cooperation with NGOs

60 minutes

☞ It is important to emphasise that this session is aimed at exchanging experiences, knowledge and ideas and not to provide "correct" answers. Therefore, ask the participants open-ended questions (questions not requiring "yes" or "no" or only one correct answer). Rather ask them to explain more detailed controversial views or ask the group whether there are different opinions. In the following, possible questions are listed.

1. **Which NGOs do you know of?**

   Write down on a flipchart all names mentioned by the participants. If participants do not know what an NGO is, start with some hints and examples (Red Cross, Greenpeace, Save the Children etc.).

   Some other helpful questions will be:

   - What charities have you heard about?
   - What about nature preservation societies?
   - What about human rights organisations?

   Also refer to local NGOs (list of local NGOs to be prepared before the session).

2. **Why do you think so many people are joining NGOs? Why are people donating to NGOs? Why do they exist at all?**

   Write down the answers in bullet points. Stress that NGOs work mostly in areas where state or local governments lack knowledge, expertise and access to specific vulnerable groups. Be prepared for answers that reflect negative stereotypes of NGOs such as "they only protest", "they misuse donated money" etc.

3. **How can organisations from outside be helpful in respect of harm reduction in your institution?**

   Write down the answers on a flipchart. If needed, challenge participants to think very broadly about any forms of cooperation and about services, information, trainings and supplies needed. Ask the participants whether they know any NGOs working in the identified areas.

The discussions can go further – how could the prison administration or staff invite NGOs and propose possible cooperation with identified NGOs? If only a few organisations are identified ask how information on more NGOs working on local, national or even international level could be collected and how it might be possible to cooperate with them.

4. **What should representatives of NGOs know before coming to your prison to deliver services, information and training?**

It is important to ask participants what they think NGOs should know before they cooperate with prisons. Who is responsible for giving this information to them?

☞ If applicable (depending on the audience), pose these further questions about a more detailed picture of an actual cooperation with NGOs:

5. **How would you organise a cooperation meeting with relevant NGOs in the area of harm reduction?**

6. **How could the work of an NGO in your institution be monitored and evaluated?**

Think about measuring knowledge, skills and attitudes, before, during and after an activity or project. Consider appropriate methods of monitoring and evaluation.

Conclusion (questions and comments)

Total time required: 10 minutes

Evaluation

Total time required: 10 minutes

3.10 HEALTH AND SAFETY OF STAFF

Target audience:

10-12 prison staff

Materials needed:

- Laptop or desktop computer
- Beamer
- Flipchart, flipchart paper
- Marker pens in various colours
- Paper
- Pencils
- Tape
- “Checklist: Prison staff are key” (Annex 19)
- “Potential stress factors“ (Annex 20)
- “What is bullying?” (Annex 21)
- PowerPoint presentation of the session

Total time required:

170 minutes

Objectives:

- To improve the knowledge and understanding of health and safety issues and needs of staff working in the prison environment.
- To provide prison staff with the knowledge and skills to enable them to comply with, support and promote health and safety in the prison environment.
- To explain why prison staff have a key role in combating the spread of communicable diseases in prison.

Learning outcomes:

This session will increase participants’ knowledge about the particular needs of health and safety issues for prison staff working in prison.

Activities:

Icebreaker (20 minutes)

Session 1 Universal health and safety precautions and post-exposure procedures (45 minutes)

- Lecture: Universal health and safety precautions and post-exposure procedures (15 minutes)
- Activity: Prison staff are key! (30 minutes)

Session 2 Stress, counselling and burn-out (85 minutes)

- Activity: Work stress and non-work stress (30 minutes)
- Lecture: Burn-out and strategies to cope with stress (15 minutes)
- Activity: What do we mean by bullying? (40 minutes)

Conclusion (questions and comments) (10 minutes)

Evaluation (10 minutes)

Resources:

Essex Health Protection Unit (2007). *Prison Infection Control Guidelines.* Retrieved September 21, 2009, from http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947346624

Garland, B. (2004). The Impact of Administrative Support on Prison Treatment Staff Burn-out: An Exploratory Study. *The Prison Journal*, 84 (4), 452–471.

Health Education Authority (1999). *A resource guide on HIV health promotion in prisons*. London: Health Education Authority. Retrieved September 21, 2009, from http://www.gserve.nice.org.uk/nicemedia/documents/prison2.pdf

Irish Prison Services (2009). *Healthcare Standards and control guidelines*. Retrieved September 21, 2009, from http://www.irishprisons.ie/documents/InfectionPreventionPolicy.doc

UNODC (2008a). *HIV in places of detention: A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*. New York: United Nations. Retrieved September 21, 2009, from http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

UNODC (2008b). *Women and HIV in prison settings*. Retrieved September 22, 2009, from http://www.unodc.org/documents/hiv-aids/Women%20and%20HIV%20in%20prison%20settings.pdf

UNODC (2008c). *HIV/AIDS Prevention, care, treatment and support in prison settings: A framework for an effective national response.* Retrieved September 22, 2009, from http://www.unodc.org/documents/hiv-aids/HIV-AIDS_prisons_Oct06.pdf

Helpful website

http://osha.europa.eu/en/front-page

Introduction

☞ The following introduction to the module is meant for the trainer, giving general background information on the topic.

Protecting staff from infectious diseases, stress, burn-out and violence is a sign of a well managed prison. It is important that prison staff are aware of their own health and safety and that they know what protocols are in place in their prisons. Prison staff also need to understand about communicable diseases and drug issues in order that they can ensure their safety at work. For example, if staff are adequately trained and equipped, the risk of contracting infections like hepatitis and HIV, which are spread through contact with blood or other body fluids, is reduced. Prisons are difficult environments in which to work and if those working in prison are well informed about health and safety they are more likely to be able to keep healthy and be able to deal effectively with prisoners. Prisons are stressful environments in which to work and often have high rates of staff turnover due to illness or a lack of job satisfaction.

The rate of infections such as HIV, hepatitis and tuberculosis amongst prisoners is generally much higher than in the community and prison staff are responsible for, and key to the care of these vulnerable prisoners who often come from marginalised and poor parts of the general population. It is not possible to create a healthy prison environment unless all staff contribute to this aim. In order to do this, prison staff need to understand and know about how infections are spread and how to maintain their own and prisoners' safety.

Access to training is crucial to staff well being and health because when prison personnel have received training they are at low risk of contracting infectious diseases. Without training, prison staff may react in negative ways; this can include being hostile to prisoners who are drug users or who are HIV-positive. Such behaviour can lead to stigma and discrimination.

Prison staff need to be aware of their own health and safety as this will help them to create a safe environment for prisoners by de-escalating violence when it happens and also by working to reduce the likelihood of violence in the first place. Prisons can be difficult places to work and some prison personnel may experience stress. The module will facilitate understanding about stress and provide some coping strategies that help to deal with it. In a work environment some people might be bullied. The module will provide information about bullying, how to recognise it is happening and how to cope with it.

This module will deal with the following three areas:

- Universal health and safety precautions and post-exposure procedures
- Stress, counselling and burn-out
- Bullying at work

Icebreaker

Total time required: 20 minutes

☞ Before starting the session, choose one of the icebreakers listed in the introduction to the manual in order to help participants feel at ease.

Session 1 Universal health and safety precautions and post-exposure procedures

Total time required: 45 minutes

Lecture: Universal health and safety precautions and post-exposure procedures

15 minutes

➢ ***PowerPoint: Slides 3-12***

☞ During the lecture be as interactive as possible by asking questions frequently and actively involving the participants.

Infectious diseases

Prison staff can adopt simple and routine work practices known as “universal precautions” that will greatly reduce the likelihood that they will contract infectious diseases. There are various international guidelines available on health and safety precautions from international organisations like WHO and UNAIDS.[2]

To prevent the transmission of infections, prisons need to be kept clean. The adoption of basic health and safety procedures will help to facilitate this. Prison personnel, for example, should wash their hands frequently and check for any cuts or breaks in the skin which should be covered with a water-proof dressing.

Hepatitis B, hepatitis C and the HI virus are usually of great concern to prison personnel and it is important to know how to reduce the risk of infection.

☞You can download and print out the international guidelines as background information if there are participants that speak English:

[2] http://www.who.int/topics/infection_control/en/ accessed at 22.01.2010
http://www.who.int/injection_safety/toolbox/en/AM_HCW_Safety_EN.pdf accessed at 22.01.2010
http://www.who.int/hiv/pub/toolkits/HIV%20transmission%20in%20health%20care%20setttings.pdf accessed at 22.01.2010
http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Techpolicies/Univ_pre_technical_policies.asp accessed at 22.01.2010
http://www.cdc.gov/hiv/resources/factsheets/PDF/hcwprev.pdf accessed at 22.01.2010

Infections in prison can be spread due to:

- Injection of drugs where sterile syringes are not provided
- Sharing other equipment used in injecting drugs (water, spoons etc.)
- Unprotected sexual relations both voluntary and coerced
- Tattooing
- Piercing
- Sharing razors, toothbrushes (can spread hepatitis B and C)
- Accidental punctures with infected needles (i.e. during searches in the cells)
- Unsafe medical equipment (dental, medical, gynaecological)

There are some situations where there is a small risk of infection when being exposed to blood or body fluids:

- Staff dealing with assaults between prisoners and between prison personnel and prisoners
- Prisoners having self-harmed
- Objects being concealed by prisoners (needles and syringes etc.)

It is important to assume that all body fluids and blood that someone is exposed to are potentially infectious. This is often referred to as adopting “universal precautions” where it is not known whether the blood or body fluids are infected. Adopting universal precautions requires:

- Use of protective barriers such as gloves, gowns aprons, masks, goggles for direct contact with blood and other body fluids
- Using a barrier if giving mouth to mouth resuscitation
- Use of latex gloves during searching (of a cell or prisoner) or cleaning up blood spills and other body fluids
- Promptly and carefully cleaning up spills of blood and other body fluids
- Safe collection and disposal of needles and sharps in puncture- and liquid-proof boxes
- Covering all cuts and abrasions of the skin with a waterproof dressing

If a member of the prison staff is exposed to body fluids or blood then post-exposure procedures need to be in place.

Post-exposure prophylaxis (PEP) is a course of HIV medication which a person can take if it has been at risk of HIV infection. The course of HIV medication lasts 28 days and, if taken within 72 hours after exposure, may be able to prevent an infection with HIV. International guidelines for post-exposure prophylaxis (PEP) are available from the WHO.[3]

[3] http://www.who.int/hiv/pub/prophylaxis/pep_guidelines/en/index.html accessed at 3.12.2009
http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf accessed at 3.12.2009

Post-exposure procedures should include:

- Clear guidelines about what should be done immediately after exposure
- Follow up actions
- A clear record made of the incident
- Confidentiality of the incident
- Counselling and necessary follow up services to staff involved in such an incident

According to UNODC (2008a), the incident can be considered to be significant:

- When a person has come in contact with body fluids capable of transmitting HIV, hepatitis B or hepatitis C, such as blood, uterine/vaginal secretions or semen and all body fluids visibly contaminated with blood.
- When one of the fluids comes into contact with the following:
  - Tissue under the skin (needle stick type injuries, bites breaking the skin, stab wounds)
  - Non-intact skin (cut, chapped, or scraped skin)
  - Mucous membranes (eyes, nose, mouth)

Fluids coming into contact with intact skin do not represent a significant exposure.

The person who has been exposed shall immediately:

- Remove all contaminated clothing
- Allow bleeding of the wound
- Wash the injured area well with soap and water (although the application of antiseptics is of no proven benefit, their use is not contraindicated; it is advised, however, that the exposed skin or wound is decontaminated with soap and water before the application of antiseptics)
- Flush eyes and mouth with large amounts of water if they are involved

Following these steps, staff who have suffered a significant exposure should immediately see the medical practitioner or the officer in charge of post-exposure procedures and arrangements for post-exposure prophylaxis treatment should be made (UNODC, 2008a).

Activity: Prison staff are key!

30 minutes

➢ ***PowerPoint: Slide 13***

Materials needed:

"Checklist: Prison staff are key" from UNODC to be distributed to participants (Annex 19)

Method:

Distribute the checklist from UNODC to the participants providing questions about health and safety measures and approaches.

Ask participants to read the checklist and use this to have a group discussion to raise key issues about

- the provision or lack of provision for training in their prison,
- access to protective equipment,
- whether they feel confident about universal precautions and PEP (after the lecture and from their experience in prison),
- whether they support the idea of making condoms, bleach, needle exchange available to prisoners to help stop the spread of communicable diseases.

Session 2: Stress, counselling and burn-out

Total time required: 85 minutes

➢ ***PowerPoint: Slide 15***

The impact of stress and burn-out can have a negative impact on prison staff's work relations both with colleagues and prisoners and in their personal life. Overcrowding in prison can potentially be a cause of stress for prison personnel. Prisons are frequently more stressful environments in which to work than those of other occupations.

Working in the prison environment can be very challenging and stressful. Prison staff can experience a number of issues not usually found in other occupations such as:

- Shift work
- Understaffing
- Threat of assault
- Potential negative public image of prisons

These issues do not only affect prison staff but might also have negative consequences for their family members as well as for the prison itself.

Prison staff often face a “circle of stress”, where the prison culture, organisation, and staff shortages can cause high staff stress levels, resulting in staff sickness, which in turn can cause greater stress for remaining staff.

Activity: Work stress and non-work stress

30 minutes

➢ ***PowerPoint: Slide 16***

Materials needed:

Flipchart, markers, paper, pencils, “Potential stress factors” (Annex 20)

Method:

Distribute paper and pencils to each participant and write the two headings “work stress” and “non-work stress” on each side of the top of the flipchart. Ask participants to write down two brief examples of something they find very stressful at work as well as something they find very stressful out of work.

Explain to participants that they should only disclose something that they are willing to share with the group (for this reason it might be advisable to use examples that occur fairly commonly and regularly rather than deep personal traumas).

When each participant has written down their examples, they should exchange papers with another group member. Then ask each group member to read out the first example of stress on the paper in front of them and ask them to say how stressful they think the example is by giving it a score of 1-10. Write down on the flipchart the examples given by the participants with the mentioned score under each heading.

Once everyone has contributed and scored the examples they read out, ask the group if any one would rate any of the examples as being more or less stressful.

Allow some minutes for discussion on personal coping strategies (strategies for coping with stress and burn-out are also listed in the following lecture).

Lecture: Burn-out and strategies to cope with stress

15 minutes

➢ ***PowerPoint: Slides 17-28***

☞ During the lecture be as interactive as possible by asking questions frequently and actively involving the participants.

Prison staff and burn-out

Burn-out is a state of long-term exhaustion. It represents a gradual process where staff have difficulty balancing their commitment and motivation with the stresses in their work.

According to the European Agency for Safety and Health at Work, burnout is defined as a syndrome of emotional fatigue, alienation and reduced abilities. It is a serious condition in which people suffer from a negative change in feelings, attitude and expectations. This is often followed by severe problems at the workplace as well as in the private context. Affected persons experience fatigue, tiredness and reduced work abilities.

Prison staff are particularly prone to burn-out at work. The likelihood of burn-out can be predicted in environments where people face danger, lack of management support and contact with prisoners. Burn-out can also occur during a period of change at work.

It may be helpful to talk about burn-out as it is important to be aware of its impact, especially when working in difficult and sometimes stressful environments like prisons.

Symptoms indicating staff burn-out

Behavioural:

- Frequent clockwatching
- Postponing activity with prisoners
- Stereotyping prisoners
- Working harder and getting less done
- Increasing reliance on rules and regulations: “Going by the book”
- Avoiding discussion of work with colleagues
- Excessive use of drugs and alcohol
- Marital and family conflict
- High absenteeism
- Irritability
- Avoiding responsibility at work

Psychological

- Not wanting to go to work every day
- Feelings of failure, anger and resentment, discouragement and indifference
- Feeling negative
- Self-preoccupation
- Feeling powerless and hopeless
- Rigidity in thinking and resistance to change
- Suspiciousness and paranoia

- Anxiety
- Depression

Physical

- Feeling tired during workday
- Exhaustion
- Not sleeping well
- Frequent colds and flu
- Frequent headaches
- Frequent gastro-intestinal disturbances
- Frequent vague aches and pains

Strategies for coping with stress and burn-out

There exist a range of coping strategies to deal with stress and burn out. Some people find it useful to join a self-help group, take up a yoga class or other activities that help them to relax. The following is a list of some techniques that can be used to deal with stress and burn-out:

- **Exercise**: After a day at work it can be very relaxing to do some cardiovascular activities such as walking, swimming, and jogging.
- **Don't bring work home with you**: If you have to bring work home get it done as early in the evening as possible leaving yourself time to relax and unwind.
- **Don't schedule all of your leisure time**: You are regulated while at work so leave yourself some "open space."
- **Get plenty of sleep**: If you are well rested, problems do not always seem so large in the morning.
- **Take up a project or hobby**: that you enjoy and helps you to forget about work for a while.
- **Keep a "to do" list**: Review it daily and do at least one or two things. As the list gets smaller, you will feel a sense of achievement.
- **Be aware of and recognize and accept your limitations**: Don't set unreasonable tasks for yourself.
- **Learn to plan**: Think ahead and develop your own method of getting your work done in an orderly manner.

Counselling is another response to help people who are experiencing stress or burn-out. Counselling is normally interactive and collaborative with confidential sessions between a person and a counsellor. Counselling is important as it enables a person to cope with the stress at work and to take personal decisions about how to deal with stress. The counselling process can be used to address issues of concern such as the personal risk of HIV transmission or bullying. Continued counselling and support should be available to staff. In some prison environments it can be difficult for prison personnel to open up and talk about their problems due to a "macho" culture where prison staff are perceived to be "strong" and able to deal with stress.

Activity: What do we mean by bullying?

40 minutes

➢ ***PowerPoint: Slide 29***

Materials needed:

Flipchart, flipchart paper, markers, paper, pencils, "What is bullying?" (Annex 21)

Method:

Split participants up into small groups. Provide each group with a sheet of flipchart paper. Ask participants to discuss and define what they think bullying involves.

Allow the small groups 10 minutes discussion time, then ask them to write down their definition on the flipchart paper. Tape each group's flipchart paper on the wall and ask the group to present their results.

Then ask each group to list coping strategies to deal with bullying behaviour in the workplace.
Allow the small groups 10 minutes discussion time, then ask them to write down their main responses on the flipchart paper. Again, tape each group's flipchart paper on the wall and ask the group to present their results.

Ensure that the prison's anti bullying strategy is discussed if there is one. If there is not one, ask the group if they would find an anti-bullying strategy helpful.

After the exercise, introduce any of the information given on the sheet "What is bullying?" that was not raised during the group discussion.

Conclusion (questions and comments)

Total time required: 10 minutes

- Group members should learn as much as they can about protecting their own health and safety and to be aware of coping strategies to deal with stress and bullying should they experience either.
- It is important that they are aware of universal precautions and PEP for their own health, their families and the health of prisoners.
- The rate of infections such as HIV, hepatitis and tuberculosis amongst prisoners is generally much higher than in the community and prison staff are responsible for, and key to the care of these vulnerable prisoners who come from marginalised and poor parts of the general population. It is not possible to create a healthy prison environment unless all staff contribute to this aim. In order to do this, prison staff need to understand and know about how infections are spread and how to maintain their own and prisoners' good health.
- Burn-out is a gradual process where staff have difficulty balancing their commitment and motivation with the stresses in their work. In order to prevent burn-out, staff require support including appropriate funding, access to appropriate education and training and other support in order to prevent high rates of absenteeism and high staff turnover.

Evaluation

Total time required: 10 minutes

Glossary

This glossary in addition to the list of acronyms is designed to provide a definition of some key concepts and terms used in the training manual and a short explanation of their meanings.

Harm reduction	"Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs" (International Harm Reduction Association).
Injecting drug use	Most injecting drug users do so intravenously. Intravenous drug use refers to a practice of drug consumption where a person introduces the drug into the vein. Injecting drug users also introduce the drug under the skin (subcutaneous injection) and intramuscular injection occurs intentionally or when a vein is missed or the subcutaneous injection failed. Any water-soluble drug may be injected. The most commonly injected drugs are heroin and other opiates, cocaine and amphetamines.
Problem drug use	Problem drug use refers to "injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines" (European Monitoring Centre for Drugs and Drug Addiction).
Poly-drug use	Broadly defined, poly-drug use refers to the use of more than one drug or type of drug by an individual, consumed at the same time or sequentially. There exist differences in the substances that are included into a definition of poly-drug use – these are mostly illegal drugs, alcohol and medicine.

Annexes

Annex 1 Participants' evaluation form

Evaluation form
- Participants -

Date:.....
Location (venue, city, country): .....
Module on .....

Please think again about the training session and rate the following questions:

		very satisfied	satisfied	neutral	dissatisfied	very dissatisfied
1.	How satisfied are you with the organisation of the training?	o	o	o	o	o
2.	How satisfied are you with the quality of the provided training?	o	o	o	o	o
3.	How satisfied are you with the material provided at the training?	o	o	o	o	o
4.	How satisfied are you with your overall training experience?	o	o	o	o	o

Please indicate your level of agreement with the following statements about the training:

		strongly agree	agree	neutral	disagree	strongly disagree
5.	The training facility was appropriate and conducive to the learning experience	o	o	o	o	o
6.	The information received during the training was useful	o	o	o	o	o
7.	The trainer was well prepared	o	o	o	o	o
8.	The trainer was knowledgeable about the topics presented	o	o	o	o	o
9.	The trainer was open to questions and took enough time to respond to questions	o	o	o	o	o
10.	The course contained too much theory	o	o	o	o	o
11.	The course contained too many activities	o	o	o	o	o
12.	The course contained too much discussion	o	o	o	o	o
13.	The training met or exceeded my expectations	o	o	o	o	o
14.	I expect this training to benefit my everyday work	o	o	o	o	o
15.	I would recommend this training to my colleagues	o	o	o	o	o

16. Please indicate your gender:

o Male o Female

17. Please indicate which of the following best describes your job:

o Security staff
o Social worker
o Medical staff
o Prison administration
o Psychologist
o Physician
o Other, please specify: .....

18. Which parts of the training did you like the most? Why?

19. Which parts of the training did you like least? Why?

20. Was there any information that you consider to be important that was missing during the training?

21. Further comments/ suggestions on the training:

Thank you for completing the evaluation form!

Annex 2 Template list of participants

LIST OF PARTICIPANTS

Date: .....

Location (venue, city, country): .....

Module on .....

TCJP
Training Criminal Justice Professionals in Harm Reduction Services

No	Name:	Email address (optional)	Signature

Annex 3 Template “Certificate of Attendance”

TCJP
Training Criminal Justice Professionals in Harm Reduction Services

Certificate of Attendance

This is to certify that

.....

Name of the attendee

attended the training session(s)

.....

Name of the respective module(s)

of the training:

“Prison staff and harm reduction”

....

Date City, Country

TCJP
Training Criminal Justice Professionals
in Harm Reduction Services for Vulnerable Groups

funded by the
Public Health Programme of the European Commission

Annex 4 True and false statements on drugs: Answer key for the facilitator

True and false statements on drugs: Answer key for the facilitator

(partly adapted from **"**Life Skills Training Guide for Young People: HIV/AIDS and Substance Use Prevention" (UNODC, 2003))

You cannot become dependent on alcohol	**False:** Alcohol is a drug like any other drug; you can become physically and psychologically dependent on alcohol.
Driving after using cannabis/marihuana is much safer than driving after drinking alcohol.	**False:** Like alcohol, cannabis/marihuana affects motor coordination, slows reflexes and affects perception (the way we see and interpret events around us). Any of these changes increase the likelihood of an accident while driving.
Cannabis is the first step towards the use of other drugs.	**True and false:** Usually people who become dependent on drugs start with a drug that is cheap and readily available like cannabis/marihuana or amphetamines. Nevertheless, most persons using cannabis stop their consumption after a certain time.
☞	Individually decide on how to proceed with scoring this statement. Either give a score if the group answered parts of the question correctly or allow the group to pick up a second statement card.
One cannot become dependent on drugs prescribed by a doctor, such as painkillers and sleeping pills.	**False:** Also prescriptive drugs can lead to dependence if taken over a long time.
You just have to have enough will power if you want stop using drugs.	**False:** Drug dependence is a very complex mental health disorder also involving physical reactions. Depending on the specific situation it can be very hard to abstain from drugs. Drug dependent people loose control over their consumption. Chemical messengers in the brain are released when drugs are taken, activating the reward system and making drug use appealing. Long-term drug use affects brain processes involved in motivation, attention, decision-making and the inhibition of impulses.
Coffee and tea contain stimulants similar to drugs.	**True:** Coffee, tea and many soft drinks contain caffeine, which is a stimulant. Caffeine can cause headaches which are a common sign of withdrawal.
Alcohol dependence is a disease.	**True:** Alcohol dependence can be seen as a chronic relapsing disease just as diabetes or epilepsy are diseases.
Drug dependence is a disease.	**True:** Drug dependence can be seen as a chronic relapsing disease just as diabetes and epilepsy are diseases.

Alcohol can have positive effects on the coronary system. ☞	**True and false:** In some individuals, low levels of alcohol can have a protective effect on the heart. However, such benefits have not been proven in the population as a whole. Indeed, alcohol consumption also has many other detrimental health consequences. For example, it also increases the risk of cancer. Individually decide on how to proceed with scoring this statement. Either give a score if the group answered parts of the question correctly or allow the group to pick up a second statement card.
A high proportion of people with problem drug use have been or are suicidal	**True:** The likelihood of suicide attempts among people with problem drug use is 6 to 10 times higher than among those without problem drug use.
Cannabis can be legally prescribed	**True:** In most countries cannabis use is against the law. However, in some countries cannabis preparations are being trialled for severely ill patients (e.g. cancer patients). It helps to relieve pain and nausea and increases appetite.
Heroin can be legally prescribed	**True**: In some countries like the UK, the Netherlands and Germany, heroin can be legally prescribed to severely heroin dependent persons not responding to opioid substitution treatment (e.g. with methadone) in order to prevent problem drug users from illegal activity and allow them an improved quality of life.
Drug dependence can lead to homelessness and loss of life.	**True:** Many drug users lose their social and economic status and can even lose their life to overdose and other complications.
One try of heroin and cocaine and you're addicted	**False:** It takes time to become addicted. Some people use cocaine and heroin regularly and do not become addicted.
Alcohol and tobacco are the most dangerous drugs in society	**True:** Tobacco smoking is the leading cause of preventable premature mortality and disability in developed countries. The European Union is the heaviest drinking nations of the world and alcohol is linked to multiple health and social problems.
Drug testing is a good way to stop drugs being used in prison ☞	**True and false:** True if drug testing is linked to a drug treatment programme. False if random drug tests of the whole prison population as prisoners can tailor/adapt the use of drugs to beat the test (i.e. heroin only shows up in the urine test only three to four days after use). Individually decide on how to proceed with scoring this statement. Either give a score if the group answered parts of the questions correctly or allow the group to pick up a second statement card.
Coca Cola used to contain cocaine	**True:** Cocaine was present in Coca Cola until 1904 and then it was replaced by caffeine.

Annex 5 Common concerns about harm reduction

Common concerns about harm reduction

(partly adapted from Bulmistre et al., 2009)

"Harm reduction does not work"

Recent research shows that harm reduction in many settings is a useful and valid method in reducing drug related harm. It is a cost effective measure with a high impact on both individual and public health.

"Harm reduction encourages problem drug users to continue their use"

Many problem drug users, despite their strongest efforts, continue using drugs because they are unable to stop. Even though a "secure" environment, drugs are widely available in prisons throughout the world. Drugs can be smuggled into prison in various ways and this cannot be expected to be fully stopped.

For those who are unable to stop, unwilling to stop or who relapse into drug use, harm reduction is an effective measure in preventing overdose and in reducing the transmission of infectious diseases (like HIV/ AIDS and hepatitis B and C). Thus it is effective in protecting both individual and public health.
Harm reduction is often the only mechanism that links problem drug users to services and often is a first step towards dependence treatment. Harm reduction allows problem drug users to be reintegrated into society and to lead productive lives.

"Harm reduction keeps people stuck in their drug using pattern"

Harm reduction complements preventative measures for drug consumption and measures reducing the overall level of drug consumption, and assists those willing to stop using drugs.

In comparison to other drug treatments like detoxification or other drug free treatment, opioid substitution treatment, e.g. with methadone, is better at retaining people in treatment and more successful in reducing the consumption of heroin, thus preventing HIV infection and reducing drug related deaths.

In general, all drug use is harmful but through harm reduction, the dangers of continuous drug use can be constrained to some extent.

"Harm reduction encourages drug use among non-drug users"

This concern assumes that by assisting drug users to avoid problems, stay healthier and alive, drug use can be seen as safe and attractive to those who currently do not use drugs.

Research shows that after the implementation of harm reduction measures, drug use does not increase.

The concern that harm reduction might encourage drug use does not take into consideration the complexity behind an individual's decision to take drugs, which can include environment, life experiences and personality traits.

"Harm reduction threatens public safety"

This concern assumes that harm reduction measures might attract drug dealers and might threaten the public safety of the surrounding community. Research shows that the opposite happened and surroundings became safer. Concerns arose for example about the implementation of needle exchange pro-

grammes. In areas where needle exchange was introduced, petty crimes, often considered to be drug related like break-ins and burglaries, decreased.

Studies show that after the implementation of needle exchange programmes in prison:

- neither drug use or injecting drug use increased,
- syringes were not misused (e.g. as weapons),
- the disposal of used syringes was uncomplicated,
- even a reduction in drug use can result as needle exchange is embedded in an improved structure of drug counselling and treatment.

"Resources should be better allocated to abstinence oriented treatment than opioid substitution treatment"

Problem drug use can be seen as a chronic relapsing disease. Heroin, for example, is a drug that in a comparably short period of time leads to strong dependence and severe withdrawal symptoms upon cessation. Drug use over a long period of time can affect brain processes involved in motivation, attention, decision-making and the inhibition of impulses. The principle of harm reduction is to assist those people in protecting themselves from further harm such as infectious disease (HIV/AIDS, hepatitis B and C) and overdose.

Annex 6 Continuum of drug use – case studies

Continuum of drug use – case studies

1. Jim, 30 years old, had a severe car accident by the age of 22. Ever since, he has had to take strong pain killers. After a time he lost his job and started also taking illegal drugs like heroin. One day, Jim got arrested for petty crime. In the remand prison he starts to show symptoms of sweat, chills, headache and other flu-like symptoms.

2. Karen is 21 and unemployed. Her last boyfriend introduced her to heroin injecting. She now has a new boyfriend. He has suggested that she has sex with other men to earn money so they can obtain heroin and enjoy life together.

3. Peter attends an office party and drinks too much. On his way home, he is stopped by the police, breathalysed and subsequently banned from driving. Peter now uses public transport but does not mind too much because this allows him to have a drink before making his way home from work.

4. John, with his friends who were all under 21 years old, go out together on a Sunday evening. During the evening they drank six large beers followed by three shots. They then went on to a club where they took ecstasy. On Monday they all were at work by 9 am.

5. Linda is now stable on a methadone programme and her partner now looks after her two children. Her oldest son, who is 17 years old, has started to use cannabis/spice at the weekends.

Annex 7 True and false statements on HIV transmission: Answer key for the facilitator

True and false statements on HIV transmission: Answer key for the facilitator

Unprotected sexual contact	**True:** Vaginal and anal sex are high risk behaviours, oral sex is medium risk. The mucous membranes of the vagina and the anus are especially sensitive and often show small almost un-noticeable lesions. In respect of oral sex, inflammations or infections in the mouth are possible entry points for transmission. Small lesions, e.g. from brushing teeth do not play a significant role in the transmission of HIV.
Sharing needles for drug use	**True:** Sharing needles for drug use is a high risk behaviour as infected blood comes in direct contact with the bloodstream. Blood can survive for a certain time in a syringe depending on certain conditions such as temperature.
Open wounds of a non-infected person coming in direct contact with the blood of an HIV infected person	**True**: But only new wounds and ulcerating wounds pose a risk; wounds that have already closed and minor scratches coming into contact with infected blood do not pose a risk of infection with HIV.
Sharing tattooing and piercing equipment	**True:** Tattooing and piercing needles come into contact with blood.
Untested blood transfusion	**True:** In general transmission can take place, but this is very uncommon. In the 1980s and 1990s transmission via blood transfusion did take place. Nowadays, due to better testing of donated blood, transmission is almost non-existent in most European countries.
From mother to foetus during pregnancy	**True:** Infection can occur depending on the health status of the mother and if prophylaxis treatment has begun.
From mother to foetus during childbirth	**True:** Transmission can occur if there is contact with blood or vaginal secretions.
Breast feeding	**True:** Transmission can occur.
Needle-stick injuries	**True:** There is a risk of transmission via needle sticks with a medium risk as blood runs out of the wound. Nevertheless, a high virus concentration in the blood and a bigger injury can result in a higher risk of transmission. Transmission via needle stick is especially high for other infectious disease like hepatitis B and C.

Medical staff reusing needles and syringes	**True**
Living with an HIV positive person	**False**
Sharing eating utensils or drinking glasses	**False**
Shaking hands	**False**
Hugging	**False**
Kissing, French kissing	**False**
Petting and mutual masturbation	**False**: This is a safe sexual practice as long as no infected semen or vaginal secretions come into contact with the mucous membranes of the penis, vagina, anus or mouth.
Tears	**False**
Swimming in a public pool	**False**
Sneezing, coughing	**False**
Vomit	**False**
Urine	**False**
Stool	**False**
Mosquito bites	**False**

Annex 8 HIV transmission

HIV transmission

Main ways of HIV transmission

- Sexual contact (through genital secretion: sperm, vaginal secretions)
- Blood
- From mother to foetus/child

Activities with a risk of HIV transmission

- Unprotected sexual contact: Vaginal and anal sex are high risk behaviours, oral sex is medium risk. The mucous membranes of the vagina and the anus are especially sensitive and often show small almost non-remarkable lesions. In respect of oral sex, inflammations or infections in the mouth are possible entry points for transmission. Small lesions, e.g. from brushing teeth do not play a significant role in the transmission of HIV.
- Sharing needles for drug use: High risk behaviour as infected blood comes in direct contact with the bloodstream, blood can survive – depending on certain conditions like temperature – up to several days in a syringe. When heroin or other injectable drugs are prepared for injecting use, they are mixed with water and cooked up in a “cooker” (usually a spoon); afterwards the solution is filtered through a piece of cotton or cigarette filter. Sharing of this equipment is also related to potential transmission of HIV.
- Open wounds of a non-infected person coming in direct contact with the blood of an HIV infected person: Only new wounds and ulcerating wounds pose a risk; wounds that have already closed and minor scratches coming into contact with infected blood do not pose a risk.
- Sharing tattooing and piercing equipment: Risk of infection because equipment comes in direct contact with blood.
- Untested blood transfusion: In the 1980s and 1990s, transmission via blood transfusion did take place. Nowadays, due to better testing of donated blood, transmission is almost non-existent in most European countries).
- From mother to foetus during pregnancy: Infection can occur depending on the health status of the mother and if prophylaxis treatment, to protect the baby from transmission, has been started.
- From mother to foetus during childbirth (transmission occurs over contact with blood or vaginal secretions).
- Breast feeding: Transmission can occur as the virus concentration in breast milk is high enough.
- Needle-stick injuries: There is a risk of transmission via needle sticks with a medium risk as blood runs out of the wound. A higher risk of transmission exists when a high virus concentration in the blood is combined with a bigger injury. Transmission via needle stick is especially high for other infectious diseases like hepatitis B and C.

Activities without risk of HIV transmission

- Living with an HIV positive person
- Sharing eating utensils or drinking glasses
- Shaking hands
- Hugging
- Kissing, French kissing

- Petting and mutual masturbation (This is a safe sexual practice as long as no infected semen or vaginal secretions come into contact with the mucous membranes of the penis, vagina, anus or mouth.
- Tears
- Swimming in a public pool
- Sneezing, coughing
- Vomit
- Urine
- Stool
- Mosquito bites

Annex 9 Definitions of mental health

Definitions of mental health

“Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

World Health Organization, October 2009
http://www.who.int/features/factfiles/mental_health/en/index.html

“Mental health has been defined variously by scholars from different cultures. Concepts of mental health include **subjective well-being**, **perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential**, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however, generally agreed that mental health is broader than a lack of mental disorders.”

World Health Organization (2001). The world health report 2001 - Mental Health: New Understanding, New Hope.

http://www.who.int/whr/2001/chapter1/en/index1.html

“Being mentally healthy does not just mean that you do not have a mental health problem. If you are in good mental health, you can:

- make the most of your potential
- cope with life
- play a full part in your family, workplace, community and among friends

Some people call mental health ‘emotional health’ or ‘wellbeing’ and it is just as important as good physical health. … Good mental health is characterised by a person’s ability to fulfill a number of key functions and activities, including:

- the ability to learn
- the ability to feel, express and manage a range of positive and negative emotions
- the ability to form and maintain good relationships with others
- the ability to cope with and manage change and uncertainty”

Mental Health Foundation
http://www.mentalhealth.org.uk/information/mental-health-overview/mental-health-introduction/

Annex 10 Blank forms: risk and protective factors regarding drug use

Risk and protective factors regarding drug use

Risk factors	Protective factors

Risk factors	Protective factors

Annex 11 Possible risk and protective factors regarding drug use

Possible risk and protective factors regarding drug use

At the level of the individual

Risk Factors	*Protective Factors*
• Poor social skills • Low self-esteem • Physical and mental problems • Sensation seeking • Early exposure to substance use (e.g. being a child of a substance user) • Dislike of school • Poor school performance • School dropout • Positive perceptions of substance use	• Good social skills (decision making, problem solving, coping skills, interpersonal/ social skills) • High self-esteem (independence and ability to cope with stress) • Physical and mental wellbeing (optimism, empathy, insight, intellectual competence) • Late exposure to substance use • Desire to be in school • Good performance in school • Critical attitude towards substance use

At the level of the environment

Family • Family disruptions • Divorce or death • Poor parenting skills • Parents and siblings who use substances • Family violence and rejection **Resources** • Extreme economic deprivation leading to lack of basic resources such as shelter and opportunities for education **Community** • Lack of recreational activities • Extreme economic deprivation (high unemployment rates, inadequate housing, high crime rates) • Reduced access to health and social services • Presence of substance use behaviours, peers using substances • Lack of reinforcement of existing laws and norms • Availability and easy accessibility of substance(s) • Low cost of the substances • No age limit on the purchase of substances	**Family** • Positive attachments that encourage caring and bonding (families, social and religious attachments) • Few stressful life events • Parental monitoring, structured and supportive family environments, effective parenting skills **Resources** • Little material conflict, • Adequate income and shelter **Community** • Availability of recreational activities • Availability of employment opportunities and of economic enhancement, • Access to health and social services • Favourable neighbourhood and an environment that encourages a healthy lifestyle • Effective policies and law enforcement that limit availability of substances; controlled advertising; taxation and substance free spaces (e.g. non-smoking areas)

Annex 12 Case study 1

Case study 1

Janis is a 19-year-old shop worker. At arrival at the prison she requests testing for hepatitis C. In a discussion of risk factors, she admits to occasionally using heroin and thinks that she might be pregnant.

Annex 13 Case study 2

Case Study 2

Children can remain with their mothers in prison up until they are three years old. After the age of six months, children have to be in the nursery during the day while their mothers are at work. This can be distressing for some mothers. What can be done to reassure the mothers and reduce their distress?

Annex 14 Statements on condom negotiation

Statements on condom negotiation

- We are both HIV infected, what's the use of a condom?
- I don't feel anything if I wear a condom!
- I don't have a condom with me!
- Condoms are too small for me!
- Only this one time without a condom!
- If you don't want to become pregnant, why don't you use the pill?
- If you do it orally, nothing will happen!
- Condoms just break!
- You wouldn't ask me this if you loved me!
- Do I look infected?
- I will take it out before the end, nothing will happen!
- Do you mistrust me?

Annex 15 Key concepts of sexuality

Key concepts of sexuality

SEX

The term ‘sex’ refers to someone’s biological characteristics – anatomical characteristics of a man or a woman (breasts, vagina, penis, testicles), i.e. the properties that distinguish organisms on the basis of their reproductive roles.

Sex is also a synonym for sexual activities or practices associated with sexual intercourse, which includes all types of it – vaginal, oral, and anal.

SEXUALITY

‘Sexuality’ is a much wider term than sex or sexual intercourse. Many people associate it with sex and confuse them.

Sexuality is an expression of who we are as human beings. It is an integral part of the personality of every human being. Sexuality begins before birth and lasts through the life span. Sexuality includes all feelings, thoughts and behaviours of being male or female, relationships, feelings and sexual activity. Sexuality is shaped by values, attitudes, behaviours, appearance and emotions. The expression of sexuality is influenced by culture, morality and spirituality. The full development of sexuality is essential for individual, interpersonal, and societal well being.

A simple way to explain the complex term of sexuality is to describe the three basic aspects that form sexuality – biological, psychological and social aspects.

Sexuality has its biological beginnings with primary sexual characteristics present already at birth. Hormonal activity is very important for the development of secondary sexual characteristics during puberty – that characterise the outer appearance of being a male or a female. Hormones play an important role in our reproductive life cycles and sexual life. Also, we can’t ignore simple anatomy – not just genitals, but also hair, skin, and body - all physical makeup is about our sexuality.

Thoughts, feelings and behaviours form a psychological part of sexuality. For example, what do you think of your body and how do you feel about that? Answers to these questions will influence how comfortable people are with their sexuality – their behavioural style. We express our sexuality by the way we move our body – consciously and unconsciously.

Sexuality is also about values, norms and roles – that is the social component of sexuality. What is acceptable and not acceptable in sexuality at any given time and culture? What is an acceptable role of a man or a woman, a mother or a father? We learn all these things from the environment we live in.
The biological, psychological and social components are interconnected; they influence and supplement each other.

REPRODUCTIVE HEALTH

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Reproductive rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence. Reproductive rights may include some or all of the following rights: the right to legal or safe abortion, the right to control one's reproductive function, the right to access quality reproductive health care, and the right and access to education in order to make reproductive choices free from coercion, discrimination and violence. Reproductive rights may also be understood to include education about contraception and sexuality transmitted infections, and freedom from coerced sterilization and contraception.

(World Health Organization and International Planned Parenthood Federation)

SEXUAL HEALTH

Sexual health includes all aspects of sexuality not necessarily related to reproduction. It recognizes the fact that people may have sex for the purposes of pleasure, not just reproduction and that people have health needs related to such sexual activity.

"Sexual health means having a responsible, satisfying and safe sex life" (International Planned Parenthood Federation).

The basic elements of sexual health include:

- A sexual life free from disease, injury, violence, disability, unnecessary pain, or risk of death
- A sexual life free from fear, shame, guilt, and false beliefs about sexuality
- A capacity to enjoy and control one's own sexuality

(International Women's Health Coalition)

Sexual health and reproductive health are overlapping terms, and usually the term sexual and reproductive health is used to include all aspects of health related to sexuality and reproduction.

Annex 16 World Association of Sexology Declaration of Sexual Rights

World Association of Sexology Declaration of Sexual Rights

(Adopted in Hong Kong at the 14th World Congress of Sexology, August 26, 1999)

1. **The right to sexual freedom.** Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation and abuse at any time and situations in life.

2. **The right to sexual autonomy, sexual integrity, and safety of the sexual body.** This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.

3. **The right to sexual privacy.** This involves the right for individual decisions and behaviours about intimacy as long as they do not intrude on the sexual rights of others.

4. **The right to sexual equity.** This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.

5. **The right to sexual pleasure.** Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well being.

6. **The right to emotional sexual expression.** Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.

7. **The right to sexually associate freely.** This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.

8. **The right to make free and responsible reproductive choices.** This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.

9. **The right to sexual information based upon scientific inquiry.** This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.

10. **The right to comprehensive sexuality education.** This is a lifelong process from birth throughout the life cycle and should involve all social institutions.

11. **The right to sexual health care.** Sexual health care should be available for prevention and treatment of all sexual concerns, problems and disorders.

Sexual Rights are Fundamental and Universal Human Rights

Annex 17 Common views on sensitive sexual issues

Common views on sensitive sexual issues

Any sexual behaviour between two consenting adults is acceptable.

A person can lead an absolutely satisfying life without sex.

Sex is good, even in prison.

Anal sex is normal behaviour.

Sex in a women's prison is more acceptable than in a men's prison.

All prisoners practicing sexual activities with persons of the same sex are homosexuals.

I can accept that there can be love and sex between prisoners and staff members.

Condom distribution in prison can encourage sexual activities.

A real man does not have sex with a man.

Sexual orientation is a free choice for every person.

Homosexuals use children for their pleasure.

I would feel comfortable listening to a prisoner telling me about sexual activities with persons of the same sex.

I would not feel comfortable working with a colleague who has sexual activities with a person of the same sex.

Annex 18 Vocabulary on sexuality

Vocabulary on sexuality

Vocabulary on sexuality to be written on cards:

Sexual identity

- *Biological sex*
- *Gender identity*
- *Gender roles*
- *Sexual orientation*
  - *Heterosexuality*
  - *Homosexuality*
  - *Bisexuality*
- *Paedophilia*
- *Transvestite*
- *Transsexual*
- *Homophobia*

Definition of vocabulary on Sexuality and Sexual Behaviour

☞ Use the following definitions of the terms to fill the gaps in knowledge.

Sexual identity refers to how people view themselves sexually, which include four main elements:

- **Biological sex** is based on our physical status of being either male or female.

- **Gender identity** is how we feel about being male or female. Gender identity starts to form around the age of two when a child realizes the difference to the opposite sex.

- **Gender roles** are socially and culturally defined attitudes, behaviours, expectations and responsibilities for males and females. It includes society's expectations of us based on our biological sex.

☞ Draw a line on the flipchart and name it "gender roles". Explain that often, a person's sexual orientation is confused with gender roles. Label one end of the line "masculinity" and the other end "femininity". For example when a man acts in a feminine manner he is considered homosexual, but this may not be true because sexual orientation and gender roles are different. Men can have feminine traits and women can have masculine traits.

- **Sexual orientation** refers to the biological sex we are attracted to romantically. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), and homosexual (attracted to the same sex).

☞ You can use the following method to clarify visually terms about sexual orientation. Often people mix up sexual orientation with gender role stereotypes or sexual behaviour.
Draw a line across the top of the flipchart and name it ”sexual orientation”. Label one end of the continuum “heterosexuality” and the other end ”homosexuality”, in the middle write “bisexuality”. Explain that the range from heterosexuality to homosexuality is a continuum. Sexual orientation of most individuals falls somewhere along this continuum.

- **Heterosexuality** is the erotic and romantic attraction (preference) to the members of the opposite sex
- **Homosexuality** is the erotic and romantic attraction (preference) to the members of the same sex
- **Bisexuality** is the erotic and romantic attraction (preference) to members of both sexes.

☞ Then draw the third line naming it “sexual behaviour”. Explain that a person’s sexual behaviour does not always indicate his or her sexual orientation. Label one end of the line “sex with men” and the other “sex with women”. One or more sexual contacts with members of their own sex do not mean homosexuality. That refers to so called “situational homosexuality” – in isolated settings persons can have sexual contacts with members of their own sex but do not consider themselves and are not considered by others to be homosexual. This can partly explain some prison homosexual behaviours.

Homosexuality sometimes is misinterpreted as paedophilia. It is important to set a clear distinction between these terms. **Paedophilia** is specified as a form of paraphilia in which an adult experiences sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age.

Many people confuse the term “homosexual” with two other terms – transvestite and transsexual. **Transvestite** refers to a person who cross-dresses, which means wearing the clothing of the opposite sex. **Transsexualism** is a condition when a person’s "gender identity“ (self-identification as woman or man) is not matching his/her "assigned sex" (identification by others as male or female based on physical/genetic sex). Neither terms refer to sexual orientation.

Homophobia is defined as an "irrational fear of, aversion to, or discrimination against homosexuality or homosexuals".

Annex 19 Checklist: Prison staff are key!

Prison staff are key!
(adapted from UNODC)

- Have you been trained to enable you to do your duties in a healthy and safe manner?
- Have you been trained in the provision of first aid?
- Do you have access to protective equipment, such as latex gloves, masks for mouth-to-mouth resuscitation, etc?
- Do you follow safe work procedures and, in particular, safe searching procedures?
- Are you familiar with the protocol for managing exposure to blood and/or body fluids?
- Have you been vaccinated against hepatitis B?
- Do you facilitate the work of peer educators and external civil society organizations and professionals?
- Do you actively support making condoms available to prisoners, or at least tolerate it and do not interfere with distribution?
- Do you support measures against sexual abuse in your prison, by taking active measures to protect vulnerable prisoners and denouncing abuse whenever it comes to your attention?
- Do you actively support making bleach and needles and syringes available to prisoners, or at least tolerate it and do not interfere with distribution?
- Finally, do you protect yourself against HIV and other infections outside your work hours?

Annex 20 Potential stress factors

Potential stress factors

Work-related stress

- Delayed or out of touch decision-making
- Lack of support
- Unsociable working hours
- Competing demands on time
- Competing roles (e.g. security and care)
- Powerlessness/ lack of consultation
- Lack of variety in working tasks
- Lack of recognition
- Lack of communication
- Friction with colleagues or supervisors
- Keeping up with new tasks
- Inadequate training
- Taking work home
- Difficult prisoners (e.g. unpredictable, abusive, unreasonable)
- Threatening situations
- Poor working conditions
- Uncertainty about the future
- Travel to work
- Institutional politics

Non-work related stress

- Noisy neighbours
- Relationship problems
- Financial worries
- Illness
- Children
- Moving house

Annex 21 What is bullying?

What is bullying?

- Bullying is actions, criticism or personal abuse in public or in private, which is offensive, intimidating, malicious or insulting.
- Bullying behaviour at work can occur between personnel of the same sex, or opposite sex, between personnel of the same grade, by a manager to a subordinate or by a subordinate to a manger.
- It is usually persistent, systematic and ongoing behaviour.
- For example, stopping a person from speaking by using aggressive and/or obscene language: constantly interrupting, publicly humiliating or ridiculing someone; finding fault, withholding information or setting meaningless tasks.

Bullying behaviour can have a serious impact on individual victims. They can feel threatened, upset, humiliated and vulnerable. Bullying can also undermine people's self confidence as well as increasing their stress levels. Bullying also impacts on the effectiveness and efficiency of the whole prison where staff have low morale and increased absenteeism related to bullying.

Bullying can also have a serious impact on the effectiveness and efficiency of the whole prison. This is because bullying reduces staff morale and increases the rate of absenteeism.

Techniques to deal with bullying

- Do not be tempted to strike back at the bully or be aggressive. You should try to be assertive. Firmly tell the person to stop, that you don't like what they are doing and then simply walk away.
- Give out the message that you refuse to be a helpless victim.
- Confide in someone you trust at work.
- Consult the anti-bullying strategy, if there is one, and follow the suggested procedure.