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An overview study:
Assistance to drug users in European Union prisons

Abridged version

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I. INTRODUCTION

At its Helsinki meeting in December 1999, the Council of the European Union formally adopted the European Union drugs strategy (2000–04). The strategy has been translated into concrete action in the third EU action plan on drugs. The action plan recommends that the Commission and Member States join efforts to reduce crime linked to drugs, notably juvenile and urban delinquency. Within this context, the EMCDDA contributes proactively to informing policy-makers and the public about drug users and drug addicts in the criminal justice system, including after arrest, alternatives to prison and treatment facilities within the penal system in EU Member States.

In line with EU priorities, the EMCDDA launched the study 'Assistance to drug users in European Union prisons' in December 1999. The aim of the study – commissioned from Dr Heino Stöver from the University of Oldenburg – was to provide an overview of the situation and the demand and harm reduction responses in a setting characterised as being enormously relevant to Member States' efforts to reduce crime linked to drugs. This abridged version highlights the main findings of the extensive research that was undertaken during the course of this project. The full report will be published by ENDHASP (European Network on Drugs and HIV/AIDS Services in Prison) in collaboration with the EMCDDA and will be available by the end of 2001.

Margareta Nilson
Programme coordinator – Drug-related responses

II. DESCRIPTION OF THE SITUATION

KEY FACTS

Drugs are seen as one of the main problems of the current prison system in Europe and in other countries in the world. The high costs of incarceration are of great concern.

In most European prisons the spread of drug use has become a real problem. Some experts say that prisons provide environments that sustain substance abuse among users and even foster drug use in non users and some empirical evidence exists to support this. Drugs are widespread, used as addictive substances or to cope with lack of work, stress and boredom behind bars. Psychoactive substances seem to be easily available in many prisons, although the frequency of use differs from drug use in the community. Many prisoners report that drugs are the central currency in prison. In some countries there is a widespread use of psychoactive medication – in particular by women – prescribed by prison doctors.

It is difficult to draw a detailed picture of prison drug use in one country and even more so for the 15 Member States. Drug use in prison takes place in extreme secrecy. According to estimates by the UN and WHO and information provided by EMCDDA Reitox focal points, drug users are proportionally over represented among the 350 000 people imprisoned throughout Europe. Figures of lifetime prevalence of any illicit drug given by European prisons differ widely, from 15 to 90%. Considering the high number of prison entrances and releases (turnover rate), 180 000–600 000 drug users pass through the system annually.

Drug-using patterns by young offenders show less cautious attitudes to drug use and include higher risks in injecting drug use. This may be due to feelings of inviolability.

II.1. Definitions

The variety of definitions for the term ‘drug user’ in the prisons and prison administration in different Member States (see Table 1) needs to be taken into account when interpreting the estimated number of drug users (shown in Table 2). Although all EU countries report that drug users are a significant and extremely problematic part of the total prison population, only a few countries provided clear definitions of the term. It has recently been pointed out that none of the reporting countries in their Council of Europe survey *"has a comprehensive system to quantify the scale of this problem, even though in most countries it is assumed that this group makes up a significant part of criminal justice and prison populations"* (Turnbull/McSweeney, 2000).

Often the definition focuses very generally on the length of drug use and the type of drug being used. Broad or even non-existent definitions make it extremely difficult to compare the situations of drug-using prisoners in different countries.

Table 1: Examples of definition of drug users in prison

Country	Definition	Source
Belgium	"Any user of sleeping pills, narcotics and other psychotropic substances that can create dependence and for which the user has no medical prescription"	Ministry of Justice
Denmark	"Drug addicts are defined as persons who more than just a few times have taken one or more euphoriants within the last six months before incarceration"	Ministry of Justice, 3 July 2000
France	"Regular use of drugs or of psychoactive medication, diverted from its proper use, during the year preceding the date of imprisonment."	Charlotte Trabut French Report to Pompidou Group, 2000
Germany	"Drug addicted is used as a synonym for a user of one or more drugs with a physical or psychological dependency potential"	State of North Rhine Westfalia, Germany
Portugal	"Drug use by drug in use (both legal and illegal drugs included)"	Machado Rodrigues, L. 2000
Spain	"Suffer from problems related to the consumption of psychoactive substances"	Garzon, Otamendi/Silvosa 20000
Sweden	"The notion of drug misuse covers all forms of drug use without a medical prescription. Anyone known to have misused drugs during the twelve months prior to deprivation of liberty is classified as a drug misuser"	Ekström et al. 1999

II.2. Characteristics of drug use in prisons

The number of prisoners in the 15 Member States of the European Union is estimated to be 350 000 – a ratio of 94 per 100 000 inhabitants – as compared with 645 in the USA.

The highest prison population per 100 000 inhabitants (see Table 2) is found in Portugal, Spain, England/Wales and Scotland, followed by Germany, France and Italy. However, the rate per inhabitant is lower in the Scandinavian countries (Finland, Denmark, Sweden) and in Ireland. The average percentage of females in the prison population is between 2.5 and 6%. There are three exceptions – Spain (9.2%) and Portugal (9.7%), where the female prison population is comparatively high and Denmark where the female prison population (0.5%) is the lowest. The Netherlands, Italy and France have the highest proportions of remand prisoners among their total prison population (60.1, 45.5 and 38.7% respectively).

In Table 2 it is important to note that the figures represent inmates on any one day and not the total population during a year. This figure has to be multiplied with the 'turnover rate' (all prisoners being in prison over one year in relation to the cross-sectional data above) which is about an average of 3 in the EU countries.

The figures differ widely not only because of the different levels of drug use in prison but also due to the different definitions applied. The prevalence of drug use varies to a very great extent. Drug use is more widespread in:

- female than in male prisons;[1]
- city prisons than in prisons in the countryside;
- juvenile than adult prisons;
- prisons with high percentage of drug user/dealer near a border.

Table 2: Prisons, prisoners and ratio per 100 000

Country	Total number of prisons[3]	Total number of prisoners (including remand prisoners)	Number of female prisoners (%)	Ratio per 100 000 inhabitants	Date
Austria	29	6 973	406 (5.8%)	84	10/2000
Belgium	33	7 867	331 (4.4%)	78	31.12.98
Denmark	14	3 477	177 (0.5%)	65	Average 1999
Finland	22	2 663	132 (5%)	56	31.12.99
France	185	52 122	1 938 (3.7%)	90	1.7.2000
Germany	222	76 495	3 473 (4.5%)	94	31.3.2000
Greece	28 [1]	7 280 [1]	436 (6%)	51 [7]	*
Ireland	18 [1]	2 983 [1]	80 (2.7 %) [7]	79	*
Italy	220	51 604 [4]	2 580 (5%)	90	*
Luxembourg	2	380	22 (5.8%)	89,83	*
Netherlands	39 [1]	12 553 [1]	564 (4.5%)	75	*
Portugal	53	12 937	1 410 (9.7%)	147	15.12.1999
Spain		38 365 [5,6]	3 523 (9.2%)	96.6	1.1.1999
Sweden	55	5 484	3 12 (5.7%)	61.8	1.10.2000
England/ Wales	132 [1]	65 298 [1]	2 299 (4.1%) [7]	106.8 [7]	*
Scotland	15	6 029	212 (3.5%)	118.0	1999

[1] according to Muscat 2000; [2] Koulierakis et al. 1999; [3] including all custodial establishments; [4] DAP – Justice Department; [5] not including Catalonia sovereign in this field, [6] according to statistics on the prison population from the Directorate General of Penitentiary Institutions;[7] 1st September 1996 (Council of Europe) [8]
* = not available.

It is difficult to draw a detailed picture of prison drug use in one country and even more so for the 15 Member States. Drug use in prison takes place in extreme

[1] Except Belgium where more woman are incarcerated for drug offences, but less drug use in female prison sections occurs .

secrecy and isolated factors such as figures of seizure quantities, discovery of needles/syringes or positive urine testing rates taken on their own only reflect only a part of the situation. Patterns of drug use vary considerably between different groups in the prison population. For instance, drug use among female prisoners is significantly distinct from men, with different levels and types of misuse and different motivations and behavioural consequences. Only by collecting and collating several types of data can an impression of drug use in prison be gained. A typical profile for the group of drug users finally ending up in prison would include the following characteristics: very socially deprived, often poly-drug users, with several stays in prison, several treatment attempts, high incidence of relapse, with severe health damage (including irreversible infectious diseases).

There are different factors which might indicate the extent of drug use in prison. On the one hand there are scientifically acquired data such as prevalence studies, which often reflect the situation in no more than one prison. Due to the heterogeneous nature of the population from one prison to another in one region and in one country, these isolated cross-sectional studies cannot be taken as representative of the situation as a whole – juvenile and women's prisons, and prisons with many migrants may have totally different drug use prevalence figures.

The number of drug-law offences in most EU countries has consistently risen over the past 15 years. Accordingly the number of drug users in prisons has risen: ENDHASP (European Network of Drug and HIV/AIDS Services in Prison) estimated that 46.5% would be users of illegal drugs prior to imprisonment. The EMCDDA Annual Report (1999) signals that between 15 and 50% of prisoners in the European Union have or have had problems with illicit drug use.

Table 3: Proportion of drug users among prisoners

Country	Proportion of drug users among prison population	Date of data
Austria	10–20%	2000
Belgium	32–42%	1.12.93
Denmark	19–36%	1999
Finland	15.2–31%	1.5.1999
France	32%	1997
Germany	20–30%	31.3.1999
Greece	26–33%	1995
Ireland	30–52%	1998
Italy	25–29% (15 097)	31.12.99
Luxembourg	36%	1.6.1999
Netherlands	14–44%	1997/8
Portugal	37.7–70%	31.12.98
Spain	35 –54%	*
Sweden	47%	1.10.1999
England/Wales	15–29%	*

[2] Except Belgium where more women are incarcerated for drug offences, but less drug use in female prison sections occurs.

Scotland	18–33%	1998

* not available

II.3. Specific groups – migrants, women and young offenders

The proportion of prisoners with foreign nationality or of other ethnic origin (as far as figures are available) is very high in all countries (average 18–20%) except for Ireland, and is above the average of the migrant proportion in the general population. "*This high proportion of migrants in prisons shows clearly the need for improvement of group specific research and information for ethnic minorities and foreigners*" (Rotily/Weilandt 1999).

Criminality seems to be to a wide extent a male problem – women on average representing approximately 5% of inmates in European prisons. This ranges from 1.8% of the total prison population in Greece, to 3% in the Netherlands, 5% in Germany, 5.7% in Sweden and 9.2% in Spain. Some countries indicate that the number of imprisoned women has risen considerably over the past decade. In Spain between 1987 and 1999 the number doubled. In England and Wales this rise happened in just over a six-year period. The English Home Office report 'Women and the criminal justice system' in 2000 states that women tend to have shorter criminal histories than men and 'grow out' of crime earlier, but are more likely to be arrested for less serious offences. The reasons for incarceration are generally shoplifting and other forms of minor theft. The report also reveals that 55% of imprisoned women have children under the age of 16 and more than a third have a child under the age of five. The percentage of drug users among women prisoners is very high in most EU countries.

In some countries, data suggests that two thirds of women entering prison report a history of severe drug and/or alcohol use prior to imprisonment. Poly-drug use is a widespread pattern. Between one half and three quarters of drug-using women earn money for drugs through prostitution (compared with 10% of men).

Female inmates often have more health problems than male inmates. Many suffer from chronic health conditions resulting from poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition and poor preventative health care. Many HIV-positive women do not receive the diagnostic and treatment services that could benefit them as early as do HIV-positive men. Also, the needs of HIV-positive women differ from those of men, and social and community support are often less frequently available and less accessible.

HIV prevalence among female prostitutes was two or three times higher than for women outside prostitution. It seems that prostitution is a behavioural marker for a high co-morbidity with sexually transmitted diseases and hepatitis infections, a high level of everyday stress, and a higher level of drug use. Women also seem to start taking drugs earlier.

The misuse of prescribed drugs is a major health threat. It is said that in some countries (England and Wales, France, Germany) there is a widespread use of psychoactive medication – in particular by women – prescribed by prison doctors.

Drug-using patterns by young offenders may be different from adult ones both in the community and in prison. An epidemiological study carried out on young offenders

found extremely high risk patterns and sero-conversions (HIV, Hepatitis B and C) and many prison experts confirm this pattern. They report less cautious attitudes to drug use and higher risks in injecting drug use. This may be due to feelings of inviolability. This behaviour becomes extremely important in the prophylaxis of blood-borne viruses.

III. ORGANISATION AND PRACTICE OF HEALTH CARE AND ASISTANCE PROVIDED TO DRUG USERS IN PRISONS

KEY FACTS

In all but three of the countries examined (France, Italy, and partly in England and Wales) health care matters are the responsibility of the Ministry of Justice. Sometimes there are drug strategy units which develop specific drug strategies for the whole or part of the country (for example the 'Prison service drug strategy' for England and Wales), or sometimes only for certain regions. In some countries (such as Denmark) specific steering groups have been set up to observe and monitor developments and attempt to improve health care for prisoners, especially for drug using inmates[3].

A number of studies have identified disparities between services inside and outside for drug and alcohol treatment. A variety of international recommendations exist which use the principle of equity as a basic supposition for the treatment and care of drug using prisoners. This principle means that prisoners should have access to the same medical and health care services as they would have outside and that the external professional standards of care and cure should be applied in prisons.

Medical services are available in all European prisons in one form or another. Larger penal institutions mostly have their own medical units, while smaller units work closely together with doctors from the community.

III.1. Models characterised by being under the responsibility of the Ministry of Justice

Prison hospitals and prison-based psychiatric hospitals for 'mentally disturbed criminals' in certain regions are models for the majority of countries in which medical care is the responsibility of the Ministry of Justice.

In most European countries treatment plans are provided for every prisoner for the duration of their prison sentence. This is also the case for former drug-using prisoners. Most countries use a model of mixed professionals for the care of drug users: external experts are integrated for consulting and therapeutic purposes and assist internal professionals in charge of care issues. This type of organisational structure enhances the link between prisons and the community and ensures the

[3] e.g. Denmark the Directorate of Prisons and Probation has appointed a permanent working group whose task it is to keep up with development in the area of alcohol and drugs to consider the principles and possibilities of treatment in relation to users in the institution system of the Directorate.

continuity of treatment for both drug users entering prison and convicts leaving prison.

III.2. Models characterised by being under the responsibility of the Ministry of Health

France, Italy and England and Wales are described below because they have reorganised their health care services in prison and form an exception[4] to the above general rule.

France. As a result of by-law no. 94-43 dating from 1994 responsibility has been transferred from the French Ministry of Justice to the Ministry of Health. Each penal institution cooperates closely with a general or psychiatric hospital team nearby. These hospital teams provide medical and psychiatric care in the prison. It is the responsibility of the psychiatrist in charge to provide drug counselling and treatment services. In 16 large, short-stay prisons there are specialised treatment centres for drug addicts which are aimed at preparing prisoners for release and coordinating help facilities in the region. In a few recently built prisons, health care for prisoners is sub-contracted to the private sector. In the other 170 prisons, external specialist treatment centres are responsible for drug services which supplement the care of the medical teams inside and are responsible for preparing drug dependent prisoners for release. Privately managed correctional establishments are themselves responsible for providing medical services in accordance with the principles and guidelines laid down by the health authorities.

Italy. A new law[5] has radically changed the position on assistance to drug users in prisons in Italy. From 1.1.2000 assistance given to drug users is the responsibility of the local Addiction Treatment Units (SERTs[6]) which are part of the National Health Service. This '*decreto legislativo*' changed completely the way that assistance to drug users is given in prison, as it is no longer the responsibility of the prisons system.

England and Wales. Rapid development of drug services in prisons is currently going on. Besides the promotion of 35 detoxification programmes, the increase in the number of rehabilitation programmes from 16 to 42 and the increase in the number of therapeutic communities from 4 to 6, CARATS (counselling, assessment, referral, advice and throughcare service) was introduced in October 1999. This is to be an integrated, overall strategy focusing on the needs of the great majority of prisoners. This strategy comprehensively links different services, which in some other European countries are separate: prisons, community services and probation. CARATS must be available in every penal establishment via local, cluster or area contacts with community agencies working in conjunction with prison and probation staff.

Although CARATS and the drug strategy is still in the hands of the Prison Services, the rest of the healthcare system is now under the responsibility of the Department of Health into which the Prison Service Directorate of Healthcare has been moved.

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[4] A shift from responsibilities for health care from the Ministry of Justice to Ministry of Health is called for by several experts (e.g. for Ireland: Dr. Joe Barry 2000 in Irish Times 9 Nov. 2000).

[5] This is a temporary law that needs to be converted into effective law by Parliament. Parliament could refuse this; however, in the meantime, it is enforced.

[6] SERTs normally operate in the community and some of them in prisons as well.

III.3. The principle of 'equity' in international guidelines and recommendations

Although the United Nations has stated that persons 'deprived of liberty' retain all other rights, and most countries are signatories to this convention[7], the realities of prison life – and death – are grim. Disease transmission in prison and the impact on the general community provides ample reason to consider the public health implications of incarceration. A number of studies have identified disparities between services inside and outside of prison, in the fields of diabetes[8], mental health[9] and drug and alcohol treatment. A variety of international recommendations exist which use the principle of equity as a basic supposition for the treatment and care of drug-using prisoners. This principle means that prisoners should have access to the same medical and healthcare services as they would have outside and that the external professional standards of care and cure should be applied in prisons.

In some countries the principle of equity of care and provision for the continuity of care is explicitly formulated in official government papers (for example in Ireland). In practice, however, healthcare provision equivalent to that available in the community is hardly ever achieved – at least for drug-using inmates. A European study on the 'Implementation of international guidelines on HIV/AIDS in prisons of the European Union' found that the WHO guidelines on 'HIV/AIDS in prisons' (1993) are not being uniformly applied in EU prisons. "*In general, the principle of equity between HIV services in prison and in the community is not applied. In particular, many of the WHO recommendations on HIV/AIDS in prisons are not implemented*", (O'Brien/Stevens, 1997). One reason for this is that different government departments are responsible for the care of drug users in the community than for the care of drug users in prison. This situation creates inherent problems for the continuity of care of drug users.

III.4. General health services and examination

Medical services are available in all European prisons in one form or another. Larger penal institutions mostly offer their own medical units, while smaller units work closely together with doctors from the community.

In nearly all European prisons every inmate is seen by the prison doctor within the first 24 hours of admission for a medical check. Nearly all prisons have a health unit including doctors, nurses and psychologists. Smaller prisons often rely on private contract doctors. The size of the team varies according to the prison and its capacities.

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[7] Standard minimum rules for the treatment of prisoners: http://www.unhchr.ch/html/menu3/b/h_comp34.htm

[8] MacFarlane, I. A., 'The development of health-care services for diabetic prisoners'. Postgrad Med J 1996; 72: 214-217.

[9] Hargreaves, D., 'The transfer of severely mentally ill prisoners from HMP Wakefield: a descriptive study'. J Foren Psych 1997; 8: 62-73.

Patients with special health needs are mostly referred to the prison hospital. They may also be referred to other facilities in the prison system or to general health services.

In all EU countries, HIV tests are generally available for prisoners, mainly on admission. In some countries, tests are offered systematically to all prisoners entering prison. In practice though there are differences in how proactively this is done.

In most countries, prisoners are tested according to a clear protocol[10] with an informed consent procedure. The HIV test results are normally not communicated to the prison administration, are strictly confidential and kept in the health record. However, in some prisons, HIV positive results are communicated to prison directors. A study carried out in 1997 found that in a third of 23 examined prison systems the identity of seropositive prisoners is routinely communicated to the prison administration. In seven other systems, the identity of seropositive prisoners is communicated 'when necessary' to the prison administration.

In a few countries, positive HIV tests have certain consequences for prisoners. In some states of Germany, and also in Greece, HIV-infected prisoners may be placed in single cells, and if they want to share a cell with other persons other inmates are informed about their serostatus. In some countries, HIV-positive (as well as hepatitis B and C positive) inmates are excluded from kitchen and/or barber work. Here again, the situation is difficult to evaluate because within each prison system the directors have a discretionary power which allows them to freely organise the placing of prisoners.

[10] For instance, in the Netherlands 'Protocol HIV-Testbeleid in Justitele Inrichtingen' from July 1994.

IV. INTERVENTIONS WITH A FOCUS ON DEMAND REDUCTION

KEY FACTS

Drug services in EU prisons have undergone considerable development recently. There is an appreciable and increasing range of interventions focusing on drug users in prison. A study of 15 European Union Member States concludes that all of them provide some form of treatment activity in their prison system[11]. Despite that, there appear to be large gaps in the adequate provision of treatment, care and prevention in prison systems. WHO/UNAIDS (1997) confirm this in a study of 23 prison systems in 20 European countries, representing 387 000 prisoners.

IV.1. Abstinence-oriented treatment

Abstinence-oriented treatment for prisoners is provided predominantly in special facilities (drug-free wings, therapeutic communities) – and is the dominant approach in existing interventions. Some countries have shown an increase in drug-free areas since the mid-nineties of three- to fourfold (Austria, England and Scotland). Access to these programmes is voluntary under certain conditions and sometimes even with certain contracts for behavioural change. The central objective is abstinence, and therefore urine testing plays a major role in ensuring drug-free status. These programmes are mostly run in separate sections of the prison with no direct contact with other inmates and a high level of control. The 'twelve steps' concept is the most common. Drug-free wings have been developed particularly in Austrian, Dutch, Finnish and Swedish prisons.

A 1998 study found that 80% of all Council of Europe countries have abstinence-based programmes. In most countries a differentiated system of sanctions and incentives has been developed in prisons in order to punish

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[11] Turnbull/Webster 1998.

[12] Bollini 1997 suggests installing demonstration projects to implement the WHO guidelines on HIV/AIDS in prison as an example: These pilot projects should be supervised and co-ordinated by UNAIDS or WHO: "*The presence of international organisations would provide symbolic and scientific authority to the program, and would ensure effective dissemination of its results. It is important to stress that harm reduction projects in the participating countries should not necessarily be the same, but should respond to the current needs of each partner. Each project should implement, and duly evaluate, one aspect of WHO Guidelines....*".

drug use or to reward drug abstinence within a unit or treatment programme. These measures are designed as deterrents for prisoners within the framework in which treatment efforts are organised. Sanctions might be: additional days of imprisonment for positive urine tests, forfeitures of privileges, stoppage of earnings, no home leaves, or no visits. Incentives are designed to encourage good behaviour of prisoners. These may be a transfer to a drug-free wing, single cell, home leave, holiday, in-cell television etc.

IV.2. Substitution treatment

Substitution treatment has been widely introduced in prisons only during the nineties. Provision of methadone treatment within prisons varies considerably between countries. Spain and Austria have high levels of provision. In Spain, it is estimated that 60% of drug users in prison receive methadone. In Austria, maintenance treatment has been offered in all prisons since 1991, and social and psychotherapeutic approaches are also offered. Prisons in Portugal provide methadone for maintenance purposes but in Belgium, Germany, Ireland, Italy, the Netherlands and the UK, provision is minimal, apart from for the purposes of detoxification. Sweden and Greece do not provide methadone in prisons. Eligibility for entering a methadone programme in prison largely depends on levels of treatment provision. In all countries where a programme is available, a user receiving treatment outside prison can continue treatment inside. In the UK, where provision is low, it is estimated that a third of those who are receiving methadone treatment before entering prison also receive it in prison. In Austria, Portugal, Spain and parts of Germany, however, a drug user can begin treatment on entering prison.

Austria. Since 1991, all prisons in Austria have been offering maintenance therapy with substitution substances during a prison sentence. Some prisons offer specific units for substitution. The prison in Favoriten (Vienna) specialises in the treatment of addicts. Amongst other things prisoners might be offered substitution treatment but they can also acquire psychotherapeutic and social support, such as job training in the form of an apprenticeship. These approaches are offered in addition to medical treatment.

Belgium. Since 1995 methadone has been used in some prisons. Methadone substitution treatment can be continued in prison, but at present this is only for patients who were in substitution treatment before being incarcerated. At present, treatment in prison consists of progressive withdrawal, but it is anticipated that substitution treatment will be initiated in prison for maintenance for specific groups.

Denmark. The policy of the Direktoratet for Kriminalforsorgen (Directorate for Prison and Probation Services) is that drug users in prison should be offered treatment coordinated with the social services and treatment institutions outside prison. In principle, treatment (including substitution treatment) should not be interrupted because of imprisonment.

Finland. Continuity of care has not been a problem during the three and a half years of a pilot programme. Four patients of the substitution treatment clinic continued receiving methadone substitution while in prison in 1998.

France. According to the results of a 1998 survey carried out by the Ministry of Health, substitution treatment discontinuation is a major problem: 22% of new inmates taking buprenorphine and 13% of those taking methadone ceased within eight weeks of incarceration. The principle of continuation of treatment in prison confirms that substitution treatments may be continued or started in prison with methadone or Subutex®. The medicine must be dispensed by the medical staff. To facilitate the integration of the correctional health service into the care system, a doctor practising in prison must be included in the departmental monitoring committee. The doctors of the prisons' internal medical services are invited to contact the attending physician and to organise continuation of treatment after release. There is a continuation of treatment on release: 95% of former prisoners taking methadone and 79% of those taking Subutex® receive medical support on leaving prison.

Germany. Currently, no exact figure for methadone patients in penal institutions is available but it is estimated at around 800. Only six of the 16 federal states provide methadone treatment in prisons (Berlin, Bremen, Hamburg, Hesse, Lower Saxony and North Rhine Westphalia) predominantly for detoxification purposes. Prescription or methadone maintenance is poorly developed. Entry criteria as well as detoxification procedures vary considerably between states, and substitution treatment is not available in all of the prisons of these states.

Ireland. In theory, prison policy is to provide the same level of substitution treatment inside prison as outside, but in practice this does not happen. There is one detoxification unit and one small maintenance clinic in the largest prison (with approximately 20 prisoners on this programme at any one time). "There is a standard detoxification programme of 14 days, which is offered to prisoners on committal if they are found to test positive for opiates. Prisoners that may have been stable on methadone in the community are generally detoxified upon incarceration" (Dillon, 2000). The situation has changed considerably in the Irish Prisons Service. Methadone maintenance was introduced in early 2000 to the new remand prison at Cloverhill (capacity up to 400 places) for prisoners who were on maintenance programmes in the community. This development was extended to the largest prison in the state, Mountjoy Prison (capacity 670) at the end of 2000. For those not receiving treatment before arrival in prison, in certain circumstances (for example HIV-positive status) substitution treatment can be commenced in prison.

Italy. Substitution treatment is received by 500 drug users out of the total 14 000 in prison (as of December 1997). Lack of continuity of treatment between the healthcare system and prison is also a major problem.

Luxembourg. Clients who are in methadone treatment before their detention continue their treatment during remand and, in cases of a long prison

sentence, undergo slow detoxification. A prisoner is allowed methadone before his release.

The Netherlands. Almost all IAVs (the 16 Instellingen voor Ambulante Verslavingszorg or Institutions for Ambulatory Addiction Treatment and Care) offer a maintenance and reduction programme. Over two thirds of clients attend maintenance programmes in the communities. One exception relates to programmes in detention centres, where addicted prisoners who are to spend more than a few weeks in detention are obliged to follow a reduction programme.

Portugal. Where methadone units are available, prisoners sign a treatment contract. In prisons with no methadone unit prisoners are supervised by the nearest Ministry of Health (CAT) treatment centre. Agreement is reached between the two services as to the use of either methadone or LAAM.

Spain. A 1990 law included a paragraph on methadone use in prisons. In August 1997 all prisons (except two) had already developed methadone maintenance programmes. These were not abstinence-oriented. When subjects are discharged from prison, they are referred by the prison to continue methadone maintenance in an outpatient centre.

Sweden. Methadone maintenance treatment is not available in Swedish prisons since one of the inclusion criteria for maintenance treatment is that the patient shall not be in custody, under arrest or in prison at the time of admission.

England/Wales. There has been considerable expansion in the growth of methadone detoxification for prisoners, but only a very limited amount of methadone maintenance.

Prescribing substitutes is one of the most common forms of treatment delivered by community treatment agencies. There is a very low level of continuity between community methadone treatment and prison methadone treatment. For those sentenced, there are reasonable levels of contact with outside specialist agencies. Short-term methadone detoxification is the most widespread approach for drug users. For example, in the women's and juvenile prison HMP Holloway in London, 1 500 withdrawal treatments are carried out annually.

Scotland. Methadone maintenance programmes reflect the prisoner's specific conditions (clinical profile, judicial and penal situation). Contact with the community prescriber is then made to confirm dosage, compliance and willingness to continue prescription on release. If a prisoner on a community methadone programme is to be in prison for more than three months, a reduction programme may be prescribed if certain conditions are met.

Table 4: Availability of substitution treatment in EU prisons

Country	Detoxification	Maintenance		Substitution substance predominantly used
		short-term prisoner	long-term prisoner	
Austria				Methadone
Belgium				Methadone
Denmark				Methadone
Finland				Methadone, Buprenorphine
France				Methadone, Subutex® (Buprenorphine)
Germany				Methadone
Greece				
Ireland				Methadone
Italy				Methadone
Luxembourg				Methadone
The Netherlands				Methadone
Portugal				Methadone, LAAM
Spain				
Sweden				
England and Wales				Methadone mostly; Lofexidine in some; Dihydrocodeine
Northern Ireland				
Scotland				

Few prisons:		**Most prisons:**	
All prisons:		**No prisons:**	

IV.3. Detoxification

Detoxification facilities (although varying in length and form) are offered in nearly all Member States. Detoxification policies vary from country to country and from region to region especially in those with a federal structure.

Methadone treatments are only implemented properly in a small number of prisons in order to reduce the physical and psychological withdrawal symptoms. A specialist withdrawal treatment based on medication also permits the detection and handling of side effects and potential sources of infection.

Contrary to new detoxification therapeutic standards, addicts in many European prisons are still subject to 'cold turkey' (immediate reduction of the dosage to zero) upon incarceration. Sometimes prisoners have to cope with the symptoms of withdrawal on their own (not least in order to punish them) or they are not treated on time or occasionally not at all. There are also cases in which staff at the healthcare units give tranquillisers to inmates which do not

have any effect on most of the withdrawal symptoms. While withdrawal from methadone outside prison takes place gradually, the dosage given inside prison is often reduced rapidly.

Germany. In many clinics, withdrawal of opiates (or partial withdrawal in cases of multiple addiction) is increasingly treated with medication. 'Cold turkey' has been replaced with a more pragmatic approach: addicts are treated with medication which permits an intense analysis of the psychosocial causes and circumstances of addiction.

Ireland. Two forms of detoxification are offered: an intense 14-day detoxification programme, or a detoxification programme which lasts thirteen weeks and involves a support group and counselling. After this programme, prisoners are either transferred to the training unit (a drug-free semi-open institution) or granted temporary release.

England. 'Post Detox Centres' have been created, such as the one in Holloway Prison. This is a community in which residents and staff work together to create a supportive and confidential environment where inmates can explore drug- and alcohol-related problems during their time of incarceration. The aim is to help inmates become drug free and cope with staying drug free, both in prison and on their release. The inmates may stay at the centre for up to three weeks.

IV.4. Drug-free units and drug-free wings

Drug-free units were developed at the beginning of the nineties, but did not reach some countries until the late nineties. In several countries the number of places is rapidly increasing (e.g. Austria). Despite this development there is very little scientific evaluation work that has been carried out.

The focus in these units is on drug-free living mostly combined with community living, in order to utilise a positive group atmosphere and the effects of peer group education in treating addiction. The basic characteristics of drug-free units are: (a) the prisoner stays in these units on a voluntary basis (b) he/she is committed (sometimes with a contract) to abstinence from drugs and not to bring in any drugs, and (c) he/she agrees to regular medical check-ups often involving drug testing. The prisons system is committed to prisoners staying in these units to enjoy a regime with more favours, such as additional leave, education or work outside, excursions, more frequent contact with the family etc.

As distinct from 'drug-free units', the term 'drug-free wings' usually does not include an addiction treatment offer. The sole aim of these wings is to offer a drug-free environment for all those who wish to stay at a distance from drug-using inmates. The essential difference between 'drug-free units' and 'drug-

free wings' is that prisoners entering the latter are not necessarily addicted to drugs.

In Portugal, drug-free units account for almost half of all general health facilities provided to prisoners (304 beds out of 741). These drug-free units include a variety of treatment offers such as 'therapeutic communities' units, methadone maintenance, motivation to treatment, and 'drop in and drop out'. Moreover, in other prisons (juvenile and women prisons) healthcare facilities for drug-using inmates are provided. The primary policy is to provide drug addicts with similar conditions as those outside prison. In France, a pilot project started in 1998 where inmates voluntarily work on their addiction problems (with alcohol, pills and illegal drugs) for 3 months. In Denmark, contract treatment is distinguished from drug-free units.

Table 5: Places in drug-free units in some Member States

Country	Places	Source
Austria	700	*
Belgium	16 (a specific programme in one prison in the Flemish region)	De Maere, 2001
Denmark	1 unit in a closed state prison (16 male) 1 unit in an open state prison (22 male/female)	Reventlow, 2000
France	No drug-free units	Khodja, 2001
Ireland	170 (1 semi-open institution training unit 96 places), 1 drug-free wing in a juvenile closed institution (St. Patrick's – 74 places)	*
The Netherlands	476 (3.6% of total cell capacity)	Van Alem et al., 1999
Portugal	304 beds (from a total of 741 beds in the health units of the whole system)	Machado Rodrigues, 2000
Spain	In 1999, 6 456 inmates were included in drug-free programmes in 14 prisons (including therapeutic drug-free orientated measures and day clinic); 1 299 inmates received naltrexone antagonist as support	Ballesteros, 2000
Sweden	346	Krantz/Ekström, 2000

* Not available.

IV.5. Self-help groups

In some countries, self-help groups appear to constitute the main approach in the support of incarcerated drug users and their families. In Greece for instance, they are run on a voluntary basis by NGO institutions. In Spain, in 79% of penitentiary centres community personnel have participated in the development of intervention programmes for drug dependence. The majority of these belong to non governmental organisations and include staff who are ex-addicts and ex-convicts.

IV.6. Auricular acupuncture

In several prisons in Europe, auricular acupuncture is used as a low-cost and popular method of assisting prisoners to detoxify from drug dependence or to remain abstinent. Helpful to prisoners in several ways, auricular acupuncture is used in some prisons in England/Wales (e.g. HMP Holloway), Finland and Germany (the state of Hamburg).

V. INTERVENTIONS WITH A FOCUS ON HARM REDUCTION

KEY FACTS

Harm-reduction measures have been developed in the past 15 years throughout Europe as a supplementary strategy to the existing drug-free oriented programmes. These measures are integrated differently into the prison environment. In fact, only a limited number of prisons have been discussing drug use in their institutions and have adopted harm-reduction measures which have proved successful outside. The main argument against the integration of harm-reduction measures in prisons is that it conveys the 'wrong message' and makes illicit drugs more socially acceptable.

In most European prison systems information for prisoners and staff is provided: condoms are distributed in 18 of the 23 systems; disinfectants are available in 11 systems.

V.1. Vaccination programmes

Vaccination against hepatitis and tuberculosis takes place in many prisons to avoid infectious diseases or re-infection.

Whether a proactive approach to offering the vaccination is adopted or whether it is a medical service 'on demand' makes a big difference. In France, a study reported that although hepatitis B vaccination is available in all prisons, not many prisoners know this or ask for it.

V.2. Provision of disinfectants

This practice of providing disinfectants is not widespread. According to the World Health Organisation's information on HIV/AIDS in prison, 16 of the 52 prison systems surveyed have made bleach available to prisoners from 1991.

Only in a few countries do national recommendations exist regarding the provision and use of disinfectants. In most EU Member States, bleach is either not available or is provided for cleaning purposes and not distributed officially. Bleach is available – even if not officially for the sterilisation of injecting equipment – in Germany, France, Spain, Switzerland, Belgium, Luxembourg, and the Netherlands. Often information on how to use bleach to sterilise syringes properly is also provided.

Austria. In 1994, the Ministry of Justice recommended practically proven measures to prevent the transmission of infectious diseases to all prisons.

Denmark. Between 1996 and May 2000 prisoners could obtain large bottles of bleach in the toilets. Prisoners used it for purposes other than disinfection and therefore the policy changed so that only small bottles could be obtained – either in the medical department or in the toilets.

Scotland. Bleach/sterilising tablets have been distributed in all Scottish prisons since 1993 together with an information leaflet giving practical instructions on how to use it to sterilise mugs, cutlery, razors, chamber pots and injecting equipment.

Spain. Every prisoner is given a kit with different toiletry products. This includes a bottle with bleach. All drug users receive instruction and leaflets about the cleaning of injecting equipment. Every three months they are given another bottle, but it is also possible at other times to buy it cheaply in the prison shop.

Table 6: Provision of bleach in some Member States

Country	Distribution of bleach	Substance, kits used	Remarks
Austria		Betaisodonna (Jodum)	Medical department. In 26 out of 29.
Belgium			
Denmark		Natriumhypochlorit	Direct access preferably in bathrooms or toilets. Medical departments only if distribution in bathrooms etc. is not possible because of sabotage.
Finland		Potassiumper-Sulphate	Individual kit given to every incoming prisoner, freely available in washing rooms and from health care unit.
France		1 small bottle of 120ml for every prisoner every 15 days.	By penitentiary administration (D. Khodja 2001).
Germany			
Greece			
Ireland			
Italy			
Luxembourg			Not available (Reuland/Schlink 2000).
The Netherlands			Bleach should be available in every prison.
Portugal			In 39 out of 53 prisons. Bleach is distributed when prisoner enters prison, continues to be regularly distributed according to the criteria of each prison.
UK			
Spain		Bottle with bleach.	Prison shop.
Sweden			

Few prisons: | **Most prisons:** | **All prisons:** | **No prisons:**

V.3. Needle exchange programmes

Needle exchange programmes are generally an efficient and well-implemented component in prevention strategy outside prison in Member

States. However, they are not implemented inside prisons in most EU countries (except Germany and Spain). Some countries do not have an official policy against needle-exchange facilities, whilst others explicitly reject this option.

Similarly, innovative pilot projects under which clean drug injection equipment is made available in prisons have been launched as a trial in Switzerland, Germany and Spain. Currently this measure is carried out in 19 prisons (see Table 7).

Table 7: Needle Exchange Programmes (NEP) in EU and Swiss prisons (chronologically)

Prison	Site	Size	Character	Sentenced	NEP since /evaluated?	Provision of sterile syringes	Exclusion	Preventive measures
Men's prison Oberschöngrün	Solothurn, Switzerland	75	Half-open	Adults	1992	Doctor/ medical depart.	Non-DU	•
Women's prison Hindelbank	Bern, Switzerland	110	Closed	Adults	1994/yes	Slot machines (1:1 exchange)	No	•
Men & women's prison Champ Dollon	Geneva, Switzerland	No detail	Remand prison	Adults	1996	Doctor	No	•
Women's prison Vechta	Vechta, Germany	169	Closed & remand dep.	Adults/ juveniles	1996/yes	Slot machines (1:1 exchange)	Women in Methadone programme, reception dep., Non-DU	•
Men's prison Lingen I Abt. Groß Hesepe	Groß Hesepe, Germany	228	Closed	Adults	1996/yes	Hand-to-hand drug counselling service	Men in Methadone programme, Non-DU	•
Men's prison Vierlande (with a section for 21 women)	Hamburg, Germany	319	Open	Adults	1996/yes	Slot machines (1:1 exchange) + hand-to-hand)****	No	•
Men's prison Centro Penitenciario de Basauri	Vizcaya, Spain	250	Half-open	Adults	1997/yes	Hand-to-hand		•
Men's prison Realta/Cazis	Graubünden, Switzerland	100	Half-open	Adults	1997/yes	Slot machines (1:1 exchange)	No	•
Women's prison Lichtenberg Berlin	Berlin, Germany	Ca. 40-50	Closed	Adults/ juveniles	1998/yes	Slot machines (1:1 exchange) ****	No	•

V.4. Provision of condoms

Nine of the fifteen EU countries have clear official policies allowing free access to condoms for prisoners, in line with WHO guidelines. The other six occupied different positions from the extreme of prohibition (based on lack of recognition of the problem) towards allowing access.

Table 8: Provision of condoms

Country	Provision of condoms	Remarks
Austria		Available in 20 out of 29, in 3 only on 'demand', in 4 not at all, in one 'in preparation'
Belgium		Varies widely depending on local prison policy
Denmark		Freely available in all prisons since 1987. Can be obtained from the prison staff and medical service. Placed in visiting rooms
Finland		At intake (entering and leaving), by medical unit, in conjugal rooms, freely available without asking
France		Medical service
Germany		Medical service, merchandiser, social worker/ psychologists. In some prisons it is difficult to purchase a condom when needed: it has to be ordered 7-14 days in advance
Luxembourg		Condoms and lubricants available in the medical department, prisoners do not have to ask for them, they can just take them out of a container
The Netherlands		Guidelines stated that condoms must be available in every prison. It is up to every local governor to make his own policy on the practical form of availability.
Portugal	40 out of 53	Medical office, nursery, educational body According to the criteria of the prison administrators
Spain		At entry, after that in all cells where prisoners meet visitors, also on demand at medical service
Sweden		Available in cells where prisoners meet visitors

Few prisons:		Most prisons:		All prisons:	

VI. INTERVENTION WITH A FOCUS ON COMMUNITY LINKS

KEY FACTS

Specific legislation in a number of countries has attempted to enhance links between the criminal-justice and health services in order to reduce the number of drug users entering prison. Despite this development, the size of the addicted population in prisons has grown. This development emphasises the need for better links between criminal-justice agencies and drug services.

Alternative measures to prison for drug-addicted inmates (such as residential treatment outside prison), pre-release and aftercare interventions, as well as work with families and the maintenance of family and social ties are essential components of intervention which focus on the preservation of community links.

The principle of 'treatment instead of punishment' is adopted in most European countries. In fact, the court may suspend the sentence and the accused can go voluntarily into an in-patient treatment centre or into ambulatory centres which are slowly but surely accepted as treatment options.

Several studies show that effective aftercare for drug-using prisoners is essential to maintain gains made in prison-based treatment. Despite this, it is a widely acknowledged fact that prisoners often have difficulties in accessing and paying for treatment on release under community-care arrangements. Through care has been developed as multi-agency cooperation in some countries, which involves intensive integration of outside agencies to continue these efforts at the time of release.

Working with families of prisoners is a central part of rehabilitation and social reintegration in many countries.

VI.1. Pre-release units and release

Most of the countries examined make strenuous efforts to reduce relapse and to provide social reintegration. Preparation for release is different in the 15 EU countries. Aside from basic social and health aims, one central aim is to continue support after release.

Austria. In the prison 'Vienna Favoriten' there is intensive support in the months preceding release. This is an intensive and additional programme to normal pre-release measures. Although an evaluation showed that the goal of continuity of support could only be achieved in 10% of the cases, the subjects judged the offer as helpful and important to prepare for life outside prison.

France. In seven prisons pre-release units have been established in order to offer groups of up to ten drug-using prisoners a voluntary four-week course of group treatment with the aim of preparing them for release.

Spain. Drug-dependent people who have been under treatment during their stay in prison are able to continue therapeutic care when they are finally, conditionally or provisionally freed. During 1998, 7 180 people were transferred to community programmes (40.7% more than in 1997).

Denmark. A treatment plan should be drawn up for each inmate and co-ordination should be ensured between the prison and social authorities when planning release and aftercare. Official guidelines have been drawn up by a working group with representatives from the Ministry of Social Affairs and the Department of Prison and Probation.

VI.2. Aftercare

Austria and Sweden have a far more integrated system of aftercare than is found in most countries. Aftercare in Sweden and Austria is largely built into the sentence plan.

VI.3. Working with families and maintaining family ties

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

VI.4. Counselling at various stages of imprisonment

Counselling is a direct, personalised, and client-centred intervention. It is designed to help initiate behaviour change to keep off drugs, avoid infection or, if already infected, to prevent transmission to other inmates or partners. It is also designed to assist referral to additional medical care and preventative, psychosocial or other necessary services in order to remain healthy.

VI.5. Through care

In some countries through care is perceived as the crucial factor in the success of tackling drug use in prison. The English/Welsh 'Prison service drug strategy' gives a definition of the concept – "By through care we mean the quality of care delivered to the offender from initial reception through to preparation for release, establishing a smooth transition to community care

after release”. This definition implies direct links with sentence management or with incentives and earned privileges schemes. Through care is similarly defined by the Scottish Prison Service.

VI.6. Treatment for sentenced offenders outside prison

Several countries have legal regulations to suspend the sentence for drug users, if the alternative serves to assist their subsequent rehabilitation in the community. In Sweden, the Prison Treatment Act states that a prisoner may be permitted – while still serving his prison sentence – to be placed in a treatment facility outside prison.

Alternatives are mostly related to the length of sentence. For example, in Germany law allows prisoners to undergo ‘treatment instead of punishment’ when the sentence to serve is no longer than 2 years. In Greece, after a period of seven to ten months in custody, a drug user may apply to the public prosecutor to continue treatment outside prison. This is the result of a law specifically designed to allow drug users to receive therapeutic treatment rather than stay in prison.

VII. Evaluation of interventions of assistance to drug users in prisons in the EU

KEY FACTS

Prisons remain an area where there is major variation in levels of provision. There are limited evaluation data to guide policy-makers in determining the best course of action for the future. More evaluation of delivered prison treatment is needed

VII.1. Evaluation criteria

To obtain reliable and comparable data, evaluation criteria for demand and harm-reduction interventions have to be developed. Overall issues in the definition of evaluation criteria are: feasibility, degree of acceptance, and effectiveness of the measures undertaken, taking into account the different interests and values of the persons and institutions involved.

As regards interventions, it is of particular importance to determine if changes in drug use behaviour occur. The following criteria may be used as a basis for this analysis:

- abstinence from drugs (abstention from drug use during specified periods);
- reduction of drug use (consumption of smaller amounts);
- reduction of harmful and damaging drug use (changes in drug-using patterns, changes in drugs used, avoidance of overdoses);
- reduction of harmful and damaging drug-use patterns (e.g. shift from injecting to smoking);
- improvement of risk-related knowledge ('safer-use', 'safer-sex');
- improvement of health status; and
- improvement of social and communicative skills and competence (e.g. participation in treatments offered, compliance with rules dominating the treatments, participation in self-help groups, involvement in peer support activities).

The prison system itself may also be the subject of an evaluation. To study the effects of interventions, the following criteria can be applied:

- scale of acceptance of the measures by prison officers, medical staff and management;
- changes in the attitude towards drug-using prisoners;
- level of credibility of the preventive measures;
- impact of the measures taken on security matters;

- consequences of participation in treatments offered for the length and quality of the sentence to be served by inmates (advantages/disadvantages, impact on family visits, home leaves etc.).

VII.2. Results of evaluations

A literature survey[15] (of mostly North-American literature) on the effectiveness of the criminal-sanction system, including correctional treatment in general and treatment designed for specific types of offenders (drug addicts amongst others) found out that programmes based on cognitive-behavioural principles seem to be the most effective. Some features of programmes most closely linked with success are:

- a theoretically sound concept;
- programme integrity;
- competent staff, good physical conditions, structured setting;
- thorough assessment of the offender and targeting his specific criminogenic needs;
- intensive service for high-risk delinquents (those at greater risk of recidivism);
- relapse-prevention and aftercare.

[15] conducted by the Scientific and Documentation Centre of the Dutch Ministry of Justice (2000).