

Access Report – Systematic Review, Inventory, Good Practices

H. Stöver, H. Zurhold

The European project “ACCESS” was aiming to increase the knowledge on practices with respect to available harm reduction services and access to treatment for drug users within the criminal justice system in European countries. Background for this project is the gap between the availability, extent, and quality of community drug services and prison drug services. Harm reduction and treatment is crucial as prisoners are at greater risk of becoming infected with HIV, hepatitis and tuberculosis than people outside. Further prisoners with a drug use history are disproportionately vulnerable to suffer from poor mental health and post-release mortality (EMCDDA, 2012; UNODC, 2012). To respond to the health care needs of prisoners, the actual EU Action Plan on Drugs (2009-2012) explicitly calls for the development and implementation of prevention, harm reduction and treatment services in prison that are equivalent to services outside prison (EMCDDA, 2012). The equivalence of services in prisons to those available in the wider community has repeatedly demanded by a number of organisations (Geneva Declaration, 2012; WHO, 2005, 2010).

In community, the main approach for the treatment of opioid dependence is medication assisted treatment, which all Member States as well as Norway, Croatia and Turkey have implemented. In prison, opioid substitution treatment has been introduced by most of the European countries, but compared to the implementation of this treatment option in community the introduction in prisons was considerably delayed by eight to nine years (Hedrich & Farrell, 2012). Out of 30 European countries only eight provide coverage of opioid substitution treatment in prison which is similar to levels of community coverage. Similarly, needle and syringe programmes, which are widely available in community, have only been introduced in some prisons in a few countries.

During the two years period of the project (2012-2013) one part of the activities consisted in a research which was conducted by the Frankfurt University of Applied Sciences.

Main objectives of the research were to

- conduct a systematic literature review on the evidence for effective harm reduction and drug treatment services in custodial settings,
- identify existing harm reduction initiatives in prisons, and the national conditions for their introduction, implementation and evaluation on the system-level, and
- to identify models of good practice.

The second objective was achieved by an inventory of harm reduction in prisons. The inventory was based on a questionnaire which was sent to the Ministries of Justice of each EU country. The identification of models of good practice was conducted by involving experts from a number of EU Member States which collated “new” examples of good practices with regard to harm reduction and treatment provided to drug users in national prisons.

Schriftenreihe „Gesundheitsförderung im Justizvollzug“ – „Health Promotion in Prisons“

Herausgegeben von Heino Stöver und Jutta Jacob

„Gesundheitsförderung zielt auf einen Prozess, allen Menschen ein höheres Maß an Selbstbestimmung über ihre Gesundheit zu ermöglichen und sie damit zur Stärkung ihrer Gesundheit zu befähigen. Um ein angemessenes körperliches und seelisches Wohlbefinden zu erlangen, ihre Wünsche und Hoffnungen wahrnehmen und verwirklichen, sowie ihre Umwelt meistern bzw. sie verändern zu können.“ Diese Gedanken leiten die Ottawa-Charta zur Gesundheitsförderung ein, die 1986 von einer internationalen Konferenz verabschiedet wurde. Versucht man den Leitgedanken der Ottawa-Charta, die Stärkung der Selbstbestimmung über die Gesundheit, auf den Strafvollzug zu beziehen, stößt man schnell an Grenzen der Übertragbarkeit: Äußere Beschränkungen, Fremdbestimmungen, eingeschränkte Rechte prägen das Leben und die gesundheitliche Lage der Gefangenen.

Mit der Schriftenreihe „Gesundheitsförderung im Justizvollzug“ wollen wir Beiträge veröffentlichen, die innovative gesundheitspolitische Anregungen für den Justizvollzug geben und gesundheitsfördernde Praxisformen des Vollzugsalltags vorstellen.

Außerhalb des Vollzugs bewährte Präventionsangebote und Versorgungsstrukturen werden auf ihre Relevanz zur Verbesserung der gesundheitlichen Situation Inhaftierter hin überprüft und auf die Bedingungen des Justizvollzugs bezogen.

Letztendlich kann nur eine größere Transparenz und Durchlässigkeit des Systems „Justizvollzug“ dazu beitragen, individuelle gesundheitsorientierte Potenziale Gefangener anzuregen und zu fördern.

Die HerausgeberInnen

Heino Stöver, Heike Zurhold

**Access to treatment for drug users
within the criminal justice system in
European countries**

- systematic literature review, existing harm reduction initiatives in prisons, and models of good practice (ACCESS)

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ACCESS to treatment and harm reduction for drug users in custody

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Abbreviations

EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MMT	Methadone Maintenance Treatment
MSM	Men having sex with men
NGO	Non-governmental organisation
OST	Opioid Substitution Therapy
PDU	Problem Drug User
PEP	Post-Exposure Prophylaxis
PNSP	Prison-based Needle and Syringe Programme
RCT	Randomised Controlled Trial
RNA	Ribonucleic acid
STI	Sexually transmitted infections
SVR	Sustained Virologic Response
TB	Tuberculosis
TC	Therapeutic Community
UNODC	United Nations Office of Drugs and Crime
WHO	World Health Organization

1 Introduction

The European project “ACCESS” was aiming to increase the knowledge on practices with respect to available harm reduction services and access to treatment for drug users within the criminal justice system in European countries. Background for this project is the gap between the availability, extent, and quality of community drug services and prison drug services. Harm reduction and treatment is crucial as prisoners are at greater risk of becoming infected with HIV, hepatitis and tuberculosis than people in the community. Furthermore prisoners with a drug use history are disproportionately more vulnerable to suffer from poor mental health and post-release mortality (EMCDDA, 2012; UNODC, 2012). To respond to the health care needs of prisoners, the actual EU Action Plan on Drugs (2009-2012) explicitly calls for the development and implementation of prevention, harm reduction and treatment services in prison that are equivalent to services outside prison (EMCDDA, 2012). The equivalence of services in prisons to those available in the wider community has repeatedly demanded by a number of organisations (Geneva Declaration, 2012; WHO, 2005, 2010).

In the community, the main approach for the treatment of opioid dependence is substitution treatment, which all Member States as well as Norway, Croatia and Turkey have implemented. In prison, opioid substitution treatment has been introduced by most of the European countries, but compared to the implementation of this treatment option in community the introduction in prisons was considerably delayed by eight to nine years (Hedrich & Farrell, 2012, Hedrich et al. 2012). Out of 30 European countries only eight provide coverage of opioid substitution treatment in prison which is similar to levels of community coverage. Similarly, needle and syringe programmes, which are widely available in community, have only been introduced in some prisons in a few countries.¹

1 UNODC 20014: Guide to starting and managing needle and syringe programmes in prisons and other closed settings, forthcoming.

During the two years period of the project (2012-2013) one part of the activities consisted in a research which was conducted by the Frankfurt University of Applied Sciences.

Main objectives of the research were to

- conduct a systematic literature review on the evidence for effective harm reduction and drug treatment services in custodial settings,
- identify existing harm reduction initiatives in prisons, and the national conditions for their introduction, implementation and evaluation on the system-level, and
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The second objective was achieved by an inventory of harm reduction in prisons. The inventory was based on a questionnaire which has been sent to the Ministries of Justice of each EU country. The identification of models of good practice was conducted by involving experts from a number of EU Member States which collated “new” examples of good practices with regard to harm reduction and treatment provided to drug users in national prisons.

2 Methodology

2.1 Systematic literature review

The systematic review addresses the following main healthcare question: For which types of harm reduction measures – ranging from detoxification, opioid substitution treatment (OST), naloxone provision, hepatitis vaccination, treatment for infectious diseases and prison-based needle and syringe programmes (PNSP) – there is scientific evidence that these measures are effective to minimise health risks for problem drug users being in prison or other custodial settings.

With respect to the healthcare question major electronic databases (Medline, Embase, Psycinfo, Psycdex) have been searched for peer-reviewed publications and primary studies by using a systematic search algorithm. Included published literature had to meet the following criteria:

- Focus: prison settings and harm reduction measures (in title or abstract) and drug use
- Type of publication: evidence reports, meta-analyses, systematic reviews. RCTs, observational studies
- Evaluation of effectiveness either in terms of social or biological outcome measures or in reduction of health risks
- Time limit: 2002-2012
- Limit to humans
- English language.

The latest search was conducted on the OVID platform on February 10th, 2012, using the search algorithm described in table 1. As it is known the systematic search in electronic databases is excellent in identifying most of published literature relevant for the review topic. However, in order not to miss relevant literature the search has been extended to reference lists of publications and grey literature which had been hand screened.

Table 1: Keywords used for systematic database searches and results

Steps	Keywords	Search results
1	(prison\$ or detention or custodial or correctional or penitentiaries or penitentiary or pre-trial or remand or arrest house).ti.	24.588
2	prison\$ or detention or custodial or correctional or penitentiaries or penitentiary or pre-trial or remand or arrest house).ab.	42.170
3	Combine 1 or 2	527.41
4	(harm reduction or harm minimisation or opioid substitution or opiate substitution or detoxification or naloxone or test\$ or vaccination or antiviral treatment or antiviral therapy or antiretroviral treatment or antiretroviral therapy or post-exposure prophylaxis or condoms or bleach or tuberculosis or HCV or HIV or hepatitis or needle\$ or syringe\$).ti.	1.574.013
5	harm reduction or harm minimisation or opioid substitution or opiate substitution or detoxification or naloxone or test\$ or vaccination or antiviral treatment or antiviral therapy or antiretroviral treatment or antiretroviral therapy or post-exposure prophylaxis or condoms or bleach or tuberculosis or HCV or HIV or hepatitis or needle\$ or syringe\$).ab.	5.150.144
6	Combine 4 or 5	5.828.160
7	Combine 3 and 6	11.118
8	(substance disorder\$ or addiction or substance abuse or IDU or drug user\$ or substance misuse\$ or dependence).mp. [mp=ti, ab, tx, ct, sh, hw, tn, ot, dm, mf, dv, kw, nm, ps, rs, ui, tc, id, tm, ax, kp, fw, cw, ia]	623.534
9	(evidence or effect\$ or evaluat\$).mp. [mp=ti, ab, tx, ct, sh, hw, tn, ot, dm, mf, dv, kw, nm, ps, rs, ui, tc, id, tm, ax, kp, fw, cw, ia]	14.980.768
10	Combine 7 and 8 and 9	960
11	limit 10 to yr="2002 –Current"	634
12	limit 11 to human	586
13	remove duplicates from 12	372
14	Hand search to remove further duplicates from 13 (n=15)	357
15	Exclusion of ineligible literature from 14	42
16	Additional references from manual search in scientific papers	9
17	Included in systematic review (combine 15 and 16)	51

* The latest run of steps 1 to 14 was the 10.02.2012

Through the search in electronic databases 357 references were found. After reading the title and abstracts of these references, 314 papers were excluded as they did not meet the inclusion criteria (step 14 to 15 in the search strategy). In detail, the following number of references had been excluded:

- 115 references without evaluation of effectiveness
- 58 are epidemiologic articles
- 46 references were not about prison but community treatment
- 34 references are on a different target groups than problem drug users
- 29 references address mainly the risk behaviours of prisoners
- 33 refer to guidelines, unsystematic overviews, case reports, protocols or conference papers

After this procedure 42 references were identified through the systematic database search. Another nine publications were identified through hand searches of reference lists. Finally 51 publications are included in the present review.

The 51 eligible publications are assessed systematically as to their research content and their methodological quality. To assess the content all studies and reviews are entered in a database which includes the following criteria

- Authors, year, country; sample; design and methods; intervention details; outcome measures; main results and limitations.

The quality assessment is done according to the methodology checklist of the SIGN guidelines developer's handbook (SIGN, 2011). The respective checklist of SIGN is used for the assessment of the internal validity of RCTs, systematic reviews and meta-analyses, cohort studies and case-control studies (Annex C of the handbook). As regards the quality assessment of RCTs the checklist of SIGN has been adapted to the study designs in the field of drug research. Out of the 10 SIGN items of the RCT checklist two items were not used, and one further item has been added.

In order to determine the levels of evidence, also the evidence statements of SIGN are used (Annex B in the handbook). The level of evidence reflects the quality of the studies and reviews, and for the purpose of this study three of the classified five evidence levels are considered (table 2).

Table 2: Levels of evidence according to SIGN (2011)

Level	Criteria
1++	High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+	1+ Well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias 1 – Meta-analyses, systematic reviews, or RCTs with a high risk of bias 2++ High quality systematic reviews of case control or cohort studies, high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2-	Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series

2.1.1 Description of literature included in the review

The 51 publications eligible for the review differ widely in their research designs (table 3). However, most of the publications consist of observational studies including case control and cohort studies (31 %). Almost one quarter of the publications consists in either RCTs (24 %) or reviews and meta-analyses (25 %). The remaining studies are case register studies, analysis of cost effectiveness and process evaluations.

The majority of the literature is of US-origin (n=23). Second most often are publications from Europe, with most of them being from the United Kingdom (n=10). In the third place follow publications from Australia (n=7). There are also publications from Canada, Iran, Taiwan and those covering the area of the United Nations.

Table 3: Overview on study designs of literature included in this review

Study design	Number	Studies	Country/Region
Randomized controlled trial (RCT)	12	Howells, Allen et al. 2002; Sheard, Wright et al. 2009 and 2011 Prendergast, Hall et al. 2003; Prendergast, Frisman et al. 2011; Kinlock, Gordon et al. 2007 and 2009; Gordon, Kinlock et al. 2008; Saber-Therani, Springer et al. 2012 Dolan, Shearer et al. 2003 Berman, Lundberg et al. 2004 Asli, Moghadami et al. 2011	UK USA Australia Sweden Iran
Reviews and meta-analyses	13	Dolan, Rutter et al. 2003; Larney 2010 Mitchell, Wilson, et al. 2007; Tripodi, Blesoe et al. 2011; Cropsey, Villalobos et al. 2005 Perry, Coulton et al. 2009; Prison Drug Treatment Strategy Review Group 2010 Lines, Juergens et al. 2004; Lines, Juergens et al. 2005 Juergens 2007; Juergens, Ball et al. 2009 Stöver and Nelles 2003; Hedrich, Alves et al. 2012	Australia USA UK Multisite United Nations Europe
Observational studies (incl. semi-experimental, controlled clinical trial, case-control, prospective cohort, cross-sectional)	16	Lubelczyk, Friedmann et al. 2002; Allen, Spaulding et al. 2003; Bauserman, Richardson et al. 2003; McGovern, Fiore et al. 2005; Braithwaite, Stephens et al. 2005; Heimer, Catania 2006; Messina, Burdon et al. 2006; Sacks, McKendrick et al. 2008; Chew, Allen et al. 2009; Joe, Rowan-Szal et al. 2010; Springer, Chen et al. 2010 Dolan, Bijl et al. 2004; Dolan, Shearer et al. 2005 Ahmadvand, Sepehrmanesh et al. 2009 Huang, Kuo et al. 2011 Skipper, Guy et al. 2003	USA Australia Iran Taiwan UK
Implementation studies	2	Gilbert, Connor et al. 2004; Perrett 2011	UK

Case register studies	4	Maru, Bruce et al. 2008; Rosen, Schoenbach et al. 2009 Farley, Vasdev et al. 2005 Bate, Colman et al. 2010	USA Canada Australia
Cost effectiveness	4	Sutton, Edmunds et al. 2006 and 2008 Tan, Joseph et al. 2008 Warren, Viney et al. 2006	UK USA Australia
Total	51		

The literature considered for this review covers a range of interventions aiming at reducing the demand for illicit drugs and preventing infectious diseases in the criminal justice system. Table 4 presents an overview of the interventions addressed in the 51 publications. Especially reviews and meta-analyses might comprise more than one intervention, so that multiple entries for one publication are possible.

Most of the literature addresses substitution treatment either in terms of opioid substitution maintenance treatment or detoxification. There are also a number of publications on effects of other types of drug treatment, which is usually abstinence-oriented treatment. As regards the issue of infectious diseases, a body of studies and reviews investigate the effectiveness of testing for HIV or HCV, treatment for infectious diseases or different kind of prevention measures such as vaccination. Only a few publications address the evidence for prison needle exchange programmes which might be due to the fact, that these programmes are still rare in prisons. Finally a couple of references is focussed on interventions which could neither be defined as drug treatment nor as prevention of infectious diseases. These interventions consist in – for example – case management offered to prisoners.

Table 4: Type of interventions addressed in studies and reviews (n=51) – multiple entries possible

Interventions addressed	Number of studies and reviews
Substitution treatment (detoxification and OST)	17
Therapeutic communities for drug treatment	5
Other type of drug treatment	7
Testing for HIV and treatment for HIV/AIDS	2
Vaccination for hepatitis, testing and treatment for HCV	13
Information and education on prevention of infectious diseases	5
Prison-based needle and syringe programmes	5
Other interventions (such as case management, enhancement)	2

The overall aim of harm reduction measures is to reduce the harm associated with the use of illicit drugs. Such measures include especially OST, testing for blood-borne viruses, treatment for infectious diseases, needle exchange programmes, and prevention strategies such as vaccination, provision of bleach and condoms. It has to be noticed that no literature could be identified investigating the effectiveness of the provision of condoms or preventive measures addressing risks due to unprotected sex or unsafe tattooing in prison.

2.2 Inventory of harm reduction

In Europe, the provision of health care in prisons is in most countries within the responsibility of the Ministry of Justice or Interior. Seven countries, namely Sweden, Norway, France, England and Wales, Slovenia, Spain and Italy, have transferred or are going to transfer the responsibility for prisoner health care to the same institutions that provide health care in the community such as the Ministry of Health or public health services. In Finland, the administrative sector of the Ministry of Justice is currently exploring the transfer of prison health care to the general health care system.

To know about the harm reduction services currently available in European prisons, an inventory of these services has been carried out. The main objectives of the inventory are to provide an overview of those harm reduction services delivered to problem drug users (PDUs) in European Prisons, and to identify the national conditions for their introduction and implementation.

This report presents the results of the inventory which comprises 27 European countries.

2.2.1 Inventory method

For the inventory a semi-structured questionnaire has been developed which allowed to be filled in electronically. The questionnaire covered the following topics:

- Interventions provided in the national prisons. The types of interventions were adopted from the comprehensive package of interventions for HIV prevention, treatment and care in prisons and other closed settings (UNODC, 2012).
- The coverage of the provision in relation to the number of prisons, where an intervention is available
- The driving factors for the introduction of main interventions for PDUs
- Barriers for not having implemented specific harm reduction measures so far.

The questionnaire was sent by email in February 2012 to all EU Member States, Norway and Switzerland. First of all the institutions mainly responsible for prison services were addressed, and in the respective countries responsibility lays either in the Ministries of Justice, the Heads of Prison Administration or the Ministries of Health. One month later a first reminder was sent out, accompanied with the request to forward the questionnaire to an expert who could provide national data on prison harm reduction services. In 12 countries at least three reminders had been sent in order to increase the response rate and coverage of the inventory. Quite often one expert forwarded the questionnaire to another, who again forwarded the questionnaire to the next one. Finally, about 165 different persons had been contacted during the period from February 2012 to the end of January 2013, demonstrating that an inventory of harm reduction services in European prisons is a huge challenge.

Table 5: Number of countries covered with the inventory

Countries	Number
AT, BE, BG, CH, CY, CZ, DK, EE, EL, FI, FR, HU, IRE, IT, LV, LT, NL, NO, PL, PT, RO, SE, SK, SL,	24
United Kingdom: England & Wales, Scotland, Northern-Ireland	1
Spain: Madrid and Catalonia	1
Germany – 6 Federal States: Bayern, Nordrhein-Westfalen, Hessen, Thüringen, Rheinland-Pfalz; Mecklenburg-Vorpommern	1
Total	27
No responses from Malta and Luxembourg	2

The response rate to the inventory was high with 93 %, and only information for Malta and Luxembourg had not been received. A number of countries made use of the possibility to add comments to the questionnaire in order to specify national or regional peculiarities or to describe recent developments. The analysis will consider these comments as they provide more detailed information.

With regard to the United Kingdom the analysis of the questionnaire has been treating England/Wales, Scotland and Northern-Ireland as separate countries. In the case of Spain and Germany, the data have been integrated to a country file. However, it has to be considered that the information on harm reduction services in Spain represent the capital Madrid and the autonomous region Catalonia. Thus, the data from Spain is limited to these two regions. Likewise in Germany only six out of 16 Federal States responded to the questionnaire (38 %). Even though information on Germany is limited to these six states, the two states Bayern and Nordrhein-Westfalen represent the Federal States with the highest prison population in Germany.

2.3 Identification of examples of Good Practices

Good practices were to be identified on harm reduction and drug treatment for drug users in prison and after release. The main focus was directed at “new” examples of good practices which were collated directly from the field and which have to meet the definition of good practice as specified by the EDDRA best practice portal. There is no precise but a broad definition of good practice which is chosen to assess interventions by using different methodologies with varying degrees of complexity and rigour. These methodolo-

gies can range from careful analysis of first-hand experience by programme managers, to programme or management reviews, to more in-depth case studies and consultations. However, general principles of good practices are to respect human rights and to be based on proven evidence. Examples of good practices aim at a better understanding of what works, how it works and in which conditions.

For the identification of good practices the following criteria had been defined:

- To collect at least three examples of “new” good practices of work on harm reduction and drug treatment in the criminal justice system. This also includes developments regarding the continuity of care in prison and after release. For this reason at least one of the three examples of good practice should include a community intervention, if applicable.
- Examples of good practice include those services addressed to drug users, and which have been implemented in prisons or outside prisons in the last 5 years (2008-2012).
- According to these criteria, good practices include interventions provided by projects, initiatives or specific interventions, which are implemented by, for example, prison administrations, health authorities or NGOs.
- *Projects* are by definition a temporary activity/intervention with a starting date, specific goals and conditions, defined responsibilities, a budget, a planning and a fixed end date.
- *Initiatives* could be a joint number of coordinated activities or interventions.
- *Interventions* refer to an act of intervening, interfering or interceding with the intent of modifying the outcome. An intervention in the criminal justice system is an intervention that is targeted at drug users in contact with the criminal justice system. This may be when they are arrested, appear before court, are in prison or when they are released from prison.

The following specific examples of good practice in relation to drugs had to be sought:

- Prevention of infectious diseases (HIV, HCV, tuberculosis)
- Prevention of drug-related infections including needle and syringe programmes
- Prevention of sexually transmitted diseases
- Opioid substitution treatment (methadone, buprenorphine etc.)

- Promotion of safer use (such as availability of bleach etc.)
- Overdose prevention
- Treatment for infectious diseases
- Drug free treatment
- Measures for safe tattooing or piercing

2.3.1 Tasks of the involved experts

For the identification of examples of good practices a group of experts from a number of European countries was appointed to work on the collation of good practices in their geographical area of expertise. A total of 15 experts from 16 EU countries have been appointed.

The experts have been briefed for their tasks in May 2012, and examples of good practices had been collated from 1st of June 2012 to 15th of August 2012. The identified examples of good practices were reported in a standardised form, and for each intervention one form had to be completed. Afterwards the experts had to assess the quality of collated examples of at least promising practice by using a so-called quality grid. With this quality grid the quality level was determined via a points system. Again for each intervention the quality assessment had to be completed by using a standardised form. The completed forms were then submitted for further analyses to the researchers.²

Table 6: Type of interventions and countries covered

Type of interventions	Countries
Cognitive Behavioural Interventions (CBT) <i>CBT – Anger Management – Psychoeducation – Motivation for prison treatment – Brief Intervention on drug addiction</i>	Bulgaria, Hungary, Italy, Lithuania, Poland
Pharmacological interventions <i>OST – Naloxone – GHB interventions</i>	Estonia, Spain, Latvia, Poland, Romania, Scotland, The Netherlands
Prevention and treatment of infectious diseases <i>HIV/STI Services in Prison – HCV – TB screening</i>	Ireland, Latvia, Portugal, The Netherlands

² The experts were provided with documents on the methodology, a glossary of terms, the good practice report form, and the quality assessment report form. The two report forms were submitted to the Frankfurt University of Applied Sciences, Germany.

Structural Responses to Prison Health Care <i>Link between prison and community – Health in Prison – Assessment at prison entry – Drug free zone – Alternatives to imprisonment</i>	Ireland, Lithuania, Slovakia, Estonia, Spain, Italy
Drug Counselling and Treatment Services and Peer Education <i>Prison Drug treatment – Drug rehabilitation after release – Court counselling – Therapeutic Community – Rehabilitation in prison – Peer Education</i>	Bulgaria, Slovakia, Estonia, Hungary, Greece, Lithuania, Italy, Portugal, Romania, Scotland

Experts involved in collating good practices were:

1. Anna Lyubenova, Initiative for Health Foundation, Bulgaria
2. Cristina Ionescu, general practitioner from Jilava Penitentiary, Romania
3. David Marteau, former Head of the Section, Substance Misuse Offender Health, England
4. Dawid Chojecki, Specialist in Rehabilitation, National Bureau for Drug Prevention, Poland
5. Diana Castro, Apdes, Portugal
6. Emilija Baltrunaite, Lithuania,
7. Ieva Pugule, Reitox National Focal Point, Latvia
8. Felice Nava, Referente Sanità Penitenziaria, Italy
9. Frances Nangle-Connor, Irish Prison Service HQ, Ireland
10. Gerasimos Papanastasatos, Kethea, Greece
11. Gergely Fliegauf, Hungary
12. Lisa Ross, Clinical Harm Reduction Nurse Specialist / NHS Highland, Scotland
13. Michel Westra, medical advisor and head of the Health Care Department, The Netherlands
14. Petra Mrvová, Senior Officer for International Co-operation, General Directorate Corps of Prison and Court Guard, Slovakia
15. Viola Läänerand, Social Rehabilitation Division, Penitentiary Department, Estonia

2.3.2 *Quality assessment of collated examples of good practice*

Considering the general lack of evaluation on drug related programmes and services in many European countries, a multi-level definition of good practice has been adopted for the scope of this research. Examples of good practice that have to be taken into consideration were divided into three different quality levels (see below). The quality level depends on how many criteria a

service or project has been tested against. The three levels start from level 1 – the lowest and reach level 3, the highest.

Level 1 – *Promising practice*: the approach has a sound theoretical basis and has proved its ability to engage the target group. Promising practice scores 12 points or less on the quality assessment template.

Level 2 – *Good practice*: this corresponds to “promising interventions” in the EDDRA definition. Good practice scores between 13-28 points on the quality assessment template.

Level 3 – *Top level practice*: this corresponds to “top level interventions” in the EDDRA definition. Criteria for this level is that the intervention has been evaluated (RCT or quasi experimental and validated instruments). Top level practice scores 29 or more points on the quality assessment template.

Criteria for level 2 and 3 have been taken from the EMCDDA criteria and quality level for inclusion in the EDDRA database (see also: <http://www.emcdda.europa.eu/themes/best-practice/examples/quality-levels>).

The quality assessment template is used to determine the points for each criteria specified in the three domains ‘logic model’, ‘evaluation’ and ‘additional information’. The quality assessment template shows the maximum sum of points an intervention or project could reach in each domain if meeting the highest quality. The quality level is finally determined by summing up the points of each of the three domains. In case of the highest quality level, a maximum of 39 points could be reached.

Each collated intervention or project has been assessed on the quality template (table 7). For all criteria in the respective domain that apply, the points are ticked and then added up. Afterwards the experts totalled the three sums to finally determine the quality level.

Table 7: Quality assessment

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Specific objectives exist	1	* Process evaluation	2	* Coordination with other services and programmes	2
Specific objectives are linked to indicators	1				
Indicators reduce the objectives into one or more quantifiable dimensions	1				
Specific objectives connected to initial situation	1				
* The presented results refer to the formulated objectives	1	Outcome evaluation: Follow-up assessment	2	Instruments used for outcome evaluation are available	2
Outcome evaluation results available	1	Pre-post design, no comparison group (naturalistic)	4	Instruments used for outcome evaluation are new	1
* The working hypothesis presented links to the initial situation	1	Pre-post design AND comparison group (quasi-experimental)	8 (12) ¹	AND are validated instrument(s)	1
* The working hypothesis is based on evidence (references to controlled trials at least)	2	Pre-post design AND comparison group AND randomisation (RCT)	12	Intervention manual is available	2
* The working hypothesis links to the specific objectives and the indicators	2	Outcome evaluation with modified instrument based on a validated instrument	2		
* Activities (programme contents) fit to objectives	1	Outcome evaluation with validated instrument	4		
* Activities fit to objectives and working hypothesis	1				
Max. sum of points	13	Max. sum of points	18	Max. sum of points	8

* Criteria that can also be met by process evaluations. The points system is arranged in such a way that an intervention which only has a process evaluation can become a quality level 2 intervention.

¹=12 points if this is the best feasible design for that setting.

3 Findings from the research

3.1 Systematic review

In many countries, a substantial proportion of the male prisoners and in particular of the female prisoners is drug dependent or has used illicit drugs at some point in their life (EMCDDA, 2012; Fazel, Bains, & Doll, 2006). Due to the high number of drug users among the prison population, the European Union as well as the World Health Organization (WHO, 2007) and the United Nations Office on Drugs and Crime (UNODC, 2012) emphasised the need to implement evidence-based health interventions in prisons. The UNODC has defined 15 key interventions for HIV prevention, treatment and care in prisons and other closed settings (UNODC, 2012) These key interventions are regarded as a “comprehensive package” being essential to address the health care needs of prisoners.

The systematic review, which includes 51 papers on the effectiveness of interventions for prisoners, is structured in consideration of the comprehensive package. However, the literature eligible for this review does not cover all key interventions of this package. Indeed, no literature has been identified on the effectiveness of a) condom distribution, b) the prevention, diagnosis and treatment of tuberculosis, c) the prevention of sexual violence and d) the prevention of through tattooing, piercing and other forms of skin penetration. With regard to the interventions covered by the 51 studies included in this review, the evidence for effectiveness is indicated for each reference according to evidence levels specified by SIGN (see table 2).

3.1.1 Effectiveness of drug dependence treatment

The majority of the literature, which was eligible for this review, focuses on treatment offered to drug dependent prisoners during their imprisonment or after prison release. Accordingly there is a body of high quality studies on detoxification and opioid substitution treatment (n=17), on therapeutic communities for drug treatment (n=5), and on other type of drug treatment such as counselling (n=8).

3.1.1.1 Detoxification

On the effectiveness of detoxification in prison there are three RTCs, all from the United Kingdom. In an older study, the efficacy of lofexidine for opioid detoxification has been investigated in a double blind RCT among 80 male prisoners in one Southern England prison (Howells et al., 2002). After proof of being opioid dependent, the prisoners were randomized to 10-day detoxification with either lofexidine (n=32) or methadone (n=36). Both groups were similar in age and severity of dependence. During the study the patients as well as the healthcare team were kept blind of the medication. Effect size was measured with self-rating scales on severity of withdrawal symptoms, the patients completed daily. The results demonstrated no significant differences for the withdrawal scores between the two groups (*evidence: 1++*). However, based on the small sample treatment retention was better for methadone compared to lofexidine (88 % vs. 69 %).

Another study evaluated with an open-label RTC design if detoxification with codeine or buprenorphine is more effective (Sheard et al., 2009). Male prisoners with a confirmed opiate addiction who were expected to be released from a Leeds remand prison in 28 days were eligible for detoxification with either daily sublingual tablet buprenorphine or daily oral tablet dihydrocodeine over a reduced regimen of no more than 20 days. A total of 90 opiate users were randomized to detoxification with buprenorphine (n=42) and codeine (n=48). Outcome measure was abstinence from illicit opiates indicated by urine test at one, three and six months post-detoxification. One major result was the high treatment drop-out rate of 30 %, and accordingly no more than 32 patients in the buprenorphine and 31 patients in the codeine group completed detoxification. At the three follow-up points there were no significant differences between the groups as regards urine samples negative for opiates (*evidence: 1-*). As 43 % of the participants continued to use opiates during detoxification, the authors concluded that opioid maintenance treatment would be more effective in prison settings. In his comprehensive review Juergens (2007) supported this conclusion. High rates of relapses to drug use after detoxification limit the effectiveness of withdrawal management and indicate that community maintenance treatment is often interrupted at prison entry.

A further open-label RCT was conducted in three prisons, two for male and one for female, in order to evaluate the effectiveness of detoxification with methadone and buprenorphine on opiate abstinence (Wright et al., 2011).

289 prisoners with confirmed opiate addiction and a remaining prison term of 28 days were included in the study, and data on follow-up was available for 113 patients in the methadone group and 100 patients in the buprenorphine group. Both groups were comparable as to age and opiate use patterns. Like in the previous study the outcome measure was abstinence from illicit opiates indicated by urine tests at one, three and six months post-detoxification. At all follow-up points the analysis showed that there was equal clinical effectiveness between methadone and buprenorphine in achieving abstinence. The logistic regression revealed that the strongest predictor for abstinence was to have achieved abstinence at eight days post-detoxification. However, the authors reported less demand for detoxification due to the increased availability of maintenance treatment.

3.1.1.2 Opioid substitution maintenance therapy

The effectiveness of opioid substitution treatment was evaluated in eight original studies from different countries, and with various methods and a huge variation in sample selection and sample size. However, in all studies no other medication than methadone was investigated (table 8). Three of the studies were a consecutive follow-up of a three comparison group RCT conducted among male pre-release prisoners in Baltimore, United States (M. S. Gordon, Kinlock, Schwartz, & O'Grady, 2008; Kinlock, Gordon, Schwartz, Fitzgerald, & O'Grady, 2009; Kinlock et al., 2007). Two further studies were from Australia, with an initial RTC of methadone patients in prison, and a subsequent cohort study on long-term effects of methadone treatment (Kate Dolan et al., 2003; K. Dolan et al., 2005). Furthermore there was one cohort study from Taiwan on mortality of treated IDUs (Huang et al., 2011), one pilot evaluation of maintenance treatment in a Puerto Rico prison (Heimer et al., 2006), and a small-scale experimental study from Iran on effects of prison-based methadone on depressive symptoms (Ahmadvand, Sepehrmanesh, Sadat-Ghoreyshi, & Zahiroddin, 2009).

Table 9: Outcomes of opioid substitution maintenance therapy based on eight studies

Authors	Study design	Treatment sample	Medication	Main results
Dolan et al. (2003; 2005) Australia	RCT on 4-month outcome Cohort study on long-term impact (medium follow-up of 4 years)	RCT follow-up sample: 253 mostly male prisoners Cohort sample: 382 (total RCT sample)	Methadone in prison and after release (up to daily dose of 60 mg)	RCT results: significant decline in heroin use (hair analyses), drug injecting, syringe sharing (evidence: 1++) Cohort results: no mortality while in treatment Out of treatment mortality rate: 2.0 per 100 person-years Treatment retention reduces rates for mortality, re-imprisonment and HCV infection (evidence: 2+)
Kinlock et al. (2007; 2009); Gordon et al. (2008) USA	RCT on outcome at 1, 6 and 12-month post release	211 male prisoners in Baltimore; at 6-month follow-up: n=201 at 12-month follow-up: n=204	Methadone in prison and after release (up to daily dose of 80 mg)	Continued treatment resulted in: a) significantly reduced positive tests for opioid use b) reduced criminal activity (evidence: 1-)
Heimer et al. (2006) USA	Case control study to evaluate pilot in one prison in Puerto Rico	60 male prisoners (self-selected and randomly assigned)	Methadone in prison (daily dose of 80-120 mg)	Progress evaluation results: According to urine testing 95 % reduction in heroin use while in treatment (evidence: 2-)
Ahmadvand et al. (2009) Iran	Semi-experimental study on effect of methadone on depression	33 IDUs with diagnosed depression	Methadone in prison (daily dose 60-80 mg) for 3 month period	While in treatment 29 individuals (88 %) showed improvement on scores for depressive symptoms. No antidepressants were given (evidence: 3)
Huang et al (2011) Taiwan	Prospective cohort study until 18 months after release	4,357 IDUs after prison release; 88 % male	Methadone after release	Mortality rate after release was 2.4 and 1.5 for males and females per 100 person-years Lower mortality rate for continued treatment: 0.24 per 100 person-years (evidence: 2++) Overdose was main cause for mortality (34 %)

The effectiveness of methadone treatment on opiate use (urine test), cocaine use (urine test) and criminal activity (self-reported) was evaluated in a sample of male pre-release prisoners by means of three comparison groups (Kinlock, et al., 2007). The first group received counselling only (n=64), the second group was actively transferred to methadone treatment upon release (n=66), and the third group was enrolled in methadone treatment in prison and after release (n=70). The 6- and 12-month follow up showed that initiation of methadone maintenance in prison and continued treatment retention is significantly more effective in reducing heroin use and criminal activities than counselling only (M. S. Gordon, et al., 2008; Kinlock, et al., 2009). At 12-month follow-up in 66 % of the counselling group the opioid test was positive compared to 25 % for those in continued methadone treatment. In comparison to counselling only continued treatment also had also a positive effect on cocaine use (73 % vs. 43 %). Results for criminal activity and re-imprisonment show no significant differences.

An Australian cohort study provide findings from a 4-year follow-up of prisoners who had been randomised to prison-based methadone maintenance or a waitlist control group (K. Dolan, et al., 2005). Based on records for re-imprisonment the findings show that the risk of re-imprisonment was lowest during methadone maintenance treatment of at least eight months. From finger-prick blood sample it was found that an increased risk of hepatitis C seroconversion was significantly associated with prison sentences of less than two months [P =0.001] and treatment episodes of less than five months [P =0.01].

The cohort study from Taiwan demonstrated, after adjusting for covariates, that the mortality rate for those prisoners who continued methadone treatment in community was significantly lower that for those who were never enrolled in methadone treatment (0.2 vs. 2.6 per person-years). Mortality most often occurred in the first week after prison release, and was mainly due to drug overdose (Huang, et al., 2011).

A number of low-quality reviews supported the findings that prison-based methadone maintenance treatment is effective in reducing the frequency of drug injecting and sharing of injecting equipment in prison (Cropsey, Villalobos, & St. Clair, 2005; Juergens, 2007), if a sufficient high dose of methadone (more than 60 mg per day) is provided and if the treatment duration is more than six months (Juergens, Ball, & Verster, 2009). A systematic review of five studies on OST provided in prison revealed (Larney, 2010):

Compared to control groups for the treatment group the use of illicit opiates was reduced by 62-91 %, injecting drug use was reduced by 55-75 %, and the sharing of needles and syringes was reduced by 43-73 %. A direct effect of OST on HIV incidence was not supported with the review (*evidence 1+*). Similarly a recent systematic review of opioid maintenance treatment confirmed that prison-based treatment with an adequate dosage and duration is effective to reduce drug-related risk behaviour (Hedrich et al., 2012). There is limited evidence for the impact of pre-release maintenance treatment on further outcomes such as cocaine use in prison and post-release mortality. Evidence was equivocal as regards effectiveness on criminal behaviour and re-imprisonment, and insufficient for the treatment impact on HIV and HCV incidence (*evidence: 1-*).

Finally there is an Australian study on the cost-effectiveness of methadone treatment provided in prison (Warren et al., 2006). Prison methadone treatment was found to be cost-effective as the treatment provides benefits for risk reduction and as the treatment costs are comparable to community treatment costs.

3.1.1.3 Therapeutic Community (TC)

The effectiveness of therapeutic communities offering drug treatment in prison has been predominately evaluated in the United States. TCs are intensive treatment programmes of 9 to 12 months, and based on a combination of behavioural therapy, individual and group counselling, and 12-step support. After prison release TC participants are usually offered aftercare.

This review included four studies on TC evaluation and one meta-analysis, which are all from the United States. Two of these studies were conducted in different prison settings in California (Messina, 2006; M. L. Prendergast, Hall, & Wexler, 2003), one study was conducted among male amphetamine users in 30 prisons in Texas (Joe, Rowan-Szal, Greener, Simpson, & Vance, 2010), and finally one study was carried out in a Denver prison for women (Sacks, 2008). Prendergast et al. (2003) evaluated the TC effectiveness at 12-month post-release in 531 male prisoners of the Amity prison, who were eligible for TC participation. Randomisation was made from the TC waiting list, and from this list 335 individuals were included in the treatment group and 196 individuals built the control group. Outcome was based on official records, self-reported drug use and drug testing result. Findings on 12-month post release showed that the treatment group performed significantly better

than controls on re-imprisonment (50 % vs. 34 %), and survival time until re-imprisonment, days to first illegal activity, and days to first drug use (*evidence: 1+*). Further, those who completed both prison-based treatment and community-based aftercare had significantly better outcomes than individuals who received lesser amounts of treatment. The second Californian study was a retrospective cohort study among 4,386 male and 4,164 female participants in 16 prison-based TCs (Messina, 2006). The aim of the 12-month post treatment evaluation was to explore gender differences in aftercare participation and re-imprisonment. At admission to treatment women compared to men had substantial disadvantages with regard to drug use history, co-occurring psychiatric disorders, and sexual and physical abuse prior to imprisonment. Results show that the treatment outcome for women was not affected by their disadvantages. For both men and women participation in aftercare was strongly associated with motivation for treatment and time spent in prison TC. Findings from logistic regression indicated that the strongest predictor for re-imprisonment was the total number of years in prison and the co-occurrence of psychiatric disorders (*evidence: 2+*).

With a control group design Sacks et al. (2008) evaluated a prison-based TC which was especially modified for female drug addicts with co-occurring severe mental health disorders. The control group received cognitive behavioural therapy (CBT) which was delivered according to a curriculum of a 90 hours course over the period of 15 days and additional mental health service. The six month post-prison interview was completed by 90 women of the TC group and 57 women of the CBT group. For outcome measure standard instruments on psychiatric diagnosis and psychological functioning has been used. Of the whole sample only 27 % has no Axis 1 diagnosis (n=40), while the majority of the women had at least one diagnosis. Findings show that the modified TC treatment programme is an effective model for female prisoners with varied mental health diagnoses (*evidence: 2+++*). For all mental health disorders TC treatment was significantly more effective for substance use, mental health and HIV sexual risk behaviour than the control condition.

Finally the process-related outcome on behavioural change and substance use was evaluated on basis of treatment records across three treatment conditions for 2,026 male methamphetamine users in 30 prison-based programmes in Texas (Joe, et al., 2010). One treatment was based on group counselling (OPT; n=1,321), one condition was an intensive TC programme modified for

heavy amphetamine users (TC1; n=450), and the third condition was a usual TC programme focussed on substance use (TC2; n=255). According to multilevel covariate analysis of the treatment records, significant improvements were found for all three treatment conditions. Thus, none of the treatments could be assessed as being the “best”, and the effect sizes corresponding to these programme differences were generally in the small range (*evidence: 2-*). However, as treatment varied over the time of the research, the findings are of limited evidence.

In general, it remains unclear whether the effect of TC programmes can be attributed to the intensity, duration and modality of the TC or the combination of TC and aftercare or the higher treatment motivation of participants who were self-selecting into the programme. A meta-analysis of the effectiveness of TCs in reducing post-release offending and drug use consistently found (Mitchell, Wilson, & MacKenzie, 2007): TCs were effective in reducing re-offending and drug use after prison release, and this finding was robust to the methodological quality (experimental, RCT), sample (age, gender, offense), and programme features such as duration, newly introduced or established (*evidence 1++*).

3.1.1.4 Other drug treatment

Other types of drug treatment comprise a variety of different interventions such as relapse prevention (Springer, 2010), group counselling (Mitchell, et al., 2007), drug-free units (Juergens, 2007; Juergens, et al., 2009), Cognitive Behavioural Therapy (CBT) (Prison Drug Treatment Strategy Review Group, 2010; Tripodi, Bledsoe, Kim, & Bender, 2011), and auricular acupuncture (Berman, Lundberg, Krook, & Gyllenhammar, 2004).

The short-term impact of treatment with buprenorphine and naloxone on relapse prevention was evaluated in 23 HIV-infected opioid dependent prisoners, who were at least 18 years old and 90 days prior to their release (Mitchell, et al., 2007). The primary outcome was retention in treatment, opiate craving and opioid-free urine testing over the period of 12 weeks. According to findings of weekly assessments retention in treatment was high as 74 % of the sample completed the 12-week treatment (n=17). Opioid craving was clearly reduced, adverse effects of the medication were few and mild, and negative opioid testing increased during treatment (*evidence: 2-*). Pre-release treatment with buprenorphine and naloxone is acceptable and feasible as relapse prevention, although evidence is limited due to the very small

sample. Auricular acupuncture for reducing craving and alleviating symptoms of discomfort was evaluated with an RTC design among 158 male and female prisoners in Sweden (Berman, et al., 2004). Participants were randomly assigned to two types of auricular acupuncture, the NADA protocol acupuncture and the non-specific HELIX acupuncture. Treatment was delivered in 14 sessions over a four week period. Due to pain caused by acupuncture there was a high dropout-rate in both groups of 40-60 %. In both groups there was a considerable reduction in self-reported symptoms of physical and psychological discomfort (*evidence: 1-*). However, due to the lack of an untreated comparison group and potential placebo effects, evidence for auricular acupuncture remains uncertain.

Group counselling, which integrates components such as education or 12-step treatment, has been evaluated in a meta-analysis of 25 studies (Mitchell, et al., 2007). As effectiveness was evaluated with week methods and without a clear description of the treatment provided, Mitchell et al. (2007) concluded that evidence is unclear (*evidence: 1++*). Limited evidence for drug-focused counselling was also reported by a review of reviews (Prison Drug Treatment Strategy Review Group, 2010).

Based on two comprehensive reviews evidence for effectiveness of drug-free units on reduction of drug use in prison is ambiguous (Juergens, 2007; Juergens, et al., 2009). According to the review a small number of studies indicated that these units may assist prisoners in reducing their drug use, but the long-term effects are unknown (*evidence: 3*).

In a systematic review evidence for drug treatment programmes incorporating Cognitive Behavioural Therapy (CBT) delivered to women prisoners was evaluated (Tripodi, et al., 2011). Based on effect size calculations participation in CBT is effective in reducing post-release substance use in women (*evidence: 1++*). The review of reviews considered the evidence base for different drug treatments in prisons (Prison Drug Treatment Strategy Review Group, 2010). The review found mixed evidence for CBT, a modest effect of 12-step treatment programmes on reduction of substance use, and an initial effect of Contingency Management (CM) in reducing cocaine use but this effect does not maintain over time. With regard to aftercare the review reported long-term effectiveness of aftercare in substantially reducing both acquisitive crimes and drug selling crimes (*evidence: 3*).

3.1.2 Effectiveness of HIV testing and treatment for HIV/AIDS

According to the search criteria used for this review, respectively only one study have been identified on effectiveness for HIV testing (Rosen, 2009) and treatment for HIV/AIDS (Saber-Tehrani A.S. et al., 2012).

Rosen et al. (2009) conducted a study on rates of voluntary HIV testing uptake among adult male and female prisoners in eight state prisons in North Carolina. As part of the medical evaluation a nurse screens prisoners for conventional HIV risk behaviours, and voluntary HIV testing is available anytime during imprisonment either by request of the prisoner or by clinician recommendation. The evaluation of the testing rates is based on electronic records on inmates who entered prison between January 2004 and May 2006. A total of 54,016 prisoners entered prisons who were mostly male (86 %). Out of them 38 % were tested for HIV. Women were significantly more likely to get tested than men (86 % vs. 32 %). However, risk behaviour related to needle sharing and sex work was found to be more prevalent among the female prison population. The evaluation also looked at associations between prisoners' characteristics and uptake of HIV testing. According to a covariate-adjusted analysis prisoners who had a history of heroin, crack or cocaine use, a conventional HIV risk behaviour or tuberculosis were at least 10 % more likely to be tested for HIV than prisoners without these characteristics. The evidence based on one study indicates that HIV testing is well accepted and effective in female prisoners, while many male prisoners with documented risk of infection were never tested (*evidence: 2-*). In general, the authors concluded that testing rates were higher when testing is easily available and offered privately. However, a major limitation of the findings lies in their depending on routinely collected administrative data.

The effectiveness of antiretroviral therapy (ART) was tested in a two-site RCT among HIV-infected adults who had been released from prison and returned to community to New Haven or Hartford, United States (Saber-Tehrani A.S., et al., 2012). The treatment group received antiretroviral therapy by trained community outreach workers who appointed the patients once per day at seven days per week and provided additional behavioural skills training during the last intervention month (DAART condition). The control group received monthly refills from the research pharmacy (SAT condition). All participants obtained pre-release support and 30 days post-release assistance. The Intent-To-Treat sample consisted of 154 men and women, with 103 individuals belonging to the treatment group and 52 individuals belong-

ing to the control group. The treatment and control group were similar in their characteristics; 81 % were male, 61 % opioid dependent, and 54 % had an underlying depression. The primary outcome of the RCT was the viral suppression (viral load) at 6 months after initiating treatment. The 6-month outcome showed that the directly administered antiretroviral therapy (DAART) is superior to self-administered therapy (SAT) among released HIV infected prisoners (*evidence: 1-*). Significantly more DAART than SAT participants had a virus load below 400 copies/mL (78.6 % vs. 52.9 %). However, DAART is a rather intensive intervention, and not needed for all HIV infected prisoners to support adherence to therapy.

A qualitative study from Canada on adherence to HIV treatment among HIV positive injecting drug users explored, that imprisonment as well as prison release is associated with the discontinuation of treatment for non-clinical reasons. Adherence to treatment was mainly hindered by difficulties to obtain the HIV medications (Small, 2009). Thus, coordination with community care is of particular importance to enhance treatment adherence in prison settings.

3.1.3 *Effectiveness of vaccination, diagnosis and treatment of viral hepatitis*

With regards to the effectiveness of hepatitis vaccination, solely two studies address this type of prevention; one study from Iran is an RCT on efficacy of vaccination against hepatitis B (Asli et al., 2011), and the other study is from the UK and assesses the effectiveness of a vaccination campaign in a prison in Doncaster (Gilbert et al., 2004). In both studies the sample consisted of male prisoners. Within the parallel-group RTC design, the efficacy of accelerated versus a classic HBV vaccination was investigated at one month and 8 months in a sample of 169 male prisoners who were not infected with HIV and hepatitis (Asli, et al., 2011). Accelerated vaccination included four doses of HBV vaccine in a two month period, while classic vaccination consisted in three doses over a 6 month period. Results show that compliance (full dose vaccination) was high in both groups, while an accelerated vaccination schedule achieved sero-protection more rapidly. However, eight months after the first vaccine the sero-protection rate was 78.8 % for accelerated and 93.4 % for classic vaccination (*evidence: 1-*). Classic HBV vaccination provided statistically higher rates of sero-protection, but in case of short prison sentences accelerated vaccination is recommended as it achieves clinical significant immunisation. The UK study focused on the successful implementation of a hepatitis A vaccination campaign, conducted in an area affected by

an HAV outbreak (Gilbert, et al., 2004). The vaccination campaign was implemented for a four-week period, following a previous intensive promotion among the prisoners. During the campaign 91 % of the local prison population was vaccinated, with 52 % of them having injected drugs. In conclusion, a large number of prisoners could be vaccinated in a short period of time, providing an effective measure to interrupt outbreaks of viral hepatitis (*evidence: 3*). The benefit of HBV vaccination offered in prison was also supported by a study modelling the HBV vaccination programme in prisons in England and Wales (Sutton et al., 2006). According to the authors HBV vaccination in prisons is an effective way to vaccinate hard-to-reach population such as IDUs.

There are two studies on effectiveness of diagnosis for viral hepatitis (Perrett, 2011; Skipper, Guy, Parkes, Roderick, & Rosenberg, 2003), and another two papers estimating the cost-effectiveness of HCV screening (Sutton, Edmunds, & Gill, 2006; Sutton, Edmunds, Sweeting, & Gill, 2008). All four studies have been rated as non-analytic studies, and thus they have a low evidence level (3). In an observational study Skipper et al. (2003) investigated the effectiveness of a prison outreach clinic for diagnosis of hepatitis C among male prisoners, who entered one of three local prisons in the UK in the period from 2000 to 2001. All new inmates were offered confidential HCV antibody testing at reception, and out of 1,618 prisoners only about 8 % accepted testing. Despite good quality counselling on HCV and confidential testing, the majority of the prison population did not ask for HCV testing. A similar result was reported by the Australian study of Perrett (2011). A nurse-led HCV testing programme offered testing to 4,500 prisoners entering a substance dependence unit at a local prison during a four-year period. Only 176 prisoners (4 %) accepted testing, demonstrating the need to encourage uptake of blood-borne virus testing in prisons. In a controlled trial conducted in England and Wales the researchers identified that it is not the testing procedures which contribute to an increase in HCV testing rates, but the greater priority to HCV testing at policy level (Hickman et al., 2008). However, a qualitative interview study explored as well personal barriers (lack of confidentiality and awareness for testing) and institutional concerns (lack of pro-active approaches, inadequate pre- and post-test discussion) which result in a low rate of HCV testing (Khaw, 2007). From an economic perspective, two modelling studies from the United Kingdom demonstrated that testing for HCV is cost-effective (Sutton, Edmunds, et al., 2006; Sutton, et al., 2008). Both studies estimated the cost-effectiveness of HCV screening for current or former IDUs on reception into prison, compared

to non-screening in prison. After calculating costs and benefits for a number of different case-finding scenarios, the results from the first study indicated that antibody and PCR tests administered to at-risk prisoners such as IDUs is more cost-effective than a non-screening practice (Sutton et al. 2006). In the later study the findings did not support that HCV screening in prison is cost-effective in general (Sutton et al 2008). In fact, cost-effectiveness for HCV screening in prison is given if screening raises awareness for HCV and increases representation for screening in community. However, the different results for the cost estimations are due to the fact that the estimation models are based on different studies and related calculations of rates of individuals progressing to chronic HCV infection.

With regard to the treatment of chronic HCV infection, six studies have been identified examining the treatment effectiveness (Allen et al., 2003; Bate, 2010; Chew, Allen, Taylor, Rich, & Feller, 2009; Farley et al., 2005; Maru, Bruce, Basu, & Altice, 2008; McGovern et al., 2005), and a further study estimated the cost-effectiveness of standard HCV treatment (Tan, Joseph, & Saab, 2008). Four of the treatment effectiveness studies are from the United States, one study is from Australia and another one from Canada, with each being based upon a different study design and sample (table 9).

The treatment outcome, measured as 6 month post-treatment SVR, varies considerably between the studies from 13 % up to 66 %. The effectiveness of standard antiviral treatment for HCV delivered in prison settings was lower in the US-studies compared to the Canadian study. The reasons for the great variation in SVR rates remain unclear as the treatment completion rates are comparable in three studies (Maru et al. 2008; Allen et al. 2003; McGovern et al. 2005), and sample characteristics are similar in all studies. Almost all patients in the studies were male, more than half of them had a history of drug injecting, and about 40 % were diagnosed for a psychiatric disorder. The history of drug use or a psychiatric disorder was no contraindication for the antiviral treatment in prison settings. In addition, close monitoring of patients with co-occurring disorders and referral to drug treatment or psychiatric care during the treatment does not seem to have an impact on the effectiveness of HCV treatment. Further, Chew and colleagues (2009) found no differences in the SVR rate for those patients with previous HCV treatment. One unique outcome of studies is that the failure of SVR was significantly correlated with the genotype 1 HCV infection. However, the majority of 65-75 % of the patients in the studies was infected with genotype 1, except from the patients in

the study of Farley et al. (2005), where treatment was in 48 % of the cases related to genotype 1. However, in general the findings of the studies are limited due to losses to follow-up and small treatment samples.

Table 10: Outcomes of HCV treatment based on five studies

Authors	Study design	Treatment sample	Treatment	Results
Chew et al. (2009) USA	Prospective cohort study at the Rhode Island prison, based on review of clinical charts	n=71 RNA-positive male patients: 68% with history of injecting n=33 completed treatment (46%)	According to standard guidelines with weight-based dosing of pegylated interferon- α 2b and ribavirin	SVR at 6 months post-treatment: 28% Lower SVR for genotype 1 compared to genotypes 2 and 3 (18% vs. 60% and 50%) (evidence: 2+)
Maru et al. (2008) USA	Longitudinal case register study during 2002 to 2006 among 22.000 inmates in 20 correctional facilities in Connecticut	n=68 prisoners without previous antiviral treatment: 85% male, 68% with history of injecting n= 47 completed treatment (69%)	Pegylated interferon and ribavirin (PEG-RBV)	SVR at 6 months post-treatment: 47% Lower SVR for genotype 1 compared to genotypes 2 and 3 (43% vs. 59%) (evidence: 2+)
Allen et al. (2003) USA	Retrospective, observational study in 1997-2001 among n=394 HCV positive prisoners at Rhode Island	n=90 HCV positive, mostly male patients (96%): 88% with drug use history n=79 completed treatment (88%)	Interferon and ribavirin	SVR at 6 months post-treatment: 46% (evidence: 3)
McGovern et al. (2005) USA	Observational study during 1999-2002 in a Boston prison among n=164 HCV positive patients with an underlying HIV infection	n=46 mainly male patients with HCV and HIV infection n=37 treatment completers (80%)	Pegylated interferon- α 2b and ribavirin according to guideline	SVR at 6 months post-treatment: 13% (evidence: 3)
Farley et al. (2005) Canada	Review of medical charts of 10 correctional facilities in British Columbia	n=80 male patients without use of illicit drugs in previous 6 months	Pegylated interferon- α 2b and ribavirin according to standard guidelines	SVR at 6 months post-treatment: 66% Lower SVR for genotype 1 compared to genotypes 2 and 3 (47% vs. 100% and 77%) (evidence: 3)

An Australian retrospective cohort study among 74 male treatment completers evaluated the post-SVR outcome over a 12-year period (Bate et al. 2010). Six months after completion of standard HCV treatment – for mainly genotype 3 (51 %), SVR was achieved for 72 % of the patients. 12 years after the end of treatment 17 % of the patients became re-infected with hepatitis C (*evidence: 2-*).

In conclusion, HCV treatment in prison is feasible and outcomes acceptable, in particular in consideration of the high rate of morbidity among the patients (drug injecting, psychiatric disorder, HIV co-infection). The importance of prisons for the management of chronic HCV infection is supported by a study on cost-effectiveness (Tan, et al., 2008). Based on the assumption that almost 80 % of the prisoners are infected with genotype 1, the cost-effectiveness of hepatitis C treatment with pegylated interferon and ribavirin was determined for the U.S. prison population via a decision analysis model. Even though there might be high re-infection rates and nonliver mortality rates, HCV treatment remained cost-effective in prisoners of nearly all age ranges and genotypes when liver biopsy was not a prerequisite to starting antiviral therapy. In patients between the ages of 40 and 49 with no fibrosis and genotype 1 infection, the treatment turned out to be not cost-effective.

3.1.4 Effectiveness of information, education and communication

Information, education and communication aim at raising the awareness of prisoners for risks related to HIV, sexually transmitted infections, viral hepatitis and tuberculosis. Four studies address these types of intervention.

Peer education as a group intervention was evaluated in an experimental case control study from the United States (Braithwaite, Stephens, Treadwell, Braithwaite, & Conerly, 2005). The aim of the study was to investigate the short-term effectiveness of peer education in reducing HIV-related risk behaviour and in reducing recidivism across four intervention conditions: 1. didactic presentation (DP) which consisted in health education on HIV and substance misuse through videos and communication; 2. peer education (PE1) which had the same conditions as DP plus additional role play, and was delivered by HIV negative imprisoned male peer educators; 3. the same condition as PE1, but peer education was delivered by HIV positive male peer educators (PE2); 4. traditional health promotion by video served as control condition (CC). Peer education was a 12-session curriculum-based intervention with two groups per week for a period of six weeks. A total of 116

adult male prisoners were randomized from four prisons in Georgia, with each prison delivering one condition. Short-term outcome of peer education on behavioural changes were measured by participant interviews at baseline prior to participation and at three months after prison release. Results show that with exception of the control group, in all other groups a substantial reduction in substance use was reported. In addition, in the three groups self-efficacy related to correct and consequent condom use was improved. With regard to substance use peer education was significantly more effective than the other two groups (*evidence: 2-*). However, the results are limited by potential response bias of the interviewees, and in particular, by different baseline characteristics between the groups. The prevalence and severity of drug use was not comparable between groups. allianz

A further study on the effectiveness of a HIV peer education programme was conducted in a male colony for drug dependent prisoners in Siberia (K. A. Dolan, Bijl, M., White, B., 2004). Between 2000 and 2001 a team of the Médecins Sans Frontiers (MSF) implemented three HIV health education training sessions. Each training session lasted one week, and was focused on best ways to disseminate information on blood-borne viral infections, condom use and use of bleach for cleaning injection or tattooing equipment. In each training 15-20 prisoners participated, who were chosen by prison staff. The effectiveness of peer education programme was evaluated prior to the training and four months after the third training. Evaluation was based on questionnaires among 153 and 124 prisoners in 2000 and 2001. Both groups reported similar level of drug injecting history (95 %) and sexual activity in prison (10-12 %). Compared to respondents in 2000 the respondents in 2001 were significantly more likely to correctly identify both how HIV can be transmitted. Further, the prevalence of tattooing in prison decreased significantly between 2000 and 2001 (42 % vs. 19 %). However, almost no use of bleach was reported. In conclusion, peer education was effective in significantly improving the prisoners' knowledge of HIV transmission and prevention (*evidence: 3*).

There are two further studies evaluating the effectiveness of HIV prevention, which are both from the United States and based on secondary analyses of a prospective cohort study (Ballard Lubelczyk, Friedmann, Lemon, Stein, & Gerstein, 2002; Bauserman et al., 2003). Lubelczyk et al. (2002) re-analysed data collected from 1,223 adult HIV-negative male and female prisoners who participated in different types of drug treatment programmes. The impact of

HIV prevention services was evaluated by a comprehensive risk assessment 12 months after discharge from treatment for four groups: two groups received HIV prevention services (77 % of the sample), but respectively one group was inside and outside prison at 12-month follow-up. The other two groups that were inside and outside prison at follow-up did not receive HIV prevention services. Sample characteristics (race, age, substances used) differed considerably among the four groups. At follow-up 56 % of the sample were out of prison. At follow-up the majority of the sample demonstrated health improvement related to needle-sharing, sexual partners and condom use (70 %). In 15 % there were no changes, and in the remaining 15 % risk behaviour increased. Control of covariates show that the reduction of HIV risk behaviour was significantly associated with having been out of prison (*evidence 2-*). However, the effectiveness of HIV prevention services is not determined as other factors such as drug treatment and age could have an effect on evaluation outcome.

In the study of Bauserman et al. (2003) the effectiveness of a skills building programme delivered by case management counsellors was evaluated for 529 male and female programme completers with available records on pre-and post-intervention data. The case management programme consisted in individual counselling combined with group educational sessions. Outcome was measured by a 52-item questionnaire on changes in HIV-related risk behaviour (self-efficacy to increase condom use, reduce injecting drug use). Among programme participants statistically significant changes were found in self-efficacy for condom use and injection drug use, and intentions to practice safer sex after prison release (*evidence 2+*). Due to the lack of a control group, the observed changes cannot be attributed to case management with certainty.

In conclusion, HIV prevention programmes delivered by peer educators or case management counsellors seem to have an impact in reducing risk behaviour related to drug injecting and sexual activity. However, results on effectiveness of HIV prevention programmes are ambiguous. A systematic review of three studies on HIV prevention came to similar results (Tripodi, et al., 2011).

3.1.5 Effectiveness of prison-based needle and syringe programmes

Although prison-based needle and syringe programmes (PNSP) had been introduced in Switzerland, Germany, Spain, Moldova, Romania, Luxembourg,

Kyrgyzstan, Tajikistan and Islamic Republic of Iran, there is limited research on the evidence for PNSP. Through systematic searches, five reviews have been identified on effectiveness of PNSP. All reviews are referring to the same evaluations available for this intervention, which is Switzerland, Germany and Spain (K. Dolan, Rutter, & Wodak, 2003; Jurgens, et al., 2009; Lines et al., 2004; Lines, Jurgens, Betteridge, & Stöver, 2005; Stöver & Nelles, 2003). As the reviews have not been conducted systematically, their evidence level is pretty poor (evidence: 3). However, in absence of more rigorous evaluations, evidence is based on results of evaluations in these three countries.

The aims of the evaluation were to assess the feasibility of prison-based needle and syringe programmes and their efficacy in reducing risk behaviour related to sharing of injecting equipment. The schemes for evaluation were different in data collection and duration. In Switzerland, PNSP does exist since 1992, and evaluations of pilots were conducted in the women's prison Hindelbank and the men's prison Realta. The 2-year evaluation of Hindelbank and the 1-year evaluation of Realta consisted in reviews of medical and prison records, interviews with staff and prisoner, and voluntary blood tests. In Hindelbank and Realta participated 137 and 234 prisoners respectively in the pilot. In Germany, pilot programmes were operated since 1996, and the pilots in the women's prison Vechta and in the mens's prison Lingen were evaluated over a 2-years period, using interviews with staff and prisoners and partly results of HIV and HCV testing. In Vechta 169 female prisoners and in Lingen 83 male prisoners participated in the pilot programme. Further German PNSPs have been evaluated in the Hamburg prisons Vierlande and Am Hasenberge, both for male prisoners, and in Hahnöfersand for women prisoners. In Berlin, a 2-year evaluation was conducted in the prisons Lichtenberg (female) and Lehrter Straße (male), using semi-structured interviews and testing for HIV, HBC and HCV. Finally in Spain, the prisons in Bilbao and Pamplona have been evaluated for a one year period since introduction of PNSP in 1997.

All evaluations of prison needle and syringe programmes have been favourable, and support feasibility and efficacy. Syringe distribution was not followed by an increase in drug use, injection drug use or the number of drug injectors (Stöver et al. 2003; Lines et al. 2005). PNSP has consistently shown to be effective in reducing syringe sharing, as sharing declined strongly. In the two German pilot evaluations sharing of syringes decreased to 11 % at

month four of the study to zero percent after month eight of the study. In addition, in two prisons in Germany (Lingen and Vechta) and in the Hindelbank prison in Switzerland a significant decrease in abscesses was observed (Dolan et al. 2003; Lines et al. 2004). Further, the evaluations show, that no serious unintended negative events, such as the use of needles as weapon or unsafe disposal of used syringes, were reported (Stöver et al. 2003; Dolan et al. 2003; Lines et al. 2004). In five prisons, blood testing was performed as part of the programme evaluation and no new cases of HIV, hepatitis B or hepatitis C transmission were reported (Stöver et al. 2003; Lines et al. 2004).

The review of Juurgens et al (2009) included 3 studies on the use of bleach for cleaning syringes in prison. As bleach has often shown to be used improperly, there is no evidence for this approach. Distribution of bleach is therefore only second-line strategy to needle and syringe programmes in prison settings.

In conclusion, scientific evaluations consistently demonstrated that PSNP is effective in reducing needle and syringe sharing. There is less evidence for prison-based needle and syringe programmes as regards their efficacy to prevent blood-borne viral infections (Jurgens et al. 2009). However, PNSP has shown to be feasible in different prison settings. Even though the programme evaluations are limited as their populations were small, feasibility of PNSP had been demonstrated also in larger prisons such as in Moldova with a prison population of at least 1,000. In conclusion, prison-based needle and syringe programmes can effectively reduce harms associated with needle sharing in prisons, and can be implemented in small to large size prisons.

3.1.6 Effectiveness of case management

The effectiveness of case management was evaluated in a multi-site trial from the United States (Prendergast et al., 2011) (M. Prendergast et al., 2011) and in a systematic review from the United Kingdom (Perry, 2009).

The effect of strengths-based case management provided during transition from prison to community was evaluated at 9-month post-release for male and female prisoners who participated in prison drug treatment and were three months prior to release (Prendergast et al., 2011). Eligible prisoners from four states were randomized to transitional case management (TCM: n=347) and standard parole (SR: n=334). Transitional case management was initiated two month prior to release and continued for six month in commu-

nity, and offered with decreasing frequency. Service and behavioural outcome relied on self-report of participants and urine testing for drug use. Findings show that there were no differences between the two groups in outcome. Both groups were similar in participation in community drug treatment (62-65 %), and in behavioural improvement. In the TCM and SR group drug use in the past 30 days declined from 82.5% and 84.1% to 29% and 26.8. Similar improvement were also reported for increase of condom use (*evidence: 1-*). However, for prisoners with drug problems case management was not superior to standard parole service. This result might influenced by the fact that all study participants had received drug treatment prior to their release.

Perry (2009) reviewed 24 RTCs for their effectiveness of interventions solely offered to drug using offenders in different criminal justice settings. Only a few studies evaluated the effectiveness of assertive case management and other community-based programs. However, due to the paucity of information no clear evidence could be drawn from these studies. Community pre-trial release with drugs testing (4 studies) or intensive supervision (4 studies) were reported to have limited or no effectiveness when compared to routine parole and probation. A meta-analysis of effect sizes of seven community studies resulted in favour of routine parole and probation (*evidence 1++*).

3.1.7 Summary of findings

In prisons harm reduction measures have been implemented since the early 1990s in order to respond to the risks of HIV and/or HCV transmissions via unprotected sex and the sharing of injecting equipment. Prisons are an important setting for health interventions, including drug treatment, prevention and treatment of HIV and HCV infection. Interventions delivered to drug-using offenders have two major aims, (i) the reduction of drug use and criminal behaviour and (ii) the reduction of viral infections related to risk behaviour. The period of imprisonment is regarded as a critical opportunity to provide adequate health care addressing drug user's problems, mental health problems and risks for transmission of HIV and hepatitis C. In prisons there is the ability to more closely monitor adherence to treatment, to provide psychiatric care, to address side effects of treatment for viral infections, and to screen and test for risks of infections. Even though injecting in prison is less frequent than in the community, each episode of injecting has the potential to increase sharing of injecting equipment, and due to the rapid turnover of prison populations injecting partners can change often. Against this background

it is of crucial importance to know which interventions provide evidence for health and cost effectiveness. When summarising the results of this systematic review, the evidence base for the different harm reduction interventions is as follows:

– Detoxification

Detoxification with methadone and buprenorphine are similar in their effectiveness to manage withdrawal symptoms in prisons (3 studies), but due to the high rate of continued opiate use after detoxification opioid maintenance treatment is recommended as first-line treatment.

– Opioid substitution maintenance treatment

All studies on prison-based opioid maintenance treatment (8 studies) and all reviews are unique in their finding that this treatment is highly effective in reducing heroin use, drug injecting and sharing of needles and syringes if the daily dose is sufficient (over 60 mg) and the treatment duration long enough (more than 6 months). The evidence for other outcomes such as cocaine use or the HIV/HCV incidence is insufficient. Further, research findings do not clearly support that an increased provision of maintenance treatment has an impact on reducing re-imprisonment and post-release mortality.

– Therapeutic Communities for prison drug treatment

Therapeutic communities (TCs) for drug dependent prisoners have consistently shown to be effective in reducing re-offending and relapsing to drug use in comparison to controls (4 studies). The high impact of TCs on successful community transition is closely related to the intensity and duration of drug treatment in prison. A meta-analysis found evidence for effectiveness of TC programmes independently from the methodological quality, sample characteristics of the study and the specific programme characteristics.

– Other types of drug treatment

Drug-free wings or units may support prisoners in achieving abstinence, but it is unclear if this effect persists after release (2 reviews). Pre-release treatment with buprenorphine and naloxone is feasible as relapse prevention, although evidence is limited (one study). Further there is limited evidence for drug-use focused counselling (2 papers). Evidence of Cognitive Behavioural Therapy (CBT) in reducing post-release substance use is ambiguous (2 papers). One review concluded that aftercare provides long-term effectiveness in substantially reducing criminal behaviour.

– Testing for HIV and antiretroviral therapy

Voluntary testing has shown to be more effective in female than in male prisoners as testing uptake was significantly higher among women (86 % vs. 32 %). However, this finding is only based on one study from the United States. Adherence to and effectiveness of antiretroviral therapy among recently released prisoners is improved if medications were directly given on a daily basis by a trained outreach worker. More favourable outcomes for directly administered compared to self-administered therapy were found in one RCT.

– Vaccination, testing and treatment for HCV

Vaccination of prisoners is an effective measure to interrupt outbreaks of viral hepatitis, and large number of prisoners could be vaccinated in a short period of time (2 studies). Despite of comprehensive actions to motivate prisoners for testing, testing rates have shown to be rather low (2 studies). As screening and diagnosis was found to be cost-effective (2 papers), there is the need to encourage uptake of blood-borne virus testing in prisons. Treatment of HCV achieved acceptable SVR in drug dependent prisoners, and those with HIV-co-infection or co-occurring mental disorders (6 studies). All studies found that lower SVR was significantly correlated with the genotype 1 HCV infection. On the other hand cost-effectiveness was also demonstrated for treatment of genotype 1 (one paper). However, the expected prison term needs to be long enough for completion of HCV treatment (48 weeks), and this represents the main barrier to expand treatment in prison.

– Information, education and communication

There is not strong evidence for the effectiveness of peer education or peer training on decreasing substance use and reducing sexual-related HIV risk behaviour (2 studies). Psycho-educational programmes to prevent risks of blood borne virus transmission had little effect on injection risk behaviour and a limited and inconsistent impact on the reduction of sexual risk behaviour among drug users in prison (2 studies).

– Prison-based needle and syringe programmes

Based on five reviews there is clear evidence that prison-based needle and syringe programmes are effective in significantly reducing sharing of injecting equipment among prisoners who inject drugs while in prison. Effectiveness has been demonstrated for different prison settings. Evidence for PNSP in reducing infectious diseases is limited.

- Case management for transition into community

There is no evidence for effectiveness of case management when compared to standard parole service in increasing participation in community treatment and decreasing post-release drug use (one study and one review).

3.1.8 Conclusion

In accordance with other reviews we also faced a number of factors that create difficulties in interpretation of the evidence for effectiveness. This does not only include the variety of methodological designs and related quality, but also the variety in samples and having a sufficient shared understanding of the definitions used by researchers to describe particular types of interventions. In this review it was attempted to reduce the risk of bias per study through providing an assessment of the quality and evidence level for more robust study designs such as RCTs, systematic reviews, meta-analyses, cohort and case control studies. Of the 51 studies and reviews included in the review

- 19 papers have the lowest evidence level 3 (37 %),
- 14 papers have rated as evidence level between 2- and 2++ (27 %),
- 11 papers have the evidence level 1- (22 %), and
- 7 papers were at highest evidence level of either 1+ or 1++ (14 %).

However, the variation in methodological quality can have a biasing effect resulting in understatement or in favour of reported treatment effects. Treatment effectiveness is often demonstrated in studies where either no control group is used or where the control group also received treatment. In addition, the treatment and control groups are not always comparable in their characteristics at baseline. Accordingly baseline differences between the groups and especially selection-bias in observational studies are sources of bias influencing the treatment outcome. Findings which include selection bias are difficult to interpret as it unclear if the observed outcome is related to the treatment effect or to the selection bias. On the other hand systematic reviews and meta-analyses of high methodological quality tend to exclusively or predominantly include RCTs which might lead to under-valuing the effectiveness reported in studies with alternative methodologies. In general, differences in research methodology and the sample may account for the variability in outcome; for instance this review found a huge variety in the effectiveness of treatment for hepatitis C. For some interventions weak studies may systematically overestimate treatment effects, while for other interventions, such as

for instance TC programmes, the methodological quality, the sample or treatment characteristics did not substantively affect effect sizes of the outcome.

Most common difficulties in interpreting the evidence are due to small sample sizes, losses to follow-up and limited duration of follow-up. In addition, most of study populations are male, and only few studies explored gender differences. In addition, in a number of studies the proportion of drug users among the study sample was not specified. Thus, the effectiveness of the treatment might differ for male and females and for non-drug users and drug users. Furthermore, a common source of bias is associated with the outcome measures. Outcome for substance use and HIV-related risk behaviour often rely on self-reports rather than on testing. Data on re-imprisonment and criminal behaviour is based on self-reports or on routinely collected administrative data such as treatment or prison records. A number of studies used records to analyse effects mortality rates, rates of recidivism or even long-term treatment effects which means to rely on data collected by others than the researchers. However, to comprise the effectiveness of harm reduction interventions in prison settings, it was useful to include a broader range of research to consider all available evidence.

Limitations of this review mainly arise from two factors, the methodological heterogeneity of the studies reviewed and the different number of studies available for the interventions considered for this review. Consequently an assessment of the evidence according to the same scheme was not possible, especially as some interventions are covered by more than eight studies while others are based on solely one study. To compensate this weakness a greater emphasis was given to research with more robust designs and higher quality scores. Despite these efforts the major limitation is the over-representation of literature from the United States and other countries outside Europe. Results from international research may not necessarily translate to Europe.

3.2 Inventory

The overview covers 29 European countries, and in these countries considerable differences in the number of prisons exist ranging from one prison in Cyprus to 215 prisons in Poland. In small countries such as Latvia, Estonia and Slovenia no more than 10 prisons are established. On the other hand countries with a huge population of more than 60 millions such as Germany, France, and Italy have more than 100 custodial institutions. However, in

Switzerland, which is a small country with a population of about 8 millions, there are 113 prisons.

With regard to the implementation of harm reduction measures it was assumed that smaller countries with few prisons would have better opportunities to establish harm reduction measures and that these measures would be available in all prisons nationwide. A first result of the overview is that between the number of interventions implemented or the coverage of these interventions and the number of prisons no distinct association was found.

Coverage is defined as availability of an intervention in relation to the number of prisons. For example, if detoxification offers are available in one of two existing prisons, the national coverage is 50 %. Based on this definition, the results on availability and coverage of different harm reduction measures are presented in the next chapters. However, the data on coverage have to be treated with caution as depending on the expert's understanding of "coverage". For instance, coverage was reported to be 100 % if treatment is in general available to all prisoners but might imply to place a prisoner to another correctional institution for receiving specialised treatment. On the other hand data might reflect if there is access to interventions rather than that there are available or not. For this reason a few countries did not answer the question of coverage as availability alone is no indicator for access to and quality of the treatment service. A number of countries responded to the coverage in the way it was intended, which is to specify the extent of availability in relation to the number of national prisons. The question on coverage followed the idea to know if equal health care is provided to prisoners, independently from the region or state where the prison is located.

3.2.1 Problem drug use in prison

One basic question was about the number of problem drug use (PDU) in prisons, and whether the information is based on data or on the estimation of an expert who completed the questionnaire. Problem drug use was according to the EMCDDA definition¹ defined as 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'. In 15 countries data on the proportion of PDUs in prison is available, while 12 countries reported on their estimations (figure 1). No information was available from Northern-Ireland and Switzerland. The expert from Switzerland commented that there

1 <http://www.emcdda.europa.eu/themes/key-indicators/pdu>

is no monitoring system and for this reason data on the whole country is not available. However, this gap will be addressed by a BIG working group which has been implemented in 2008 to combat infectious diseases in prison.

Across Europe there is a significant variation in the proportion of PDUs among the prison population, ranging from 4 % (Poland) to 80 % (Sweden, Ireland). Of the countries with data on PDUs, Portugal is on top of the drugs problem in prison as on average 66 % of the whole prison population are problem drug users. Similarly, in Spain and the Netherlands more than half of their prisoners are known to be PDUs.

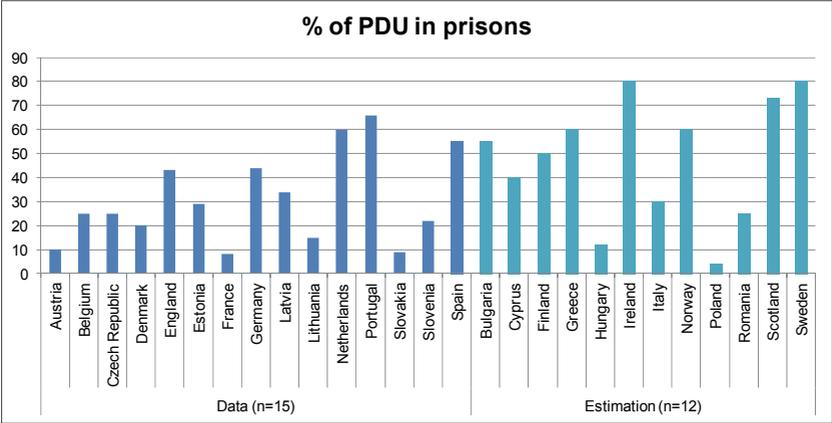


Fig. 1 Percentage of problem drug use (PDU) in European prisons

Among the countries with estimations of the proportion of PDUs in Ireland, Sweden and Scotland a vast majority of the population is estimated to be problem users of opiates, cocaine or amphetamines. Further, in Greece, Norway and Bulgaria more than half of the prisoners are reported to be problem drug users.

All but four countries, Hungary, Bulgaria, Cyprus and Romania, confirmed to conduct an initial screening for drug use problems at prison entry. Thus, an initial screening for drugs problems is performed in 86 % of all European countries.

3.2.2 Provision of drug treatment

One section of the questionnaire asked for availability of specialised drug treatment. In most of the European countries options for drug treatment in prison are available (figure 2). Detoxification is provided in prisons in 22 countries. 24 countries offer initiation of opioid maintenance treatment with e.g. methadone or buprenorphine, and/or continue substitution treatment for those prisoners who were enrolled in community treatment. Maintenance treatment for drug dependent prisoners has not been introduced so far in Bulgaria, Cyprus, Hungary, Lithuania and Slovakia. From Greece it was reported that maintenance treatment is available in prisons. However, the recent EMCDDA prison report identified Greece along with Bulgaria, Cyprus and Slovakia as one of the countries where prison doctors are not allowed to prescribe long-term substitution treatment (EMCDDA, 2012). In Hungary, maintenance treatment has been officially allowed in prisons since in 2001, but has not yet been implemented. Overdose prevention with naloxone and relapse prevention through initiation of OST prior to prison release is provided in 19 and 13 European countries.

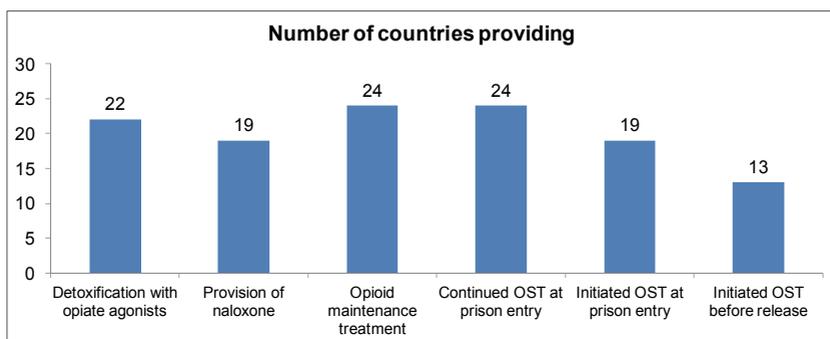


Fig. 2 Provision of drug treatment in prison

For those drug treatment options provided in prisons, the national coverage of availability has been requested, and about half of the countries specified the coverage.

For the respective number of countries that reported on coverage it has been analysed, if the treatment option is available at least in 91%, which means in almost all prisons, or if availability is less than 90 % (figure 3). The results show that in about half of the reporting countries opioid maintenance, either continued or initiated in prison, is available in nearly all existing correctional institutions. In eight out of 18 countries opioid maintenance treatment is imple-

mented in all national prisons; this is the case for Austria, Belgium, England, France, Ireland, Norway, Scotland and Slovenia.

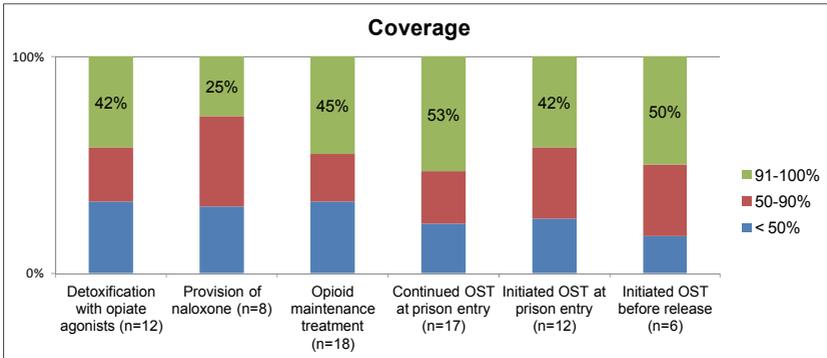


Fig. 3 Coverage of drug treatment in European prisons

In Ireland opioid substitution treatment is provided in closed prisons. If this service is not available in an institution, prisoners with an opiate dependence problem are referred to another institution where they can get the appropriate treatment. The expert from Ireland reported that on any one day about 17.5 % of the total prison population is in receipt of methadone.

With regard to the provision of naloxone, only in England/Wales and Scotland naloxone is provided in all prisons. From Spain it was reported that naloxone is available in all prisons in Madrid. On the other hand, in Bayern, Germany naloxone is provided in seven out of 28 prisons (25 % coverage).

3.2.3 Prevention and treatment of infectious diseases

24 countries (83 %) reported to carry out an initial screening of prisoners for infectious diseases. This screening is not performed in Romania, Slovenia, England, Bulgaria and Hungary. With regard to the provision of measures to combat infectious diseases, the results display that all European countries deliver testing for HIV, and treatment for HIV/Aids and tuberculosis (figure 4). HCV testing and treatment for hepatitis C is offered in prisons in all countries, with exception of Latvia and Bulgaria. However, it remains unclear how many HCV-positive prisoners actually receive this treatment. Post-exposure prophylaxis after needle-stick injuries is available in all but three European countries (Latvia, Greece, and Finland). However, it is unclear if PEP is only

provided to prison staff or as well to prisoners. Vaccination for hepatitis A and B is less common in European prisons, as this prevention measure is provided by no more than 23 countries.

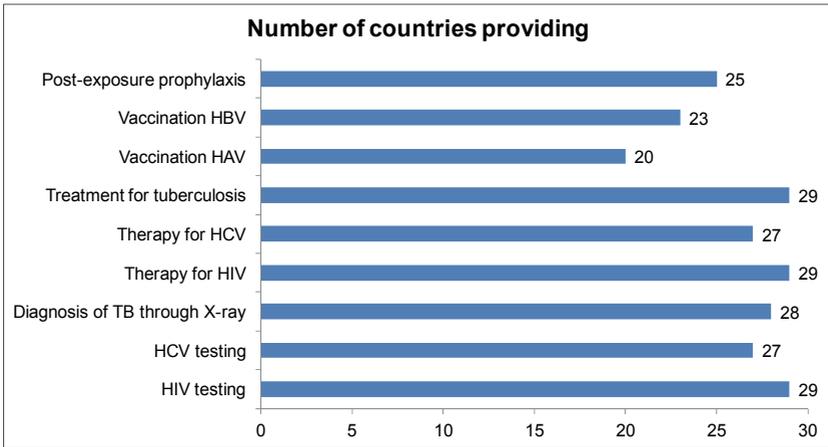


Fig. 4 Availability of measures for the prevention and treatment of infectious diseases

Slightly more than half of the countries with available prevention and treatment programmes reported on the coverage. In general, coverage of measures to prevent infectious diseases in prisons is rather high (figure 5), especially if compared with the coverage of drug treatment provision. In many European countries prison policy seems to place more emphasis on prevention and treatment of infectious diseases than on drug treatment. In 14 out of 17 countries treatment for tuberculosis is provided in all prisons. According to the data in Germany, Estonia and Spain there is a low coverage of tuberculosis treatment. In 13 countries counselling and testing for HIV is available in all prisons while a low coverage of less than 50 % was reported from Czech Republic, Greece, Italy, and Spain. A full coverage of testing for HCV was confirmed by 11 European countries. A poor coverage exists in four countries, where HCV testing is only available in about half of the prisons (Lithuania, Greece, Italy, and Spain). Antiretroviral therapy for HIV/AIDS is provided in almost all prisons in 16 European countries. In Estonia HIV treatment is available in two of the four existing prisons. Finally, in 12 European countries antiviral therapy for HCV is provided in nearly all prisons. A considera-

ble poor coverage for HCV treatment of less than 10 % was found in Estonia and Lithuania.

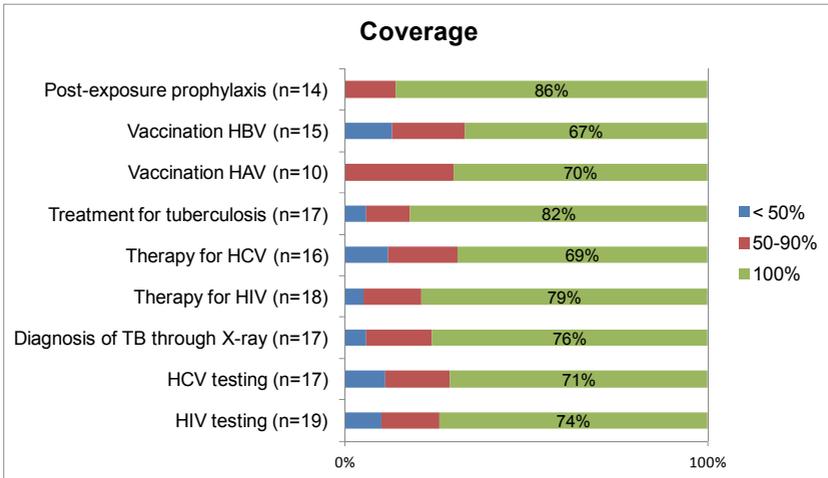


Fig. 5 Coverage of prison-based measures to prevent infectious diseases

Some countries commented on the coverage of interventions to prevent infectious diseases.

– Ireland

There is a 100 % coverage for testing, counselling and vaccination for hepatitis, but not 100 % uptake by prisoners. There is a continued policy to encourage testing and early intervention, for e.g. through having a community HIV/STI consultant physician and a hepatologist present in two Dublin prisons. In the case of drug using prisoners, treatment for HCV is provided if they have achieved a level of stability in terms of their drug use. As in stable on methadone for a period of time or drug free, if that is the preference of the prisoner, the same criteria apply to persons in the community and are set out by the community treating physicians.

X-ray for tuberculosis is done if there is an indication, and then referral to external hospital respiratory physician will be made. Any person found to have active TB will be transferred to community hospital for expert care and treatment.

– England

Prisoners are not tested for HIV or blood-borne virus infections on entry to prison but are given information about these infections and also offered a vaccine for Hepatitis B. To offer a test at point of entry to the prison is not considered as best practice. Instead prisoners are given further information and opportunities to test for infection during their period of incarceration.

All prisons have access to treatment for HCV infection via a mixed economy of prison-based services and NHS acute trust based services. There is variation across the country of the quality of these services particularly relating to continuity of care on discharge into the community. However, no prisoner is denied access to care required.

Diagnosis of TB using CXR is available to all prisoners where it is recommended, following NICE guidelines. Eight large prisons serving populations with high prevalence of TB have been provided with new digital X-ray machines linked to a national centre of excellence for reading and reporting images, but all prisons have either direct access (through prison-based X-ray machines) or indirect access (via NHS Acute Hospital Trusts) to X-rays for the diagnosis of TB if appropriate. In general, prisoners with a history consistent with TB are immediately investigated appropriately in partnership with public health specialists.

– Germany – the Federal States Bayern and Thüringen

Bayern: Counselling, vaccination, testing and treatment for hepatitis, HIV and tuberculosis and post-exposure-prophylaxis are available for all prisoners. Treatment for tuberculosis is provided in one prison which is specialised in delivering this treatment, requiring transferral of prisoners if treatment is indicated.

Thüringen: All juvenile prisoners below the age of 18, who are not yet vaccinated for HAV and HBV, are being vaccinated in prison. Vaccination of adult prisoners is done if there is a medical indication. At prison entry each prisoner is informed about the opportunity to uptake HIV testing free of charge.

3.2.4 Prevention of risks related to drug use and sexual activity

In the questionnaire interventions to prevent sex-related health risks covered measures to combat sexual violence, the distribution of condoms and lubricants, and training on safer sex. Requested interventions to prevent-drug-related health risks included the distribution of bleach, training on safer use and prison-based needle and syringe programmes. The data analysis shows

that a limited number of countries provide any of these measures in prison (figure 6). In no more than in 19 European countries condoms are distributed to prisoners, accounting for 66 % of all European countries that responded to the questionnaire. Furthermore, measures to combat sexual violence and training on safer use are available in about half of the European countries. Prison-based needle and syringe programmes (PNSP) have only been implemented in a few prisons in the four countries Spain, Switzerland, Germany and Romania. Again the coverage is varying. In Germany PNSP is available only in one out of 190 prisons, which is about 0.5%.

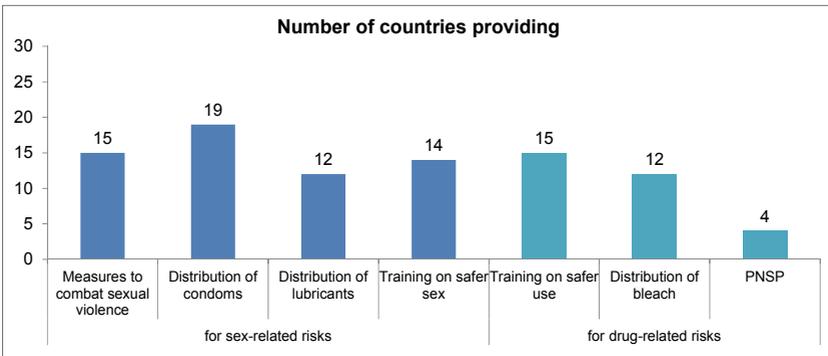


Fig. 6 Availability of measures to prevent sex- and drug-related risks

In countries with measures to combat sexual violence, the reported measures are highly different. In Hungary, sexual violence such as rape is prosecuted but rarely has any legal consequences. In Czech Republic violent prisoners are housed in a separate cell. Ordinary institutional procedures such as supervision (e.g. during taking a shower), separation from other prisoners, transferal to other prisons etc. has been reported from one German Federal State (Bayern). From Ireland it was reported that there is an increased awareness of sexual violence, and prisoners are encouraged to report such issues. A specific healthcare policy on the management of such incidents increases reporting. All such reports are managed in a professional manner which affords the prisoner dignity, respect and support. In Lithuania there is a psychological programme for violent prisoners, and in Austria mediation and training is provided to combat sexual violence in prison.

With regards to the provision of condoms there are also different procedures in place in European prisons. In Hungary and Bulgaria, NGOs distribute con-

doms free of charge, but in Hungary the work of NGOs is not much supported by the prison management. Quite often condoms are only available on request at medical services or the prison health service. This procedure was reported from Slovenia, Finland, Belgium, Portugal, the Netherlands, France, Poland, and partly in Germany. In some prisons condoms can also be bought in prison shops. In Switzerland, condoms are distributed discretely through machines, while in Spain condoms are distributed monthly by prison guards. Further, condoms are provided during conjugal visits (Lithuania, Belgium, and Sweden). In Scotland various procedures for the provision of condoms are in place, ensuring discrete access by prisoners.

Bleach to disinfect injecting equipment is rarely available in European prisons, and only available in 12 out of 29 countries (41 %)². In five of these countries bleach is distributed by the prison health care service (Romania, Portugal, Germany (some Federal States), Switzerland and Belgium). Bleach is distributed by prison officers in Norway, and by the penitentiary administration in France. In Spain, bleach is provided always at prison entry, and afterwards monthly. In Finland and England, bleach is available in prisons through dispensers filled by prison staff on wings.

The results on the coverage of measures to prevent health risks are limited to those types of interventions where data are available from most of the countries (figure 7). The coverage for the distribution of condoms is high, as this intervention is most often available in all prisons. Bleach is available to all prisoners in France and Scotland. Finland did not provide information on coverage of the dispensing machines. From England it was reported that disinfectant tablets are made available to all adult prisoners in England & Wales, and therefore the coverage is 100 %. However, from sampling studies it is known that this is not always implemented consistently, and for this reason new performance measure was recently introduced to capture activity. In addition, there is no information if the type of bleach or disinfectants distributed is effective as regards its concentration. Training on safer sex and/or safer use has not been widely implemented in European prisons. Based on the data reported, training on safer sex is implemented in all prisons in England, Scotland and Romania, and training on safer use was only from Scotland reported to be available in all prisons.

2 Bleach is available in Belgium, England, Finland, France, Germany, Lithuania, Norway, Portugal, Romania, Scotland, Spain and Switzerland.

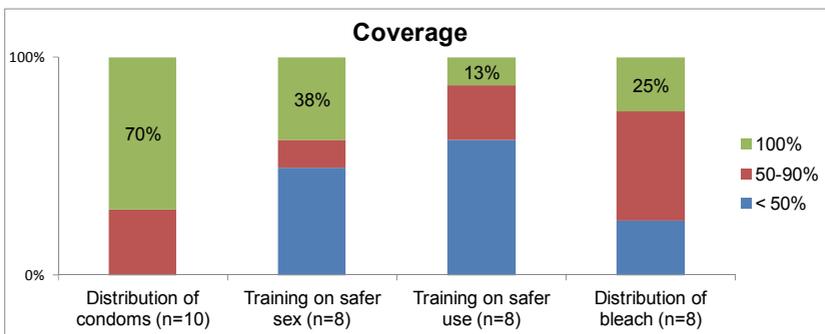


Fig. 7 Coverage of condom and bleach distribution and training on safer sex and safer use

3.2.5 Information and education

Information, education and communication aim at raising the awareness of prisoners for risks related to HIV, sexually transmitted infections, viral hepatitis and tuberculosis. In all European countries but Sweden education on drug-related health risks and education on how to prevent drug- and sex-related infections is available in prisons (figure 8). As well information on safer tattooing and piercing is available to prisoners in the majority of European countries. Measures for safer tattooing and piercing were only reported by four countries, which are England, Scotland Spain and Slovakia.

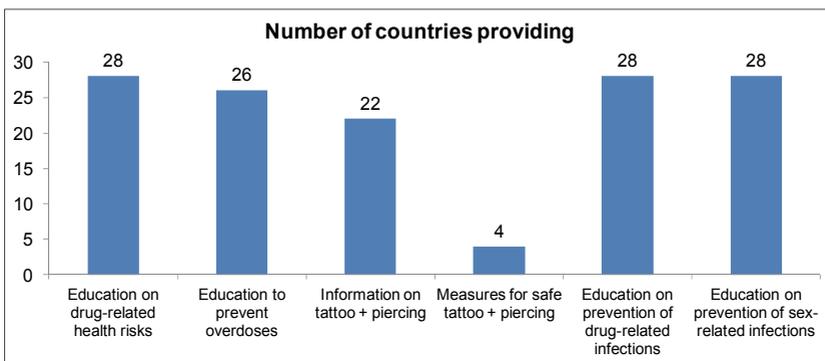


Fig. 8 Availability of information and education to prevent infectious diseases

In England, the policy followed in prison is to empower prisoners with information about a disease, to provide access to testing and treatment, and engage prisoners in designing their own care. From the Netherlands it was reported that since 2012 a new programme on health education for prisoners is elaborated. This programme includes education on drugs, drug use, tattooing, and piercings. The programme will be part of the daily programme for prisoners and will be implemented in 2013. With respect to measures for safer tattooing and piercing, in England disinfectant tablets are distributed, and in Catalonia/Spain, a pilot in one prison has started which aims at educating prisoners in tattooing with sterile material.

Based on countries that specified the coverage, the results indicate that in about half of the countries education and information on health risks, prevention of the transmission of infectious diseases, and overdose prevention is available in all prisons (figure 9). Full coverage of these interventions was reported from Cyprus, Ireland, England, Scotland, Romania, Latvia, Lithuania Poland, Slovakia and Slovenia.

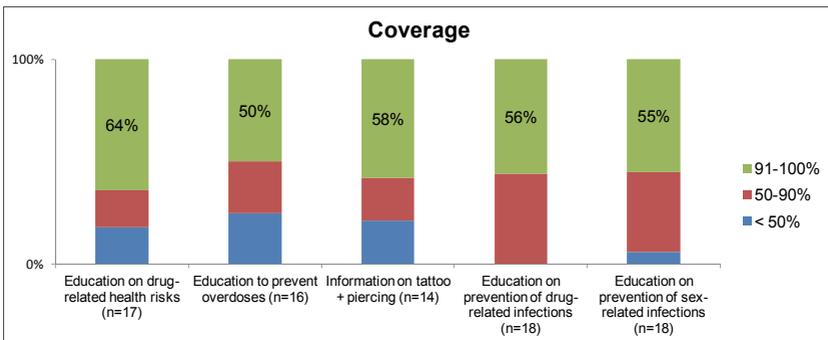


Fig. 9 Coverage of education and information in European prisons

3.2.6 Range of interventions implemented in European prisons

In total, the questionnaire asked for the availability of 28 interventions. To know how many of these interventions are implemented in European prisons, the number of different interventions has been counted per country (figure 10). In each of the 29 countries/states a minimum of 12 different interventions are available in European prisons. 13 European countries have implemented 12-19 different interventions, and another 12 countries have implemented 20-

24 interventions. Almost all of the 28 interventions are available in the four countries/states England, Scotland, Spain and Germany.

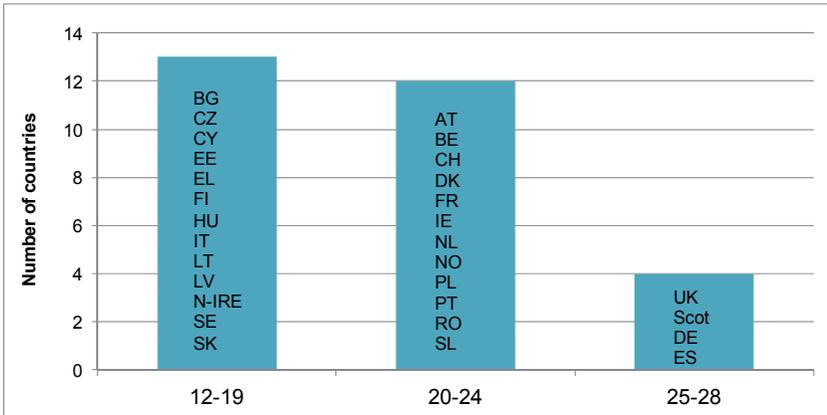


Fig. 10 Number of different interventions implemented in European prisons

In a further analysis it was investigated, which of the most important harm reduction measures are available to prisoners in the 29 countries/states covered by this inventory. As *most important* the following was defined:

- Drug treatment: Detoxification *and* provision of naloxone *and* opioid maintenance treatment *and* continuity of community OST in prison.
- Prevention and treatment of infectious diseases: HIV testing *and* HCV testing *and* PEP *and* diagnosis of TB *and* treatment for TB *and* treatment for HIV *and* treatment for HCV.
- Prevention of drug-related risks: Training on safer use *and* distribution of bleach *or* PNSP.
- Prevention of sex-related risks: Distribution of condoms *and* (measures to combat sexual violence or training on safer sex).
- Information and education: All interventions with the exception of measures of safer tattooing and piercing.

According to the definitions for most important harm reduction measures the results show (figure 11), that in particular measures to prevent and treat infectious diseases such as TB, HIV and HCV have been implemented in prisons in most of the European countries/states (n=24). Second most available in European prisons is information and education on health risks (n=21). Most important harm reduction measures to prevent sex-related risks in prisoners have

been implemented in about half of the European countries/states (n=15). Unexpectedly, interventions targeting explicitly at prisoners with a problem drug use have a low availability if compared with other interventions. Most important options for drug treatment in prison are not even in half of the European countries available (n=14). Furthermore, most important harm reduction measures to prevent drug-related health risks are only available in 35 % of 29 countries/states (n=10). This finding clearly indicates the need for many European countries to improve availability of drug-related interventions in prison.

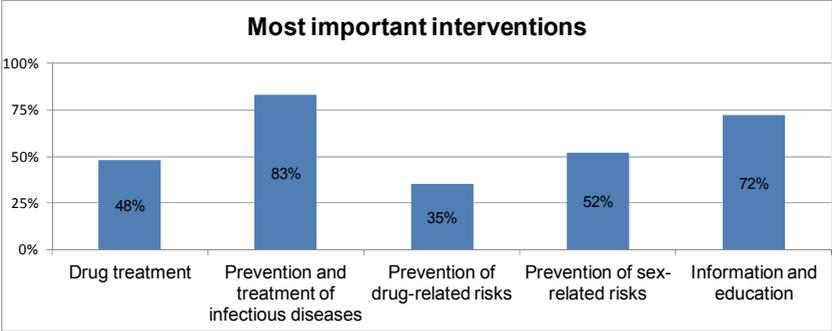


Fig. 11 Proportion of countries that implemented most important harm reduction measures

All most important drug treatment services are available in the following 14 countries/states: England, Scotland, Spain (covering Madrid and Catalonia), Germany (covering six states), Austria, Denmark, Estonia, France, Greece, Italy, Northern-Ireland, Slovenia, Switzerland and Sweden.

All most important measures to prevent drug-related risks are available in the following 10 countries/states: England, Scotland, Spain, Germany, Belgium, Finland, Lithuania, Norway, Portugal, and Romania.

Only five countries have not so far implemented the most important measures for the prevention and treatment of infectious diseases, namely Bulgaria, Finland, Greece, Latvia and Portugal, which all reported a considerable drug users population in prisons.

3.2.7 *Prison policies in European countries*

In the final chapter the prison policies are described with regard to the driving factors that resulted in introducing drug treatment and harm reduction services in the prisons of the respective European country or state. The main aim was to

learn about the national conditions for implementing these services. If a country has not implemented these services so far, the national experts were asked to describe the main barriers for non-introduction. Furthermore, the legal framework for the provision of health care services was requested.

The question on introduction or non-introduction of drug treatment and harm reduction services was limited to the following six services:

- Detoxification with opioid drugs (e.g. methadone)
- Opioid substitution maintenance treatment
- Distribution of condoms
- Needle and syringe exchange programmes
- HIV and/or HCV testing and counselling
- Treatment for HIV and / or HCV

However, it has to be noticed that not all countries included in this overview described the reasons for the implementation or the barriers to implementation of health care services.

3.2.7.1 Driving factors for introduction of drug treatment and harm reduction

There are a number of different reasons for having implemented detoxification with opioid drugs in prisons. However, the driving factors for the introduction of detoxification are to provide treatment that is equivalent to the treatment in the community, and to respond to the increasing number of prisoners with drug problems (table 10). In a number of European countries detoxification is defined as part of the standard medical treatment in the community, and prisoners have to be provided the same treatment services as other citizens.

Table 11: Reasons for introducing detoxification in prisons

Reasons	Countries reporting this reason
Principle of equivalence between community health care and health care in prison	Belgium, Czech Republic, Germany, Ireland, Sweden
Due to the increase in PDUs and opioid addicts in prisons	Austria, Belgium, Northern Ireland
Due to self-harm and suicide risk	England
Part of the Scottish Governments National Drugs Strategy 'The Road to Recovery'; related to the management of drugs in prison	Scotland
Harm reduction is part of the Swiss drug policy, which is also the policy in prisons	Switzerland, Spain

From some countries restrictions in detoxification were mentioned. Thus, Belgium and Italy reported that detoxification in prisons is only allowed by trained physicians. In Greece, detoxification is provided only at prison entry to those prisoners who were in community opioid substitution programmes before their imprisonment. In France, detoxification is seldom provided as maintenance therapy with methadone and buprenorphine is the primary drug treatment in prisons.

Similarly to detoxification, opioid maintenance treatment was introduced to provide services in prisons which are equal to community services (table 11). In Spain and France opioid substitution treatment has been introduced already in 1992 and in 1996.

Further driving factors were the spread of infectious diseases in drug using populations and the increase in prisoners sentenced for drug-related crimes and having a history of drug use. For instance, from Portugal it was reported that between 2001 and 2007, the proportion of drug users in prisons was estimated to be 80-90 %, and 75 % of the prisoners were sentenced for drug-related crime. Against this background the National Institute of Drugs and National Prison System reinforced treatment for drug users, and except from a few prisons opioid substitution treatment in prisons is managed by the National Institute of Drugs.

In Austria, Scotland and Finland also a legal framework for prison-based drug treatment was the main driving factor for the implementation of opioid maintenance treatment. In Scotland the Scottish Prison Service established in 2010 the framework for the management of substance misuse in custody. In Finland a Decree of the Ministry of Social Affairs and Health has been issued in 2008, and according to this decree OST can be provided to patients who have not been enrolled in detoxification. The treatment need has to be assessed and initiated by the health care unit of the Criminal Sanctions Agency. To date the health care unit only confirmed the treatment need in prisoners who were in community opioid substitution treatment.

Restrictions to opioid maintenance treatment in prisons were also reported for Greece, Poland and Sweden. In Greece the prison policy is clearly oriented towards a strategy of drug abstinence, and consequently OST is only in operation in very few penitentiary institutions. Similar to Greece also in Poland opioid substitution treatment is currently only available in 23 out of 157 penitentiary institutions. In Sweden, there is only a limited availability of opioid

maintenance treatment which is due to the restricted community opportunities for a continuous treatment after prison release.

Table 12: Reasons for introducing opioid maintenance therapy in prisons

Reasons	Countries reporting this reason
Principle of equivalence between community health care and health care in prison	Belgium, Czech Republic, Germany, Ireland, Norway
Increase of drug users in prisons and of sentences for drug-related crime	Latvia, Portugal
Aids epidemic and spread of infectious diseases	France, Northern Ireland
Evidence-based to reduce post-release overdose	England
Because of establishment of a national legal framework	Scotland, Austria, Finland
Harm reduction is part of the Swiss drug policy, which is also the policy in prisons	Switzerland

With regards to the distribution of condoms in prisons, the main reasons for introduction of this harm reduction measure was to respond to the prevalence and incidence of infectious diseases, in particular HIV/AIDS, in the prison population by promoting safer sex. The distribution of condoms is regarded as a measure to reduce transmission of infectious diseases. In England, the distribution of condoms to prisoners is integral part of public health and sexual health policy. In Romania, the introduction of condom distribution was depending on the legal support and funding from national and international non-governmental organizations.

With respect to the provision of condoms, experts from Sweden, Portugal and Belgium commented on procedures of condom distribution. In Sweden, condoms are only available at conjugal visits prisoners received. In Portugal and Belgium prisoners have to ask for condoms at the prison medical services, and due to the lack of confidentiality and anonymity requests for condoms are rare. In Belgium a distributing device is now in place in order to ensure low-threshold accessibility to condoms in prisons. In every prison, a needs assessment is carried out to examine the number of distributing devices needed to enable a low threshold accessibility to condoms.

Prison-based needle and syringe exchange programmes are only available in Switzerland, introduced in 1992, Spain, introduced in 1997, Romania and Germany. In Spain PNSP was implemented despite opposition of the prison

staff. In Romania, PNSP was introduced with financial, logistic support and training sessions from the UNODC. Driving factors for the introduction were repeated behaviour surveillance studies which proved the need for this specific prevention measure.

HIV and/or HCV testing and counselling was mainly introduced to control and prevent transmission of blood-borne diseases in prisons (table 12). Testing was regarded as a need resulting from injecting drug use in prisons, and was often supported by the prison health policy. For instance, in Scotland testing for infectious diseases is part of the National Policy and Health Care Standard and the Sexual Health and Blood Borne Virus framework. In France there is a strong support by public authorities for testing in prisons since 1996, and in Finland testing is strongly recommended to prisoners.

From Estonia it was reported that testing is widely implemented in prisons, and each year about 5,000 HIV tests are conducted. Testing is performed at prison entry and repeated after 12 months. However, no information was given if the testing is voluntary. In Hungary, HIV testing at prison entry is voluntary, but the high costs for testing present a major barrier to the availability of testing. In Portugal HIV and HCV testing is implemented in all prisons, however, despite existing guidelines for HIV intervention, the procedures in prisons depend on the available staff resources, either from medical staff of NGOs or from temporary collaboration with external clinics.

Table 13: Reasons for introducing testing for HIV and HCV

Reasons	Countries reporting this reason
Standard of medical care	Germany
Principle of equivalence	Czech Republic, Norway
To control and prevent spread of blood-borne diseases	Austria, Belgium, Lithuania
Support by prison health policy on blood-borne diseases	England, France, Finland, Scotland
Needed due to injecting drug use	Northern-Ireland, Poland, Romania

The driving factors for the introduction of treatment for HIV and HCV infection are similar to those for introducing testing for HIV and HCV (table 13). In many European countries treatment for viral infections follows the principle of equivalence, and is provided as standard medical care in case of medi-

cal indication. Furthermore the treatment provision is regulated or supported by the official health policy, the prison law or guidelines for the management of viral infections.

However, partly treatment for HIV is available but not for HCV. For example, in France and Hungary HIV treatment is available to all prisoners, while the treatment of HCV depends on the availability of a protocol for treatment in prison settings. In France, public authorities have not yet developed an official recommendation for HCV treatment in prison.

According to the report from Greece there are many discussions on the appropriateness of treatment provided in prisons. In Lithuania the expert comment indicates that not all prisoners with medical indication are treated because of the limited budget for treatment. In Portugal indicated treatment is provided if there is sufficient medical staff in prison or sufficient cooperation with local hospital services.

Table 14: Reasons for introducing treatment for infections with HIV and HCV

Reasons	Countries reporting this reason
Standard of medical care, medical indication	Germany, Belgium, Austria, Ireland, Greece
Principle of equivalence	Czech Republic, Norway, Spain
Support by prison health policy, prison law	Cyprus, England, France, Scotland
Needed due to injecting drug use	Northern-Ireland, Poland

3.2.7.2 Main barriers for non-introduction of drug treatment and harm reduction

Barriers resulting in non-introduction of drug treatment and harm reduction services in prison were mentioned by a few and mainly Eastern European countries. The reasons for not having implemented these services are country-specific.

In Latvia, the lack of financial resources has been mentioned as the main barrier for not providing detoxification, condom distribution, and testing and treatment for HIV and HCV. Detoxification and opioid maintenance treatment is not implemented in Slovakia as both are not regarded as necessary for treatment. In Lithuania and Bulgaria both drug treatment options have not

been implemented so far due to the lack of political will. In Cyprus the lack of human resources and an appropriate infrastructure are reported to be the main barriers to the implementation of detoxification and opioid maintenance treatment.

As regards to the provision of condoms in prisons, again the lack of human resources and an appropriate infrastructure was identified from Cyprus as main reason for not providing condoms. In Hungary, the proper provision of condoms is limited due to the costs for condoms. In Estonia, condoms are not distributed as sexual contacts in prison are considered to be involuntary and as a behaviour of domination. In Greece no condoms are provided as sexual activity in prisons is forbidden, and this policy is in place despite knowing that sexual relations are not rare in prison. From Northern-Ireland it was reported that the distribution of condoms interferes with security issues. In one Federal State of Germany (Rheinland-Pfalz) there was a pilot on condom distribution in prisons, and it was said that the acceptance of condoms during the pilot was low. However, there is no further information on the procedure of condom provision during the pilot, and therefore it remains unclear if the lack of confidentiality was the reason for the low acceptance. Finally, in Ireland condoms are not yet available but there is a recommendation for provision from the Education Sub Committee of the National AIDS Strategy Committee.

The introduction of prison-based needle and syringe programmes is an issue of controversial discussion in most of the European countries. A number of countries included in this inventory argued in detail why PNSP has not been introduced so far in any of their prisons. If summarising the main reasons mentioned for not having introduced PNSP, four different levels of arguments can be identified.

Rational approach:

- Belgium, The Netherlands: The proportion of injecting users is low, and they represent only 1 % and 3 % of Dutch and Belgian prison population.
- Estonia, Ireland: The Estonian prison system does not see the need for PNSP as the use of syringes is very rare, and thus effectiveness of this measure is assessed as rather questionable. A jointly commissioned study between Department of Health and Justice, demonstrated very low levels of needle use among Irish prisoners.
- England: the evidence-base for PNSP introduction in English prisons is inconclusive and more research needed to conclude on the balance of

risks versus benefits. Other components of harm-reduction strategies may be as effective and more acceptable in the prison context.

- Germany (one Federal State), Portugal: German pilot projects on PNSP demonstrated negative effects, and thus disadvantages of PNSP are out-balanced. In Portugal, the introduction of PNSP was piloted in 2007, and due to the experiences that no needles were exchanged the programme stopped. However, different procedures between the Ministry of Health, which promoted PNSP, and the Ministry of Justice, which managed the implementation), prisoners basically prisoners could not access the programme.

Security issues

- Norway, Northern-Ireland: The introduction of PNSP is not feasible due to safety reasons.
- Germany (2 Federal States): PNSP undermine efforts to impede the possession of illicit drugs in prison. The provision of injecting equipment would imply an inconsistent procedure of the criminal justice system. Furthermore, needles and syringes can be used as a weapon, threatening the safety and health of prisoners and prison staff.

Neglect of the drug use in prisons

- Bulgaria, Greece: PNSP would require to officially admitting that it is possible to purchase drugs in prisons. Further, PNSP will support the use of drugs in prisons.
- Sweden: Drugs are not available in prisons.

Contradiction to health care responsibility

- Greece, Slovenia: PNSP represent a contradiction to the responsibility of the prison management to provide health care, and health care is predominately focussed on abstinence-oriented measures.
- Germany (2 Federal States): The use of drugs in prison, which is forbidden anyway, should not be supported by providing injecting equipment. The prison administration is obliged to prevent self-harm of prisoners, which includes drug use, and to promote health care. PNSP undermine the objective of health care to support abstinence from drugs.

In addition, it was explained that there is simply no national discussion about introduction of PNSP (Poland, France), or that the introduction of PNSP it is simply regarded as not necessary (Slovakia, Finland). In Finland, the main

reason for not introducing PNSP is the availability of disinfectants in prison clinics and anonymously through dispensers.

Some experts made their comments on the arguments for non-introduction of PNSP. Thus, it was criticised that in Finland the dispensers are not used by prisoners as they believe the use of disinfectants is monitored by prison staff. The expert from Portugal explained that the negative outcome of the pilot on PNSP is related to the procedures of distribution. Those prisoners who would made use of the programme were informed by the prison staff that they have to accept urine testing, resulting in a lack of confidentiality among the prisoners.

From Scotland it was reported that the Hepatitis C Action Plan for Scotland foresees the implementation of needle exchange programmes within prisons as an aim. Whilst it remains the policy of the Scottish Government to carry out a pilot on PNSP, implementation is hampered by the ongoing opposition of the Prison Officer's Association which is concerned about health and safety issues for its members. Despite, the provision of other injecting equipment, excluding needles and syringes, is already offered to prisoners in custody by health staff. However, for the successful and effective introduction of a needle exchange trial it is regarded as essential to get the support of all staff groups. The Scottish Government and the Scottish Prison Service will continue to engage with the Prison Officer's Association in respect of their concerns.

3.2.8 Legal framework for health care for drug users in prison

One section of the questionnaire was about the legal framework for health care delivered to drug users in prison (figure 12). The analysis of this topic shows that in 23 out of 29 countries/states there is a regulation of legislation for prison-based drug treatment (85 %). Secondly, in 22 European countries a guideline or strategy for testing and treatment of infectious diseases in prison settings is in place (78 %). Guidelines or strategies for harm reduction in prison, either during imprisonment or on release are less frequent and available in 16 and 11 European countries (55 %, 38 %).

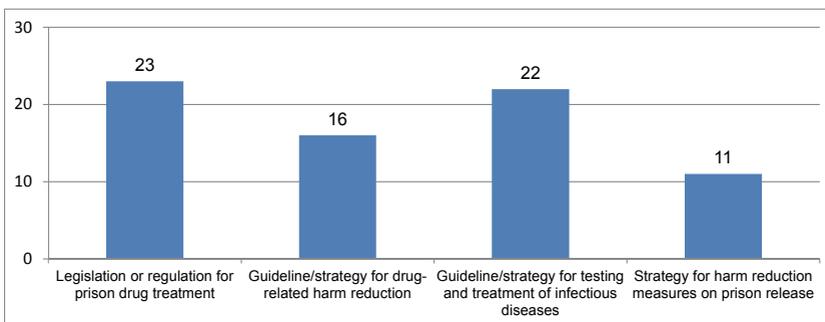


Fig. 13 Number of European countries with legal framework for drug treatment and harm reduction in prison

3.2.8.1 Legislation or regulation for drug treatment of prisoners

Based on the descriptions given by the national experts, the following regulations are in place in the European countries.

- Austria: At present a working group is developing standards for counselling and treatment of drug addicts in correctional institutions. The recent drug law (2011) and the prison law build the framework for the national regulation of substitution treatment in prison, following the principle of equivalence.
- Czech Republic: There are internal regulations of the Prison Service on infectious diseases, provision of OST (since 2006), and instructions for provision of counselling and therapy (since 2001, amended 2010).
- Estonia: Drug treatment is regulated in the “Concept of fight against drugs in prison”, established in 2009. Each prison works according to its own concept.
- Finland: Under the Act of Welfare for substance abusers (1986) local authorities are responsible for providing drug treatment in prison.
- France: Prison drug treatment has been regulated by Ministry of Health and Ministry of Justice in 1996. The regulation includes OST and to organise a follow-up after prison release.
- Germany: There are specific regulations in each Federal State. In one State (Nordrhein-Westfalen) there are medical guidelines and standards for drug treatment in prisons and for cooperation with external services. Further there is joint decree of the Ministry of Interior and Justice and the Ministry of Women, Youth, Family and Health of 3 November 1998 on

prison-based drug counselling. Most recent are medical guidelines for the medical treatment of opioid addiction in prisons, OST, from 2010. On the contrary, in another State (Bayern), there is no specific guideline for drug treatment of prisoners. Instead the general recommendations for health care are in place. However, in Bayern OST is not part of the drug treatment strategy and thus only offered to a few prisoners.

- Hungary: Drug prevention units were introduced by a decree of the Ministry of Justice in 1999. The national legislation on treatment of drug abuse and educational also include the prison setting.
- Ireland: Drug treatment, specifically, is not mentioned in the Prison Rules. However there is an aspiration articulated to provision of equivalence of care which does include drug treatment.
- Latvia: The Cabinet of Ministers Rules No. 70 on “Treatment of alcohol, narcotics, psychotropic, toxic substances and gambling or gaming addicted patients” is also regulating drug treatment in prison.
- The Netherlands, Norway: the same health regulations for community treatment are applicable to prisons. In the Netherlands, there is also a guideline on OST from 2012.
- Poland: Drug therapy provisions are present in several legal acts. The most important ones include Articles 81 and 96 of the Executive Criminal Code from 6 June 1997, the Article 29 of the Act from 29 July 2005 on counteracting drug addiction, and the Regulation of Minister of Justice from 21 December 2006 on specific terms and conditions of drug treatment, rehabilitation and reintegration in prisons.
- Portugal: The National Action Plan of War on Drugs (1999) refers to the need to guarantee drug users same conditions in community and prisons. The National Action Plan of War on Drugs in 2001 considers the objective to provide harm reduction to 100% of the prisoners till 2004.
- Romania: Drug treatment in prison is regulated by the Common Order of Ministry of Justice, the Ministry of Internal Affairs and Administration and the Health Ministry NO 1216/C-13.
- Scotland: The provision of health and addiction services in Scottish prisons became the responsibility of NHS Boards from 1st November 2011.

- Slovenia: In 2009 institutional clinics became part of public health services, implying that local health centres implement healthcare for prisoners.

In Belgium a strategy for prison-based drug treatment is lacking, but there is a ministerial Circular (2006), which, however, does not include clear objectives and related actions. A strategy for drug policy in prison from the European level would be a reference to initiate such a strategy for Belgian prisons.

3.2.8.2 Guideline or strategy for testing and treatment of infectious diseases in prison

With regard to the countries that provided details on the guideline or strategy for testing and treatment of infectious diseases, the following legal framework is in place:

- Czech Republic: There do exist regulations regarding TB (2003), the prevention and treatment of HIV (2005), the detection and prevention of infectious diseases (2007; 2008), and the prevention and treatment of HCV (2011).
- England: For the prevention of infection and communicable disease control in prisons and places of detention the legal framework consists in: 1) A manual for healthcare workers of 8 August, 2011. 2) Department of Health, Health Protection Agency. Tackling Blood-Borne Viruses in Prisons: A framework for best practice in the UK, 2011. 3) Department of Health, National AIDS trust. Multi-Agency Contingency Plan for the Management of Outbreaks of Communicable Diseases or Other Health Protection Incidents in Prisons in England & Wales. 4) Department of Health, Health Protection Agency, August 2008. 5) Guidance for Health Protection Units on responding to TB incidents and outbreaks in prisons, Health Protection Agency, 2008. 6) Chief Medical Officer for England. Action Plan on TB. HMSO; 2004.
- Estonia: There is a national strategy for HIV and AIDS in place.
- Finland: Under the Communicable Diseases Act the government is responsible for the prevention of communicable diseases in prison. Health care staff has to ensure that prisoners are instructed in protection as regards transmission through blood or sexual contact. Prevention is done through health education and distribution of hygiene pack to each prisoner.

- France: HIV prevention in prisons is regulated by a 1996 Ministry of Health and Ministry of Justice joint circular. This includes education, HIV and hepatitis screening, anti-retroviral treatment, post-exposure prophylaxis, access to HAART and hepatitis C treatment, bleach distribution, and condom distribution. Some recommendations are included in a guideline for sanitary staff from 2004.
- Germany: In the Federal State of Thüringen the national law for the prevention of infectious diseases is the basis for strategies and procedures ensuring hygiene in prisons. In each federal prison there is a designated prison staff member who is educated as disinfectant. In the Federal State Bayern, the regulation for health care is included in the Federal prison law. Specific sections of this law define procedures for the prevention of infectious diseases. In the Federal State Nordrhein-Westfalen there is an administrative rule of the 3 Mai 2012 for tackling infectious diseases in penal institutions.
- Ireland: Testing and treatment is included in clinical drug policy document (2008).
- Latvia: Testing and treatment is included in the “Human immunodeficiency virus (HIV) and AIDS control program 2008-2012” and in the “Tuberculosis diagnostic and treatment guidelines”.
- Lithuania: Testing and treatment is regulated in the order of the Ministry of Health and the Ministry of Justice from 2002.
- Poland: Penal institutions follow the same guidelines and standards that are followed in community.
- Portugal: The National Action Plan to Fight Against Infectious Diseases in Prison Context (2006) recommends the implementation of harm reduction strategies, prevention and treatment of infectious diseases inside and outside prison, to ensure funding, to involve professionals and prisoners in implementation, and to guarantee continuity of care.
- Romania: The legal framework is the “Plan for Development of HIV preventive services in Romanian Penitentiary System” from 2012.
- Scotland: The Scottish Governments National Drugs Strategy “The Road to Recovery”, chapter 4, provides information relating to the management of drugs in prison.

- Slovakia: The legal framework consists in internal directives for the treatment of TB, HCV, HIV, and parasitic diseases.
- Switzerland: Standards for the prevention and treatment of infectious diseases in prison will be developed by a working group of the BIG (combating infectious diseases in prison).

3.2.8.3 Guidelines or strategies for drug-related harm reduction measures in prisons

The following guidelines or strategies regulate procedures of drug-related harm reduction measures in prison:

- England: 1) Prison Health Performance and Quality Indicators, National Offender Management Service, Department of Health, 2008. 2) Dear Colleague Letter: Letter introducing a leaflet and other promotional materials for use in prisons, 2009. 3) Prison Service Order 3200, 2003. 4) Health Promotion in Prisons, HMPS. Prison Service Instruction 05/2005 on the re-introduction of disinfecting tablets. 4) PSO 3050 on the Continuity of Healthcare for Prisoners.
- Finland: Each prisoner receives a hygiene pack which includes instructions for condom use.
- France: There are no specific guidelines for harm reduction, but in 2003 recommendations concerning OST care in prison are available.
- Ireland: The clinical drug policy document (2008) is currently under multidisciplinary review and will be available in April 2012. Substitution, testing and vaccination are all part of harm reduction strategies. The National Health Service Provider in the community Health Service Executive (HSE) is currently drafting a document based on the NICE guidelines, which will have a section on prisons.
- Northern Ireland: In February 2012 the “Strategic Framework for the Reduction and Management of Substance Misuse in Custody” was released. As regards overdose prevention, prisoners are supplied with naloxone pre-filled syringes 01.02.1.
- Portugal: The National Action Plan to Fight against Infectious Diseases in Prison Context (2006) recommends a) access to condoms, water based lubricants, bleach and instructions for its use, b) availability of piercing and tattoos equipment, c) PEP, d) diagnosis of infectious diseases, e) pro-

moting PNSP, and f) implementing a pilot of NSP vending machines in four prisons.

- Scotland: In recognition of the increased risk of overdose following release from custody, the SPS is a key partner in the roll out of the National Naloxone Programme. This programme commenced in Scottish Prisons in February 2011.
- Spain: There are no specific harm reductions guidelines, but in prison the Health Administration guidelines are used.

From Czech Republic it was reported about the intention to provide overdose prevention in all prisons in the near future.

3.2.9 Health care services currently lacking in prisons

From the national experts a number of interventions are considered as currently lacking in their prison systems. Partly this includes the initiation of harm reduction measures which are not available so far, and partly this implies the improvement of availability and access to harm reduction in prisons. The identified services which need to be introduced or improved are directed to drug treatment or other treatment, basic harm reduction measures, continuity of care after prison release and cross-sectional tasks.

With regard to treatment delivered to prisoners, most often the introduction or expansion of opioid substitution treatment is considered as a current gap in service provision. To increase availability of OST in prison is mentioned by Finland, Italy Bulgaria Cyprus, Estonia, Hungary and Sweden. The expert from Norway goes one step further and stated the need to introduce heroin substitution programmes in prison. For countries providing heroin substitution in the community this should be debated as an issue of equivalence in health care. A number of countries reported on the need to implement options for drug-free treatment and rehabilitation in prison (Belgium, Bulgaria, France, and Lithuania). Further, cognitive behavioral treatment for drug users is regarded as missing in prisons (Belgium, Romania). In Belgium a pilot project on this type of treatment is carried out, and currently there are discussions for expansion to other prisons. In Germany, the availability of treatment for co-morbidity is stated to be lacking, and in Latvia the treatment for HCV infection is considered to be missing in prisons.

A number of harm reduction measures are assessed to be currently lacking in prisons. Among the measures needed predominately the need to introduce

prison-based needle and syringe programmes are cited. Experts from Bulgaria, France, Northern-Ireland, Scotland, Slovenia and Italy are unique in their opinion that PNSP should be introduced. Second most often the need to implement overdose prevention, either through education or provision of naloxone, is expressed (Czech Republic, France, Portugal, and Sweden). In addition, the provision of disinfectants is currently either completely lacking and needs to be introduced (Czech Republic, Sweden), or universal availability of disinfectants is not achieved so far and needs to be ensured (England). Finally experts from Cyprus and Poland stated that harm reduction measures are more or less unavailable in their prison system, and thus should be introduced.

To improve transition into the community, improvements in discharge planning and continuity of care are assessed by a number of countries to be essential (Ireland, Portugal, Germany, Norway, Sweden). From Norway and Sweden in particular the need is expressed to increase the capacity of community opioid maintenance treatment. At present availability of maintenance treatment in community is low, meaning that treatment in prison cannot be continued after release, which in the end results in low treatment opportunities in prison.

The expert from Switzerland stated the need for more research in prisons, and both, the expert from Switzerland and Finland confirmed the need to implement and improve monitoring of drug users and harm reduction in prison in order to increase knowledge on the drugs problem in prison.

3.2.10 Summary of findings

The inventory comprises information on available harm reduction measures in prison settings from 29 European countries/states. Thus, an updated overview on drug treatment and harm reduction delivered to drug users in prison is provided. For this overview a huge number of national stakeholders from the Justice or Prison Department and experts in the prison field have been contacted to provide information. The findings of this inventory are based on the information provided by these stakeholders and experts.

The main results achieved from the analysis of the questionnaire, which was completed by the respondents, are as follows:

– Problem drug use in prisons

An initial screening for drug use related to opiates, cocaine or amphetamines is performed in 25 European countries/states. Between 4 % (Poland) and 80 % (Sweden, Ireland) of the prison population are assessed to be problem drug users. In 13 countries less than 30 % of the prison population is estimated to be PDUs, while in 9 countries clearly more than half OF the prisoners are estimated to be PDUs (Portugal, Scotland, Ireland, Sweden, Spain, the Netherlands, Greece, Norway and Bulgaria).

– Provision of drug treatment

Detoxification is provided in the prison system in 22 European countries/states, and opioid maintenance treatment is initiated and/or continued in prisons in 24 countries. Maintenance treatment is currently not available in five countries, and unclear in the case of Greece. Opioid maintenance treatment is available to almost all prisoners in need in about half of the European countries/states that reported on coverage. Overdose prevention with naloxone is provided to prisoners in 19 countries, but only implemented in all prisons in England/Wales and Scotland.

– Prevention and treatment of infectious diseases

24 countries (83 %) perform an initial screening of prisoners for infectious diseases. In England screening of prisoners at reception is not considered to be best practice. Instead information is provided on testing for blood-borne diseases during the period of incarceration. All 29 European countries/states deliver testing for HIV, and treatment for HIV/Aids and tuberculosis. HCV testing and treatment for hepatitis C is offered in prisons in all countries, except from Latvia and Bulgaria. Vaccination for hepatitis A and B of prisoners is less common and provided by 23 countries. The coverage of measures to prevent infectious diseases in prisons is considerably high. A low coverage of less than in half of the prisons is reported from respectively four countries for HIV and HCV testing (e.g. Greece, Italy).

– Prevention of risks related to drug use and sexual activity

In no more than in 19 European countries condoms are distributed to prisoners. Most often condoms are only available at prison health services on the prisoners' request. In Switzerland and Scotland condoms are distributed discretely through e.g. machines. Bleach is available in 12 countries, and mainly distributed by the prison health care service. In Spain, bleach is regularly distributed to prisoners, and in Finland and England bleach is available to prisoners through dispensers. Further, in France and Scotland disinfectants

are available to all prisoners. Measures to combat sexual violence and training on safer sex or safer drug use are available in prisons in about half of the European countries. To combat sexual violence usually supervision is increased and violent prisoners are separated from other inmates. Only from Ireland it was stated to encourage prisoners in reporting on such incidents.

– Information and education

In all European countries but Sweden prisoners are delivered education on drug-related health risks and on the prevention of drug- and sex-related infections. Education and information on health risks and related prevention, and overdose prevention is available in all prison in about half of the 29 countries/states. Measures for safer tattooing and piercing were only reported by four countries (England, Scotland, Spain and Slovakia). In Spain a pilot on educating prisoners in sterile tattooing has started in one prison, and in the Netherlands such an education will be implemented in 2013.

– Main reasons for introduction of drug treatment and measures to prevent infectious diseases

The introduction of prison-based drug treatment and treatment of infectious diseases was in many European countries determined by the decision to provide equivalent services in prison to what is standard health care in community. Further driving factors for the introduction of detoxification, opioid maintenance treatment and testing for HIV/HCV were the increase of opioid dependent and injecting drug users in prisons and the high prevalence of infectious diseases in the prison population. Prison policy needed to respond to these health problems in order to control and prevent the transmission of blood-borne diseases in prisons, and to provide drug treatment to those in need. Accordingly, for instance, in Switzerland, harm reduction policy has become the main approach in prison health policy.

– Main barriers for non-introduction of drug treatment and measures to prevent infectious diseases

The main barriers for not having introduced harm reductions measures so far are in particular related to the provision of condoms and the provision of sterile injecting equipment in prisons. Arguments of the prison administration for not providing condoms are that either sexual contacts are forbidden in prisons anyway (Greece) or that sexual contacts in prison are regarded as always involuntary contacts (Estonia). Many reasons are mentioned for not having introduced PNSP. The primary objections to PNSP are that these programmes are not needed due to the low number of injecting drug users in

prisons, that experiences from pilots demonstrated low utilisation of these programmes, and that PNSP is not feasible due to safety reasons (syringes as weapons against prisoners and staff). Furthermore, PNSP is regarded as contradiction to the principal rule that drug possession and drug use is forbidden in prison. In addition, the provision of sterile injecting equipment would undermine abstinence-based efforts of prison health care.

– Interventions that needed to be introduced in prison

From the perspective of the respondents especially three types of interventions are currently lacking in prisons. First of all, the introduction or enlargement of opioid substitution treatment in prison is assessed to be needed. This was stated by five of the European countries. In Sweden and Norway it is regarded as essential to increase the capacity of community opioid maintenance treatment in order to scale up provision of OST in prison. Six European countries expressed the need to introduce needle and syringe programmes in their correctional institutions. Finally, four countries confirmed the need to implement overdose prevention, either through education or by provision of naloxone.

3.2.11 Conclusion

In European prisons most of the main important measures to prevent infectious diseases are already implemented, even though they might not always be available in all prisons or to all prisoners. Thus, essential measures to prevent and treat infectious diseases such as TB, HIV and HCV have been implemented in prisons in 24 out of 29 European countries/states. However, important harm reduction measures to prevent sex-related risks of prisoners (such as condom provision) have been implemented in not more than 15 countries.

With regard to evidence for effective harm reduction delivered to problem drug users in prisons, many European countries definitively need to improve availability and access to drug treatment and interventions for the prevention of drug-related health risk. In fact, in only 14 out of 29 European countries detoxification, opioid maintenance treatment and the provision of naloxone is provided in prison. Most important measures to prevent drug-related health risks, such as training on safer use or the distribution of bleach or sterile needles and syringes, are only available in 10 countries/states. This finding clearly indicates that harm reduction directed to prisoners with drug problems need to be improved substantially in many European countries. An increase

in the availability of drug treatment options and harm reduction is especially demanded in countries with a high proportion of PDUs among the prison population, such as Greece, Bulgaria, Cyprus, but also Sweden and Norway.

The overview has several limitations. The findings are completely relying on the information provided by the respondents of the questionnaire. All respondents are known to be experts in the health care provided in prison in their country of origin, however, especially in large countries with many prisons their knowledge on availability and coverage of health care services might be limited. In addition, Spain and Germany are only represented by a limited number of states. In Bulgaria the information on availability was collected from a few NGOs working in prisons.

Limitations are also given in the findings on coverage as the understanding of the questions on coverage differed between the respondents. Partly it was indicated if a specific intervention is available in a prison, and partly it was indicated if an intervention is available to all prisoners. For instance, opioid maintenance treatment can be available to all prisoners but not in all prisons, implying to move a prisoner to that institution which provides treatment. Moreover, in Portugal the data on coverage are based on the perception of NGOs providing services in prisons. The respondent from England explained, that the estimate of cover reflects uncertainty about complete implementation across the estate although it more accurately reflects intermittent nature of availability of intervention rather than complete lack of access.

Taking these limitations into account, the overview basically provided updated information on general availability of drug treatment and harm reduction in European prisons rather than on access to treatment and harm reduction. Finally harm reduction and health care services might be available theoretically but the actual utilisation is either unknown or very poor and patchy. This accounts for HCV treatment, from which prisoners benefit only in a very small percentage related to the spread of this infection.

3.3 Good Practices: Type and quality of interventions

This chapter summarises the findings on the good practices that were identified and reported by the appointed experts from the 15 European countries. The reported good practices are structured according to the type of intervention, and five main areas of interventions are differentiated:

- Cognitive behavioural interventions
- Pharmacological interventions
- Prevention and treatment of infectious diseases
- Structural responses to prison health care
- Drug counselling, treatment services and peer support

The respective interventions in these areas are summarised as to date of implementation, their coverage, target group and the provider of the services. Furthermore the processes of the intervention with regard to access, programme, and outcome are described. Finally it is presented, if the intervention has been evaluated as this has an impact on the quality level. For each intervention the respective quality level is indicated at the end of the description of the intervention.

3.3.1 (Cognitive) Behavioural interventions

3.3.1.1 CBT for Offenders, Bulgaria

Table 15: Structural data on the offender programme “My new abilities”

Topic	Details
Starting and end date	1 January 2008 – ongoing
Provider	NGO “Crime Prevention Fund IGA”, www.iga-bg.org
Coverage	One town in Bulgaria (Pazardjik)
Main type (s) of intervention	Social reintegration programme Aftercare based on cognitive behavioural approach
Target group	Offenders with drug use problems who are on probation or are already released from prison. Drug problems are mainly related to the use of heroin and amphetamine.
Staff	2 staff members: psychologist and social worker
Budget and source(s) of funding	Annual budget: about 750 € ¹ Funding: European Commission and international foundations (e.g. OAK foundation)
Evaluation	Yes, repeated internal evaluation. The most recent evaluation was in September 2010.

¹=There is no budget dedicated specifically to the intervention. The costs for the intervention are included in the overall budget, the NGO receives for their activities for a 5-year period.

In Bulgaria, a cognitive behavioural training has been implemented for drug using offenders who are sentenced to probation or are released from prison. The programme is called “My new abilities” and provided by an NGO in Pazardjik, a town in Bulgaria. The programme was started upon request of the local prison and court in order to address the growing number of offenders with drug use problems and the high rate of relapses to crime among this group.

Background and objectives of the programme

Both, the court and the prison in the town of Pazardjik expressed the need for a programme directed to drug dependent offenders who either are already released from prison or supervised by probation officers. The main intention of the programme was to reduce relapses to drug use and crime. Furthermore, psychological studies demonstrated that a considerable number of offenders tend to have cognitive and behavioural deficits, such as impulsiveness and misinterpretations of social situations. For this reason a cognitive behavioural training programme has been implemented in 2008. The main aim of this programme is to enhance basic psycho-social skills among offenders. Through the development of these skills, drug use and delinquency should be reduced.

Description of the programme

The cognitive behavioural training programme is provided as a group intervention, and is based on a manual developed by the programme staff. The manual guides the training through explaining the aims, methods and training sessions. For psycho-social interventions delivered to vulnerable groups the NGO runs a specially equipped centre which is located in the town centre.

The programme consists of a 24 hours cognitive-behavioural interactive training, conducted during six hours a day within four days. The theoretical background of the programme is the cognitive behavioural approach as outlined in the American D.A.R.E. Manual (1994) and in the Juvenile Justice Training Manual from UK (United Nation Children’s Fund 2006). The group training consists of 10 to 12 participants. Topics of the training sessions are: attitudes and values, anger control, family support, decision making and communicating.

Access to the programme

There is no defined number of participants. All offenders with drugs problems who are referred by the court or prison can participate in the training programme.

Evaluation

The intervention is repeatedly evaluated on basis of an internal evaluation of the NGO which provides the service. One staff member is a sociologist whose main tasks is to evaluate the activities of the NGO. For the evaluation of the CB training a short questionnaire was distributed to the training participants and the probation officers. The main indicators for evaluation were the number of offenders participating in the training and the delinquency during and six months after the end of the programme. Since the beginning of the training programme in 2008 a total of 90 drug using offenders participated. The evaluation results are related to these 90 participants.

According to the evaluation results 90 % of the participants completed the 24hours training programme. The remaining 10 % dropped out due to their own decision. 80 % of the participants assessed the programme as helpful in developing social skills while the minority reported not to have experienced any impact of the programme. In the six months after the end of the training 65 % of the completers did not commit any offence. Out of the 90 participants 34 individuals entered drug treatment after the programme; 16 for drug addiction and 18 for alcohol addiction. Most of the probation officers confirmed positive effects of the programme (65 %), and about one fifths recommended combining the programme with labour activities (20 %).

Table 16: Quality for the CBT “My new abilities”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	11	Sum of points	6	Sum of points	7
Total Score	24	Quality level 2 – Good Practice			

3.3.1.2 Anger Management, Hungary

Baracska is an agricultural barrack-type prison which belongs to the National Prison of Central Transdanuba. In 2008, in the Baracska block of the prison

the new project started on training the inmates in becoming professional fishermen. The project participants can either be the members of the Drug-Prevention Unit (DPU) or members of the so called healing-educating group. The latter consists of prisoners with personality disorders like ADHD, antisocial personality disorder, drinking problems etc. In addition, prisoners with any drug problem are accepted for the training, which was delivered in terms of a workshop.

The training is offered by one prison security officer who is a professional fisherman. He and a social worker from Baracska unit escort the inmates to the nearby lake (Velence Lake). After finalising the training prisoners can receive a national permission for fishing, and this permission is completely equivalent to that one which is provided by authorities outside the prison. The training programme is highly supported by the prison staff members.

Table 17: Structural data on the program “new intervention techniques and anger management”

Topic	Details
Starting and end date	2 January 2008 – ongoing
Provider	Közép-Dunántúli Országos Büntetés-végrehajtási Intézet www.kdobvi.hu National Prison of Central Transdanubia
Coverage	The prison unit Baracska
Main type (s) of intervention	Changing drug use habit, through training, reintegration
Target group	Offenders with drug use problems, who are on probation or are released from prison. All kind of drugs, disease: HIV, HCV
Staff	5 staff members: senior social worker, psychologist, officer on duty, medical doctor, psychiatrist
Budget and source(s) of funding	Annual budget: no information Sources of funding: Prison service
Evaluation	No

Background and Objectives

The main objective of the training programme is to improve anger management in prisoners by allowing prison leaves to a relaxing environment in the nature and by drawing their attention to the fishing activity. Staff realised the need for a specific programme as some prisoners used benzodiazepines to cope with their anger problems. However, in Hungary fishing is not a real

profession but a hobby. Prison programmes are supported by donations of the Reformatory Church.

Description of the programme

The Drug-Prevention Unit (DPU) in the Barackskaprison started in 2003. Since then a total of 184 inmates with drugs problems participated in the DPUs. Within the DPU, no home leaves are allowed in the first five years. Among the participating prisoners a huge number of disciplinary measures were imposed because they broke the rules of the DPU.

The main training activity for fishing takes place outside the prison. For participating in the training, the inmates are transported from the prison to the Velence Lake by official prison transport vans. The participants can wear their own clothes during the training sessions.

Access to the programme

All offenders with drug use problems, including the use of benzodiazepines and clonazepam, are allowed to participate in the training programme. In addition, other prisoners with anger problems can join the programme.

Evaluation

There is no evaluation of the training in fishing. However, staff members continuously monitor some outcome criteria of the programme. The criteria cover results of results of urine tests, number of home leaves and family visits, number of disciplinary procedures, number of participants, and activities during group sessions. Since the start of the programme in 2008 no disciplinary procedures occurred.

Table 18: Quality for “New intervention techniques in anger management in the National Prison of Central Transdanuba”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	4	Sum of points	0	Sum of points	2
Total Score	6	Quality level 1 – Promising Practice			

3.3.1.3 Psychoeducation – Free Vision Programme, Italy

The “Free Vision” (LiberaVisione) programme is provided in the Padua prison; a prison for offenders awaiting the trial or serving a sentence of not more than 3 years. About 250 detainees are placed in this prison. In this setting, psychoeducation is provided to drug addicted prisoners, and delivered in a group of about five participants. The topics of the group sessions range from drug addiction, marginalisation, and family problems to deviance. In relation to the respective topic a movie or a short documentation is shown. The groups last about three hours (2 hours for the movie and 1 hour discussion), and they are conducted by a psychotherapist.

Table 19: Structural data on the programme “Free Vision”

Topic	Details
Starting and end date	1 February 2012 – 31 January 2013
Provider	Associazione di Promozione Sociale "Nemesi"
Coverage	Padua Prison
Main type (s) of intervention	Assistance to drug users in custody and prison Psycho-social intervention Measures to combat violence
Target group	Adults with a problem of drug use
Staff	3 staff members: psychologists
Budget and source(s) of funding	Annual budget: 7,130 Euro Funding: National government
Evaluation	Yes, repeated internal evaluation. The last evaluation was in July 2012

Background and Objectives

Detention is regarded as a period which should be used to stimulate prisoners with drug problems to behavioural changes. The main objectives of the psychoeducational group sessions is to support prisoners with drugs problems in acquiring social competences, and in the long-term prevent relapses to drug use and re-offending.

Description of the programme

The programme „Free Vision” is carried out by the organization called Nemesi which is a social association working in Padua. The psychoeducation primarily aims at increasing the awareness for drug use risks among drug dependent offenders, and to promote their social, interpersonal and communi-

cation skills. In addition the group intervention aims at improving the skills to control anger and aggressiveness. In this respect the programme is regarded as a measure to combat violence. The main activities of the programme include focus and group therapy, psychoeducation, and vocational skills.

Access to the programme

Since the beginning of the programme 150 problem drug users participated. Out of them 75 drug users completed the programme.

Evaluation

Table 20: Quality for the psychoeducation programme “Free Vision”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	8	Sum of points	2	Sum of points	0
Total Score	10	Quality level 1 – Promising Practice			

An internal evaluation is carried out regularly by using questionnaires to measure the programme satisfaction and the acquired social skills. Furthermore the drop-out rate is documented. However, no results of the evaluation are reported.

3.3.1.4 Psychoeducation – Prison Umbrella, Poland

Table 21: Structural data on the programme “Parasol Więzienny (Prison Umbrella)”

Topic	Details
Starting and end date	1 February 2009 – ongoing
Provider	The NGO “Centrum ProfilaktykiiEdukacjiSpo³ecznej PARASOL”. info@parasol.org.pl
Coverage	Four penal institutions in Krakow area
Main type (s) of intervention	Reduction of overdoses Prevention of infectious diseases Psycho-social intervention
Target group	Adult inmates with drugs problems (including alcohol)
Staff	3 staff members: sociologists
Budget and source(s) of funding	Annual budget: 44,460 PLN Funding: Local authorities and the National Bureau of Drug Prevention (agency of the Ministry of Health)
Evaluation	Yes, repeated internal evaluation. The most recent evaluation was in December 2011.

Psycho-education is provided to prisoners with drug problems in two detention centres and two prisons (one prison for men and one for women) in the Krakow area. The description of the intervention is related to the men's prison 'Zakład Karny Kraków Nowa Huta'.

Psycho-education is delivered in both individual and group meetings, and the duration of the intervention is based on an agreement between the participant and the programme staff. The main objective of the intervention is to prevent the problem use of psychoactive substances through a) improving the normative behaviour regarding drugs and b) promoting healthy attitudes towards drug use and other risk behaviours. All the programme participants have the history of drug use and serve drug-related sentences.

Background and Objectives

For many prisoners imprisonment is a turning point in their life which creates an ideal point for providing harm reduction measures. Furthermore the penitentiary is regarded as best opportunity to reach prisoners with qualified activities. Staff of the four penitentiaries where psychoeducation has been implemented experienced the drug use among the prisoners as a serious problem. The level of detection of illegal substances in those detention units is at highest in the whole "krakowskie" area. However, drug dependent prisoners are offered the alcohol mainstream treatment which clearly focuses on abstinence and which is not specifically addressing problems related to illicit drugs. The psycho-education programme is directed to problem users of opioids, amphetamines and other psychoactive substances, and its objective is primarily to motivate the participants in changing their way of living.

Description of the programme

As mentioned above, psychoeducation is provided in groups and individual sessions. Group meetings are conducted in a form of lectures and trainings on a series of topics which are called 'thematic cycles'. One 'cycle' consists of 12 meetings which each are focusing on specific issues such as safe and unsafe modes of drugs administration, HIV and other sexually transmitted diseases, etc. Individual meetings cover the assessment of the current situation, the identification of the participant's needs, the motivation and support for change, the establishment of contacts to relevant drug services, and the signing of a so called help contract. In addition, cooperation with families of the prisoners, judges and prosecutors take place if needed and reasonable.

After the completion of the programme the participants receive a written certification which is also included in the programme documentation. If participants would like to enter community treatment after release, they receive written information on the concrete possibility to undergo treatment in a defined facility.

Access to the programme

The staff of the programme recruits eligible prisoners through two different approaches: the psychologist of the prison unit sends prisoners with drugs problems to the consultation with the staff of the psycho-education programme or prisoners with drug problems apply themselves for participation in the programme. After an initial interview the programme staff decides on the participation and determines the form of participation. In 2011, 90 prisoners with drug problems participated and completed the psycho-education.

Evaluation

An internal evaluation is repeatedly conducted to monitor the achievement of the programme’s objectives. Indicators for the evaluation are: the number of participants; the improvement of knowledge on consequences of risky sexual behaviours and of drug use; the increase of the awareness for health, including the reduction of harms related to STDs; the number of participants entering community treatment after release. The evaluation also covers the assessment of the participants and the staff on the quality and usefulness of the psycho-education programme.

The results of the process evaluation showed that 331 individual meetings (200 hours) and 105 group meetings (420 hours) took place. Furthermore, a number of participants had contacts with their family and/or with community drug services. Within the prison units 42 consultations with the psychologists of prison services, 33 consultations with the chief prison guard, and a few consultations educational officers and the prison governor took place.

Table 22: Quality for the psychoeducation programme “Parasol Wiezienny”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	8	Sum of points	2	Sum of points	2
Total Score	12	Quality level 1 – Promising Practice			

3.3.1.5 Motivation for prison treatment, Lithuania

To motivate convicts to enter drug treatment, so called introductory groups were implemented. The groups were offered to drug users who have been convicted and serve their sentence in a Correction House. The group activities consisted in lectures about causes for drug addiction, related consequences, introduction in treatment methods and potential difficulties and relapses during treatment. All convicts with drugs problems who want to discuss about drug dependence are allowed to participate.

Table 23: Structural data on the programme “Introductory group”

Topic	Details
Starting and end date	10 March 2010 – 05 November 2012
Provider	Correction House of Vilnius
Main type (s) of intervention	Assistance to drug users in custody and prison Psycho-social intervention or drug free treatment
Target group	Adult drug users
Staff	10 staff members: psychologists as well as addiction advisers
Budget and source(s) of funding	Annual budget: None
Evaluation	Yes, repeated internal evaluation.

Background and Objectives

There were three main reasons for the implementation of the introductory groups. First of all, drug users continued the use of drugs in the Correction House. In addition, a number of convicts used psychoactive substances for their first time while in detention. Secondly, diseases associated with drug addiction such as HIV and hepatitis were rather prevalent. And finally, the majority of prisoners with drugs problems did not know about treatment opportunities in the correction house.

The main objectives of the programme were to motivate convicts to enter drug treatment, to support them in improving their quality of life and the emotional and physical well-being, and to contribute to the development of life skills.

Description of the programme

The introductory group sessions were held once a week over the period of three months. One group consisted of 7-14 convicts. Those who attended the group over this period are programme completers. During the group sessions for instance biographical films were shown, and discussed afterwards. The groups were led by psychologists and addiction advisers who work in the correction house and who have completed the special training. For each meeting the psychologist has to prepare the topics which should be discussed in the group.

Access to the programme

The programme is accessible for convicted drug users who are motivated to enter drug treatment. During the 32-months programme period a total of 14 drug users participated.

Evaluation

A repeated internal evaluation is carried out. According to the evaluation the participation in the introductory group results in a positive motivation to undergo drug treatment. Those who completed the group programme were more likely to enter treatment. However, many participants dropped-out because they experienced it as quite difficult to attend group sessions over a longer period of time.

Table 24: Quality for treatment motivation “Introductory Group”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	8	Sum of points	2	Sum of points	2
Total Score	12	Quality level 1 – Promising Practice			

3.3.1.6 Brief Intervention for drug addiction, Poland

Brief intervention has been introduced in a number of detention and prison units with the aim to address offenders with harmful or dependent drug and alcohol use. Out of 156 existing penitentiary units in Poland, in 2011 brief intervention was reported to be provided by 128 units.

The intervention should support these offenders in reducing or quitting their substance use. A brief intervention is based on a cognitive-behavioural approach and intends to change the drug use behaviour as a first step in a therapeutic process. Participants should be motivated to enter prison drug treatment. The intervention is provided by prison psychologists who are specially trained in this method.

Table 25: Structural data on the programme “KrótkaIntrwencja” (Brief Intervention)

Topic	Details
Starting and end date	2 January 2010 – ongoing
Provider	Central Board of Prison Service bdg@sw.gov.pl
Coverage	About 128 detention and prison units
Main type (s) of intervention	Interventions at the stage of arrest Assistance to drug users in custody and prison Psycho-social intervention
Target group	Problem drug users including alcohol addicts
Staff	239 staff members: trained prison psychologists
Budget and source(s) of funding	Annual budget: no information Funding: prison service
Evaluation	Yes, repeated internal evaluation. The most recent evaluation was in December 2011.

Background and objectives

An estimated 20-25 % of all convicts are drug dependent with a vast majority of them being dependent from alcohol (about 90 %). Accessibility of prison drug treatment is still limited even though 17 new therapeutic units have been opened during the last ten years. In fact, the waiting list for entering the therapeutic units has not yet been shortened. Due to the cuts in the national budget not further prison drug treatment will be implemented. However, the long-term prison drug treatment is not the most adequate option for all prisoners with drugs problems. For this reason there was the need to implement other types of drug services in addition to drug treatment.

The main objective of the brief intervention is to decrease harm related to the continuation of substance use. This aim will be achieved by discussing the positive aspects of abstinence, by establishing alternative priorities, by im-

proving skills and abilities for applying on the labour market, and through focusing on the here and now.

Description of the programme

The intervention is based on the methods of the motivational interviewing (Rollnick & Miller) and cognitive-behavioural approach. It consists of a minimum of three and a maximum of five individual meetings, each meeting lasting about 50 minutes. In total, there are 239 staff members who are trained in providing brief intervention to convicts or prisoners. The psychologists introduce the intervention, carry out an assessment of the individual problem, and discuss potential changes. For the assessment standardized questionnaires are used, e.g. the AUDIT which is a tool to identify alcohol disorders. During the meetings objectives and conclusions are established between the psychologist and the participant, and an information feedback takes place.

Access to the programme

The target group of the intervention are drug and alcohol users, who either

- want to qualify for the prison drug treatment programme (usually a Therapeutic Community) or
- who cannot enter the drug treatment programme due to their short prison sentence but are in need for support. These participants would also be willing to enter treatment after their release.

In 2010, a total of 1,336 prisoners with substance problems participated in the brief intervention. In 2011 this was the case for 3,714 prisoners (among them 358 drug users).

Evaluation

A process evaluation was conducted to measure the satisfaction of the psychologists with the brief intervention, and to monitor the number of participants. However, the evaluation indicators do not correspond with the programme objectives.

According to the results, 1,336 prisoners participated in 2010, 13 % of the interventions were conducted due to drug problems with 87 % due to alcohol problems. The psychologists reported to be satisfied with the brief intervention, and perceived this intervention as useful. In their opinion, the intervention has increased the self-consciousness of the participants with regard to

their substance use (94 %), has changed their attitude towards drug treatment (66 %), and has motivated them to enter Anonymous Narcotics /Anonymous Alcoholics (52 %).

The evaluation also demonstrated that participants with mental health problems adhere to the medications prescribed much better. Furthermore prisoners as well as the prison staff reported a higher acceptance for brief intervention compared to abstinence-oriented prison drug treatment. Last but not least, a brief intervention has several structural advantages. It is economic as this intervention can be implemented in any prison setting, it is less expensive than drug treatment and it does not create any transport expenses, for instance to move prisoners to institutions with prison drug treatment programmes.

Table 26: Quality for the brief intervention “KrótkaIntrwencja”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	9	Sum of points	2	Sum of points	2
Total Score	13	Quality level 2 – Good Practice			

3.3.2 *Pharmacological Interventions in prisons*

3.3.2.1 Methadone Treatment, Poland

Topic	Details
Starting and end date	Implemented: 2 January 2009 – ongoing
Provider	Regional Inspectorate of the Prison Service in Wroc ³ aw oisw_wroclaw@sw.gov.pl
Main type (s) of intervention	Substitution treatment Interventions at the stage of arrest Prevention of infectious diseases
Target group	Opioid dependent adults prisonerswho at least are dependent on opioids since 3 years
Staff	5 staff members: psychologists, psychiatrists, nurses
Budget and source(s) of funding	Annual budget: no information Funding: Prison Service
Evaluation	Yes, repeated internal evaluation

The Polish methadone treatment programme “Meta 1” is provided to opiate dependent prisoners who were already in substitution treatment in the community before entering the prison. The seamless continuation of substitution treatment is not always possible as not all detention units provide methadone.

Wrocław is the capital of the dolnoslaskie region, and in this region there are an estimated 2,000 problem opiate users. In fact, the dolnoslaskie region has the second highest problem drug use population in the whole country of Poland. In Wrocław the problem use of opiates is known since a long time, and the “Meth 1” programme in prison responds to this problem.

The overall objective of the methadone programme is to improve the health of the patients through the reduction of reducing illegal drug use and the prevention of infectious diseases such as HIV/AIDS, HCV, HBV. Opioid substitution treatment also aims at reducing drug-related offences, fatal drug overdoses, and social reintegration.

Description of the programme

After admission to treatment patients receive their daily dose in the morning in the surgery room which is situated in the hospital ward in the Wrocław prison No. 1. In this ward there is one physician with a certification in drug treatment, one head of the ward, two nurses with qualification in methadone treatment, and one psychologist who is trained in addiction therapy. Methadone has to be taken under supervision of the staff in order to avoid misuse of the medication. At least once a month urine testing for psychoactive substances is obligatory. Along with the daily dose a nurse takes the pulse blood pressure of the patient. In addition, there are consultations with a psychiatrist every week at the treatment beginning and later if this is necessary. Patients are assessed as to their administration of drugs (e.g. injecting), blood-borne diseases (HIV, hepatitis), TB and mental disorders. If needed, consultations with specialists for infectious diseases are organised within the prison.

All “Meta 1” patients participate at least two hours per week in psychotherapy and rehabilitation meetings. These meetings are delivered either as individual or group sessions provided by the psychologist, the psychiatrist or the prison ward.

Access to the program

The prison methadone treatment programme is only accessible for inmates who were already in a community methadone programme and who can confirm this when being imprisoned. However, prison methadone treatment is mainly directed to prisoners who are at least three years addicted to opiates and who had previous unsuccessful attempts of drug-free treatment.

Evaluation

Patients of the methadone treatment programme are assessed at the beginning of the treatment, and then on follow-up six months until their release from prison. The assessment covers mental health, somatic health, social functioning and changes in the attitude. However, this is more a patient record than an evaluation, and no report on results is available.

Table 27: Quality for methadone substitution “Meta 1”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	5	Sum of points	0	Sum of points	2
Total Score	7	Quality level 1 – Promising Practice			

3.3.2.2 Methadone Treatment, Romania

Since 2008, methadone substitution programmes have been implemented in nine prisons in Romania (Jilava Penitentiary, Jilava Hospital Penitentiary, Rahova Penitentiary, Rahova Hospital Penitentiary, Colibasi Penitentiary, Colibasi Hospital Penitentiary, Targosor Penitentiary, Giurgiu Penitentiary and Braila Penitentiary). At the beginning the substitution treatment was performed in the detoxification department in the Rahova Hospital Penitentiary. Many of the patients have entered substitution treatment before imprisonment, but a part of them initiated substitution treatment while in prison. Some of the patients continue treatment after release in the centres of the National Antidrug Agency or in other centres. Due to the increasing use of new psychoactive substances during the last two years, the number of registered prisoners is decreasing. In Romania, methadone is administered as a pill.

Table 28: Structural data on the programme “Methadone Substitution Programme”

Topic	Details
Starting and end date	2 June 2008 – 1 November 2011
Provider	UNODC and National Administration of Penitentiaries Medical Direction of National Administration of Penitentiariesdm@anp.gov.ro
Main type (s) of intervention	Assistance to drug users in custody and prison Substitution treatment Reduction of overdoses
Target group	Drug users who mainly use heroin
Staff	62 staff members in the nine prisons: nurses, medical doctors, psychologists
Budget and source(s) of funding	Annual budget: no information Funding of methadone in 2008-2011 by UNODC. In 2012 funding is provided by the Ministry of Justice
Evaluation	Yes, external evaluation

Background and Objectives

Before the methadone substitution treatment was implemented, evidence shows a high prevalence of injecting drugs in prisons in Romania. A few cases of opioid overdoses were registered. However, less than 1 % of the prisoners admitted injecting drugs before imprisonment. A national strategy related to HIV infection was in place, and in addition in 2006 there was the first Ministry order to implement interventions for drug users in arrest settings and in prisons. This order was signed by the Ministry of Health, the Ministry of Justice and the Ministry of Internal Affairs). Every two years in the whole Romanian penitentiary system a Behaviour Surveillance Study is being conducted, with the aim to evaluate the effectivity of existing services and the need for further interventions.

Description of the programme

At admission each patient signed an informed consent on the regulations of the methadone programme. The methadone pills are administered in one daily dose which has to be taken in presence of the staff. In the detoxification department of the Rahova Penitentiary Hospital detoxification, substitution maintenance, initiation of OST, urine testing for different drugs and treatment of infectious diseases is provided.

Access to the programme

In particular those prisoners with problem opioid use are targeted by the programme. During the period from June 2008 to November 2011 in the Rahova Penitentiary Hospital 52 inmates were treated with methadone.

Evaluation

There was an external evaluation of the programme, which was conducted by the Netherlands and completed in 2011. The main evaluation indicator was the number of prisoners who access the programme during one year. However, no results were available due to the Romanian expert.

Table 29: Quality for “Methadone substitution”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	5	Sum of points	6	Sum of points	5
Total Score	16	Quality level 2 – Good Practice			

3.3.2.3 Methadone Treatment, Latvia

Methadone maintenance treatment (MMT) is provided in Latvia since 1996. Until mid-2009, MMT has only been implemented in the Psychiatry and Addiction Centre in Riga, and this is still the only institution in Riga providing MMT. The low coverage of MMT resulted from the lack of understanding of the benefits of this treatment by the medical staff and the clients, the non-client orientation of the service and the relatively low level of funding. On the other hand an increasing number of drug users were treated with MMT. With the financial support from the UNODC methadone programmes were launched in two further cities in 2009 (Jelgava and Liepaja), and in 2010 methadone programmes were also implemented in additional six cities (Jurmala, Olaine, Salaspils, Daugavpils, Kuldiga and Rezekne). At the end of 2011, in Latvia methadone maintenance treatment was available in nine sites serving a total of 193 clients.

The Riga Detention Centre is the largest detention centre in Latvia and the only detention centre in Riga. MMT became available in this centre because of an increase of offenders being in MMT in the community. Due to the cooperation between UNODC, the State Police and the administration of the

Riga Detention Centre MMT was introduced in 2009 in the detention centre. At present the Riga Detention Centre is the only prison in Latvia where MMT is available. The predominant aim of MMT is to provide treatment continuity, and for this reason MMT is accessible only for offenders being already in MMT before their imprisonment.

Table 30: Structural data on the programme “MMT in Riga Detention Centre”

Topic	Details
Starting and end date	Implemented: 2009 – ongoing
Provider	Riga Detention Centre
Main type (s) of intervention	Interventions at the stage of arrest Substitution treatment
Target group	Opiate dependent in community MMT
Staff	1 staff member: medical doctor
Budget and source(s) of funding	Annual budget: no information Funding: National government
Evaluation	Yes

Background and objectives

At present the Riga Detention Centre is the only correctional institution providing MMT to arrested offenders or prisoners. MMT was implemented in this large detention centre because of several reasons:

- According to the PDU estimation carried out by the Health Economic Centre in Latvia 18,888 problem drug users lived in Latvia, of whom 10,169 were users of heroin or other opioids. In 2010, there were 237 clients in OST, even though this is still one of the lowest coverage rates of OST in the EU Member States.
- According to the data from a study carried out in 2010 in the Latvian detention centres in 66 % of the convicts used drugs prior to detention and 39 % of them have used drugs in the past month before detention. 32 % of the convicts had used drugs at least once while imprisoned.
- If substitution treatment is interrupted by imprisonment, withdrawal from methadone might lead to return to drug use in prison, often via injection.

To prevent risk behaviour there is the clear recommendation to continue community OST during imprisonment (UNODC 2008).³

Thus, methadone maintenance treatment has been implemented in the detention centre with the main objective to ensure a continuity of treatment initiated in the community for the period of detention.

Description of the programme

Methadone is delivered to the detention centre by Riga Psychiatry and Addiction Centre. A medical doctor working for the addiction centre provides the arrested offenders with methadone. For the daily methadone dose there is a separate room in the detention centre, and the intake of methadone has to be done in front of the doctor. Except from the daily dose there is no other service provided within the MMT.

Access to the programme

The methadone treatment programme is only accessible for arrested offenders who have been in MMT outside the criminal justice system. Eligible offenders have to provide a written agreement with the Riga Psychiatry and Addiction Centre that proves their status as a MMT client. In detention, 30 patients are treated with methadone each year.

Evaluation Outcome

There is no outcome evaluation of the programme but a regular treatment monitoring. The monitoring covers the doses for each patient, the time of methadone intake and the number of patients in treatment. This information is collected through communication between the physician and the administration in the Riga Detention Centre.

Table 31: Quality for “Methadone substitution treatment in Riga Detention Centre”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	9	Sum of points	2	Sum of points	2
Total Score	13	Quality level 2 – Good Practice			

3 See: <http://www.unodc.org/balticstates/en/grants/latvia/all.html#Prison>

3.3.2.4 Methadone Treatment, England

Table 32: Structural data on the programme “Methadone in prisons: Integrated Drug Treatment System”

Topic	Details
Starting and end date	1 April 2010 – 1 December 2014
Provider	Kings College, London
Main type (s) of intervention	Assistance to drug users in custody and prison Substitution treatment Detoxification Reduction of overdoses
Target group	Drug users who mainly have drugs problems related to heroin, methadone and buprenorphine
Staff	8 staff members: psychiatrist, psychologist, analysts, research assistants
Budget and source(s) of funding	Annual budget: £ 44.5M for OST services £1M for evaluation Funding: National government
Evaluation	Yes, interim qualitative report in September 2012

The English prison’s Integrated Drug Treatment System (IDTS) now provides Opioid Substitution Treatment (OST) and psychosocial support to prisoners with heroin addiction. However, there is no data on the impact of prison initiated OST on post-release outcomes. This study is the first nationwide evaluation of OST in the UK. Commissioned by the Department of Health and Ministry of Justice, the study tests whether OST before release reduces fatal overdose, helps ex-prisoners to engage in treatment, and reduces offending. In addition the study will provide the first representative descriptive data of IDTS clients post release. This is a post release case-control study to evaluate differences between IDTS clients released on OST and those released drug-free after opiate detoxification. The main outcome is drug related mortality in the period immediately following prison release. There is consistent research evidence that prisoners with drug dependence are at substantially increased risk of death after leaving prison primarily due to drug overdose (Farrell & Marsden, 2007; Stewart, 2008). Considerable efforts and investment has gone into developing a more integrated health led system of care between prisons and community treatment services (Marteau, Palmer, & Stöver, 2010). The IDTS is a major component in this more integrated &

comprehensive system of treatment for drug users. A significant aspect of the IDTS initiative has been the institution of more consistent and widespread opioid substitution treatment in prisons, particularly the option for opiate dependent drug users to continue to receive methadone or buprenorphine in prison, thereby lessening the likelihood of illegal drug use in prison, experiencing opioid-related overdose upon release, and disengagement from community services upon release.

Background and objectives

The policy towards OST in prisons in England was reviewed by an expert group in 2004. In common with almost all prison systems around the world at that time, Prison Service Order 3550 recommended detoxification as the standard clinical response to cases of opioid dependence in prisons. At that point (years 2003/2004) 50,701 opioid detoxifications were prescribed to prisoners, the great majority of these treatments were provided to men and women entering prison from the courts following arrest. This default approach of detoxification was in marked contrast to standard practice in English community drug treatment services, which favoured methadone maintenance as the primary clinical response to heroin dependence.

Factors that were taken into consideration as part of this evaluation of prison “detoxification” policy were:

- the vulnerability of drug-using prisoners to suicide and self-harm in prison, and to death upon release from custody due to accidental opiate overdose;
- prison regime management problems related to illicit drug use in prisons;
- the impetus to provide clinical services that correspond to national and international good practice;
- the need to provide clinical interventions that harmonies with practice in community and other criminal justice settings; and
- the need to integrate further clinical and psychosocial services in prisons, to create multidisciplinary drug teams.

On this first point, the vulnerability of drug users in prison to suicide in prison and to death on release, the review panel took account of a newly published report of an enquiry into 172 suicides in prisons in England and Wales (Shaw, Appleby, & Baker, 2003). The enquiry had found that half of the investigated 172 suicides occurred in the first 28 days of custody, and that drug-dependent individuals entering prison had double the risk of suicide in

the first week of custody compared with all prisoners. This finding reinforced a recommendation made by the Prison Service in 2001 that the “Prison Service should pay special attention to the safe management of prisoners in the early stages of custody in a prison, with a focus on excellence of care for all prisoners in reception, first night, induction and detoxification units” (HM Prison Service, 2001).

At the time of the review, there had been limited experiences of substitution treatments in prisons across the country, but methadone detoxification and maintenance programmes had become widely available in women’s prisons. Although no detailed data were available to the review panel in relation to its effectiveness, a sense of greater stability with a consequent reduction in self-harm was reported by many prisons that had introduced methadone programmes. The introduction of these methadone programmes also coincided with a fall in self-inflicted deaths in women’s prisons from a total of 36 in the preceding three full years (2002-2004) to 15 in the three years 2005-2007. Crucially, self-inflicted deaths among women with drug dependence problems fell from 23 to three within these respective three-year periods, suggesting a strong association between methadone treatment and reduced suicidality. The very high number of fatal opioid overdoses amongst drug users leaving prison (Farrell & Marsden, 2007) was also a key issue addressed by the review.

Review panel individuals with a history of heroin addiction released from prison have a risk of death in the first month that is up to a mean average 36 times greater than the general population (Farrell & Marsden, 2007; Stewart, 2008). Opioid substitution treatment (OST) substantially reduces this risk (Dolan K. et al., 2005; M. S. Gordon, Kinlock, T.W., Schwartz, R.P., O’Grady, K.E., 2008). A 2007 study of mortality following prison release that identified high rates of mortality was retrospective – linking nearly 50,000 records from the prison service to the Office of National Statistics mortality records – and did not have specific information on drug use or drug treatment history (Farrell & Marsden, 2007). By contrast, the evaluation of the IDTS is prospective and requires information both on drug history and drug treatment during prison.

Description of the programme

The principal research question for the study is whether IDTS clients who leave prison still receiving a stable dose of oral methadone or buprenorphine medication (case group) are less likely to die in the first eight weeks after

release compared with IDTS clients who have received opioid detoxification while in prison (control group). In addition to mortality rates the study will compare rates of accessing community based treatment and re-offending and re-incarceration rates between the case and control groups.

Access to the programme

Drug users who mainly use heroin, methadone or buprenorphine can access the programme.

Evaluation

Indicators are determined by the research team, but they include mortality rates among OST maintained and detoxified (opiate free, formerly dependent) individuals. The study will compare rates of accessing community based treatment and re-offending and re-incarceration rates between the case and control groups. For the study that will comprise 20,000 participants, several data sources will be used:

- Drug Intervention Records/Minimum Data Set forms from the DIRWEB database.
- NHS Medical Research Information System for mortality data.
- Police National Computer criminal records.
- National Drug Treatment Monitoring System data information from within prisons and on engagement with community drug treatment services after prison release.
- Prison staff will directly provide participant identifiers with pharmacy prescription data for the week prior to prison release.
- The Ministry of Justice statistical office will provide prison release dates.

Table 33: Quality for “Methadone in prisons (Integrated Drug Treatment System)”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	10	Sum of points	16	Sum of points	5
Total Score	31	Quality level 3 – Top Level Practice			

3.3.2.5 Methadone Treatment, Estonia

In the Estonian Prison Service OST was initiated in 2008. During the first years of introducing OST the main activities were focused on its implementation. However, now OST is available in all Estonian prisons. The treatment is carried out in the medical department and delivered by the medical staff. The continuation of community OST in prison is possible in all Estonian prisons, while the initiation of OST is only available in the Tartu prison because this is the only prison providing specialised treatment and rehabilitation to drug addicts.

Since the introduction of OST in the Estonian criminal justice system the number of patients is increasing; from two patients in 2008 to 123 patients in 2010 and 217 patients in 2011. The increase in OST provision is partly explained by the fact that the Ministry of Interior manages this type of treatment in a number of detention centres. For instance, there is a good cooperation between the detention centres in Viru and Tallin area with the local prison, and the prison medical staff delivers the methadone treatment to convicts in the detention centres. Another reason for the growing number of offenders in OST is the increased availability of qualified staff motivating prisoners to enter drug treatment.

Table 34: Structural data on the programme “Methadone in prisons: Integrated Drug Treatment System”

Topic	Details
Starting and end date	1 January 2008 – ongoing
Provider	Estonian Ministry of Justice info@just.ee
Main type (s) of intervention	Assistance to drug users in custody and prison Substitution treatment Detoxification Reduction of overdoses
Target group	Adult male and female opioid users
Staff	Specialists working in medical departments such as psychiatrists, nurses, psychologists
Budget and source(s) of funding	Annual budget: Opioid substitution treatment is financed from the general budget of prison medical service. Sources of funding: Prison service and Ministry of Justice
Evaluation	Yes, repeatedly internal evaluation

Background and objectives

More than one fourth of all prisoners in Estonia are drug dependent which translates into about 900 inmates (including pre-trial detainees). About 40% of all released prisoners are supposed to commit a new crime within a year after release. Detoxification with methadone is available in Estonia since 1998, but officially this treatment was introduced in 2001. With the opening of a specialized centre in 2003 OST became more relevant. Over the years an increased number of individuals were in substitution treatment before entering prison. Accordingly the need for OST in prison rose. In addition, there is a defined objective stating the need to provide access to health care for drug users in prison in order to prevent and reduce health-related harms associated with drug abuse. This objective is related to the development and implementation of prevention, treatment, harm reduction and rehabilitation services people in prison that are equivalent to services available outside prison.

Description of the programme

OST is provided in all prisons and in some detention houses, and delivered by qualified medical staff. Even though opioid substitution treatment can be provided during the whole period of imprisonment, the aim is to reduce the dose. Prisoners who have been in community-based OST are offered a continuation of their treatment while in prison. In case of a medical indication it is also possible to start with OST while in prison. OST is provided together with counselling on the motivation to deal with the drug-related problems. If OST is initiated in prison this usually implies a detoxification treatment which on the average takes between 4 to 8 weeks. However, in single cases opioid maintenance treatment is started during imprisonment.

The medical department collects data on the diagnosed drug dependence. Opioid substitution treatment in prison is financed from the general budget of the prison medical service.

Access to the programme

Prisoners with opioid-related problems are allowed to enter OST. In detail, the main target group are adult male and female opioid users.

Evaluation

Short-term evaluations are carried out on the basis of qualitative data collected by the prison service. In addition, continuous monitoring is conducted though collecting data on the number of prisoners with diagnosed drug dependence, the number of qualified staff, results of drug testing, and number of patients in detoxification, opioid substitution treatment and drug rehabilitation units etc. In line with the plan, the utilisation of OST in prisons has increased in the past few years.

Table 35: Quality for “Opioid Substitution Treatment in prisons and detention houses”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	10	Sum of points	2	Sum of points	2
Total Score	14	Quality level 2 – Good Practice			

3.3.2.6 Naloxone programme, England

The N-ALIVE project (NALoxoneInVEstigation) has two stages: the pilot randomized trial and the main randomised trial. Ultimately, a total of 56,000 participants are planned to be recruited in total. The Main N-ALIVE Trial is a large prison-based randomized controlled trial, designed to test the effectiveness of giving naloxone-on-release to prisoners with history of heroin use to prevent fatal opiate overdoses. Naloxone is an opiate antagonist commonly used to reverse the effects of a heroin overdose. The Pilot N-ALIVE Trial is aimed to demonstrate feasibility by recruiting the first 10% of participants (5,600 participants). The Main N ALIVE Trial will assess the number of lives that could be saved by routine provision of naloxone-on-release to adult prisoners aged 18-44 years with a history of heroin injection who are released after 7 or more days in prison (whether post-detoxification, on maintenance treatment, or otherwise). The Pilot Trial includes an ancillary study in which the participants who give their additional consent will be contacted once by phone. This sub-study will allow the collection of additional qualitative information on opiate use, overdoses, and naloxone use soon after release. Eligible prisoners who give informed consent will be randomized to receive, on release from custody, either a pack containing a single ‘rescue’ injection of naloxone or a control pack containing no naloxone. The trial is ‘double-blind’ prior to the participant’s release so that neither the participant nor prison staff

will know the allocation until the participant opens his/her assigned pack after release.

Table 36: Structural data on the naloxone programme “N-Alive”

Topic	Details
Starting and end date	Implemented: 1 March 2012 – ongoing
Provider	Medical Research Council (MRC) http://www.ctu.mrc.ac.uk/
Main type (s) of intervention	After care Prevention and reduction of overdoses
Target group	Problem drug users who mainly use heroin and other opioids
Staff	50 staff members: nurses, prison officers, pharmacists
Budget and source(s) of funding	Annual budget: £1M Sources of funding: National government
Evaluation	Yes, external evaluation

Background and objectives

Heroin-related deaths account for around 8 % of all UK deaths in individuals aged 15-44. For UK prisoners, the risk of a drug-related death is 7.5 times higher in the first fortnight after their release than at comparable other times at liberty. One in 200 released prisoners, with a history of heroin injection, dies from a drug-related death within 4 weeks of leaving prison. Nearly all these overdose deaths are potentially preventable. However, existing prevention approaches have not adequately resolved the high risk of overdose death soon after release from prison or other settings where drug tolerance may be reduced. Against this background a trial with naloxone has been implemented. Naloxone is known to immediately reverse opioid overdose, but there is no high-quality evidence that naloxone issued to a drug user is likely to be used successfully by another person to save the life of that drug user, should he or she overdose. Thus, the main objective is to learn whether or not naloxone provided to a prisoner with a history of injecting drug use can prevent fatal overdose through administration by a third party (partner, family member or associate).

Description of the programme

N-ALIVE's intervention has been specifically designed to fit in with prison procedures and to disseminate information about emergency naloxone to prisoner-peers (whether randomized or not). It needs prison-based staff specifically for N-ALIVE – as per any well-delivered intervention for prisoners (e.g. hepatitis B immunization; methadone maintenance).

The N-ALIVE Pilot and Main Trials have to be randomized for the following reasons. First, at the moment take-home naloxone is not routinely issued by English prisons, nor by any prison system outside of the UK. Scotland's policy on take home naloxone has, however, changed in 2011. Second, the risks for ex-prisoners are unknown (even by them). We cannot anticipate how availability of naloxone-on-release might alter the riskiness of their heroin use behaviour and thus there is the possibility that providing naloxone in this way may do more harm than good. We shall only be able to clearly assess this through a randomized trial. Third, there is also the possibility that providing naloxone in this way has no effect because either the individual does not carry the naloxone with them or, when needed, the naloxone is not used or not appropriately used. Fourth, the N-ALIVE awareness/information video is a prison-wide backdrop, which aims to reach all prisoners attending the prison's induction session on drug awareness – not only to inform them about N-ALIVE but so that, as peers, they know about, and how to use, emergency naloxone, and also understand why it is necessary to randomize. Fifth, prisoners realise better than anyone that, for prisons to improve (health) services to prisoners, effectiveness has to be beyond question for the public to be persuaded – and that requires randomization. Sixth, we are dealing with a 'captive population', and thus prison-based research must cleave to the highest ethical and scientific standards, which means randomization of individuals and the need for prevention policies to demonstrate cost-effectiveness.

Access to the programme

Prisoners with a history of heroin injection are eligible to access the naloxone trial.

Evaluation

The main questions of the Pilot Trial are: What happens to the naloxone and the participants, in terms of heroin use and overdoses (witnessed or experi-

enced) within 4 and 12 weeks after release? Do 75 % of prisoners assigned to naloxone carry it with them in the first 4 weeks after release? Do prisons and prisoners participate in the numbers expected and required for the Main Trial? Do the N-ALIVE procedures work well logistically in the National Offender Management Service, or will they need to be changed for the Main Trial? If changes are necessary, what needs to be done? The Main Trial will be focused on the question: Does giving naloxone on release to prisoners with a history of heroin injection reduce heroin overdose deaths by 28 % in the first 12 weeks after release?

Table 37: Quality for the naloxone programme “N-Alive”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	9	Sum of points	16	Sum of points	3
Total Score	28	Quality level 2 – Good Practice			

3.3.2.7 National Naloxone Programme, Scotland

Drug related deaths are a major public health problem globally, with rates in Scotland higher than any other region in the UK and among the highest in Europe. One of the most important public health interventions to emerge aimed at tackling rising DRD rates is the distribution of naloxone for peer administration. ‘Take home’ naloxone can legally be administered by anyone for the purpose of saving a life. The supply of a “take home” naloxone kit follows training on how to administer it safely and quickly. The aim of the National Naloxone Programme is to increase the availability and awareness of naloxone across Scotland and to contribute to a reduction in fatal opiate overdoses in Scotland. An investigation into drug related deaths in Scotland and more recent information from Scotland’s national drug related deaths database has shown that the majority of these deaths are opiate related, the majority are “accidental” overdoses, the majority are “witnessed” and 50% have been in prison. A national coordinator and training team were established to facilitate delivery of the programme and assist all Health Boards across Scotland to embed “take home” naloxone programmes in their own areas and the Scottish Prison Service; ensuring that at risk prisoners could be trained on the use of naloxone and be provided with a supply at the point of their liberation from custody. Partnership working was essential and involved

all relevant local agencies including Health Boards, Police, Local Authorities and local drug services in the Voluntary Sector. Alcohol & Drugs Partnerships had a key role in the strategic leadership of development of local Naloxone programmes.

Table 38: Structural data on the programme “Scottish National Naloxone Programme”

Topic	Details
Starting and end date	1 November 2010 – ongoing
Provider	Scottish Government scottish.ministers@scotland.gsi.gov.uk
Target group	Problem drug users who mainly use heroin and other opioids
Staff	All relevant agencies such as the HealthBoards in Scotland and the Scottish Prison Service. Both agencies are working with people at risk of opiate overdose
Budget and source(s) of funding	Annual budget: £600,000 for the period 01/11/2010 – 31/03/2012 £400,000 for the period 01/04/2012 – 31/03/2013 Sources of funding: National government
Evaluation	Yes, external evaluation carried out in August 2012

Background and objectives

Scotland has a population of 5,222,100 (2010 estimate), and covers an area of 78,782 square kilometres. The most recent estimate for problem drug use in Scotland was 59,000 individuals. In 2010/11 10,813 ‘new’ individuals received a specialist assessment of their drug use and care needs, which equates to a rate of 219 per 100,000 of the Scottish population.

Drug related deaths in Scotland have been on an upward trend since 1997, with rates in Scotland higher than any other UK region and amongst the highest in Europe. For 2006-2010, for Scotland as a whole, the drug related mortality rate was 0.10 per 1,000 population. The pathological findings of those who died in 2010 indicated that, as in 2009, the majority of individuals died from the effects of more than one drug. Of all 485 drug-related deaths recorded in 2010, heroin/morphine was implicated in, or potentially contributed to 52 % of drug related deaths (n=254). The findings from earlier research show that those most vulnerable to a drug related death are male, living in the most deprived areas, and aged 25 to 44 years. Also, the majority of deaths take place in a home environment where there is often someone nearby,

thus offering an important window of opportunity for someone to intervene and potentially save a life.

Findings from the National Database in 2010 also showed that two-thirds of those who died had been in contact with a drug treatment service, thus identifying opportunities to engage with and support those vulnerable to a drug related death.

Description of the programme

A short life working group was formed, the remit of which was to develop a national naloxone training programme and a national patient group directive (PGD). A PGD is a legal document that allows the supply of a named medication for a specific situation by named clinically trained staff. This allows medication to be supplied without the need for an individual prescription or referral to medical practitioners.

The Scottish Government resourced a national training team and National Naloxone Advisory Group. The role of both was to be able to support and advise and to provide training and national information materials for all participating Health Boards so that Health Boards could develop their own local take home naloxone programmes. Support was provided to the Scottish Prison Service in recognition of the increased risk of overdose following release from prison custody.

The training team provided specific “training for trainers” sessions across all participating Health Boards and prisons. This enabled staff to develop their own local programmes and provided them with the skills and knowledge required to provide training sessions in their own local areas. Local staff then cascaded the training out to those at risk of opiate overdose, their friends and family members and staff working for services likely to come into contact with those at risk. The training provided to those at risk covered the following elements:

- DRD’s; nationally & locally.
- Overdose; risk factors, high risk times, signs & symptoms, myths, barriers to appropriate interventions.
- Calling 999.
- Naloxone; actions, kit assembly & administration.
- Basic Life Support & Recovery Position.
- Practice.

Supplies of naloxone could then be issued following completion of training. The Scottish Government reimburses Health Boards (including Prisons) for all supplies of naloxone that are made. A national monitoring and evaluation programme was developed and put in place to assess the reach and impact of the national naloxone programme.

Access to the programme

Following the recommendations from two independent expert forums and the successful outcomes of local ‘take-home’ naloxone pilots in Scotland, the Scottish Government supported the rollout of a National Naloxone Programme in Scotland. Under this national programme, naloxone is provided to those at risk of opioid overdose once they have undergone training. This training is also available to family and friends and to service workers.

Evaluation

Monitoring and evaluation of supplies within the community and prisons are ongoing. The impact of the naloxone Programme is assessed by measurement of the number of (opioid) drug related deaths before and after the implementation of the programme.

This report presents data on the number of ‘take-home’ naloxone kits issued as part of the national programme during 2011/12. The data are presented separately for kits issued in the community and kits issued by prisons, prior to prisoner release.

- There were 3,445 ‘take home’ naloxone kits issued in Scotland in 2011/12 as part of the National Naloxone Programme. This includes kits issued in the community and kits issued by prisons.
- There were a total of 2,730 ‘take home’ naloxone kits issued in the community in Scotland in 2011/12, as part of the National Naloxone Programme. By January 2012, 13 of 14 NHS boards were participating in the programme.
- The majority of kits issued in the community (2,370, or 87%), were issued to individuals at risk of opioid overdose, 295 (11%) were supplied to service workers, 60 (2%) to family and friends (with the recorded consent of the person at risk) and five (<1%) ‘unknown’ who they were supplied to.
- Of the total 2,730 kits issued in the community in 2011/12, 2,287 (84%) were reported to be a ‘first’ supply, 348 (13%) a ‘repeat’ supply and 95

- (3%) ‘unknown’ if first or repeat supply. In 132 cases ‘repeat’ supply was due to use of the previous kit on a person at risk.
- In addition to the kits issued in the community, there were a total of 715 ‘take home’ naloxone kits issued by prisons in Scotland in 2011/12, as part of the National Naloxone Programme, all to persons at risk of opioid overdose.
 - Of the total 715 kits issued in prisons in 2011/12, 679 (95%) were reported to be a ‘first’ supply and 36 (5%) a ‘repeat’ supply. Where the supply was noted as a ‘repeat’ supply this could be following initial supply in the community, or it could be that the previous supply was made on release from a previous stay in prison (i.e. issued by a prison).
 - When compared with kits supplied to persons at risk of opioid overdose in the community, recipients in prisons were more likely to be male and their age profile was ‘relatively’ younger.

The supply of ‘take home’ naloxone by prisons was introduced, incrementally, from February 2011 and by June 2011 all Scottish prisons were participating in the programme.

Table 39: Quality for “Scottish National Naloxone Programme”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	11	Sum of points	6	Sum of points	7
Total Score	24	Quality level 2 – Good Practice			

3.3.2.8 GHB interventions, The Netherlands

GHB-dependent individuals are regularly dispatched from prosecution as specialized medical care in the police or the prison is not sufficient. GHB withdrawal symptoms and complications during detoxification can lead to life threatening situations due to psychological complications such as delirium with hallucinations, psychosis, severe agitation, and somatic complications such as high blood pressure (hypertension), heart rate, vomiting, respiratory depression and respiratory arrest. Withdrawal symptoms usually begin within a few hours after the last GHB intake.

Table 41: Structural data on the programme “GHB addiction in detention”

Topic	Details
Starting and end date	15 March 2012 – 31 December 2012
Provider	Dienst JustitieInrichtingen, Agency of Correctional Institutions www.novadic-kentron.nl
Main type (s) of intervention	Interventions at the stage of arrest (police station Breda) Detoxification or withdrawal treatment
Target group	Drug users who primarily use GHB (gamma hydroxybutanoic acid) and who are arrested by the police
Staff	50 staff members: nurses, doctors, psychiatrists, policy-makers, penitentiary workers
Budget and source(s) of funding	Annual budget: no information Sources of funding: Prison Service
Evaluation	Yes, internal evaluation

Background and objectives

In early 2011, the Public Ministry placed a call that an increasing number of GHB addicts had to be left free again soon after arrest because of severe medical risks of withdrawal. GHB dependent people could not be treated at the police station and in judicial establishments. At the same time an early release was unwanted. However, GHB addicts cannot be sent away from the police station for medical reasons, and thus there had to be found a solution for arresting them or placing them in prison.

Gamma hydroxybutyrate (GHB) is a naturally occurring transmitter in the mammalian brain. It has been used as an anaesthetic agent because of its marked sedative effect. The substance is now being misused especially within the rave and dance club scene, where the substance is known as ‘GHB’ or ‘Liquid Ecstasy’. It is sold by mail (or it can be easily made by oneself with a receipt from the web). GHB is available in a liquid, powder or capsule form. Reported desired effects include a feeling of euphoria and disinhibition.

Description of the programme

GHB dependent persons, who are accused of (serious) crimes and arrested by the police, should be transferred as soon as possible to facilities where they receive adequate medical care in terms of detoxification. In this respect, 3 cells at the police station at Breda are established for medical care of GHB addicts

since the 15 March 2012. The GHB treatment is provided by the institution for addiction care ‘Novadic Kentron’. Addicts get for the first 3 days therapeutic GHB, and afterwards they are transported to PI Zwolle or JMC (Medical Centre within the justice system) where he or she will undergo detoxification from therapeutic GHB. After detoxification the detainee will be placed in a regular prison until the end of the sentence.

Access to the programme

The treatment is addressed to GHB-dependent individuals arrested by the police. The Agency of Correctional Institutions in cooperation with the police and two institutes of addiction care have developed procedures for keeping GHB addicts in the police station for initial treatment and transferring them to subsequent detoxification.

Evaluation

In May 2012 an internal pre-and post-programme evaluation has been carried out. However, no results are reported.

Table 42: Quality for “GHB intervention”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	8	Sum of points	8	Sum of points	3
Total Score	19	Quality level 2 – Good Practice			

3.3.3 Prevention and Treatment of Infectious Diseases

3.3.3.1 Pre-release programme „Protect yourself“, Latvia

The programme ‘Protect yourself’ addressed young drug users who are in prison. According to estimates 65 % of the prison population has life-time experiences with drugs, and the majority of them are aged 15 to 24 years. About 5 % of the prisoners are suggested to start drug use while in prison. In view of these data, a programme was implemented to increase the awareness among pre-release prisoners for their strategies to protect themselves from infectious diseases such as STIs, viral hepatitis and HIV after prison release. During the 12 lessons programme one further objective was to promote a healthy lifestyle through quitting drug use. For this purpose voluntary HIV

testing and consultation with a doctor was offered. In addition activities such as a poster competition and the event “A day without drugs” were organised. For prison release programme participants were given a package containing information leaflets and condoms.

Table 43: Structural data on the programme “Protect yourself”

Topic	Details
Starting and end date	10 November 2008 – 10 October 2009
Provider	Latvian Prison Administration
Main type (s) of intervention	Selective prevention in prison Prevention of infectious diseases
Target group	Experimental substance users in the Cesis Correctional Institution
Staff	4 staff members: 1 psychologist (project leader), 1 medical doctor and 2 nurses
Budget and source(s) of funding	Annual budget: 6,539.69 LVL (approx. 9, 500 EUR) Sources of funding: international organisation, national government
Evaluation	Yes

Background and objectives

In 2012, 149 underaged were in Latvian prisons, which is 2.1 % of the total prison population (n=7055). The majority of the minors are serving their sentence for property offences (thefts, robbery). HIV infections as well as hepatitis and tuberculosis, smoking, and drug and alcohol use are significant problems in the Latvian prisons system. In 2005, a research was conducted among 100 inmates of the Cesis Correctional Institution for juveniles. The results show that the juveniles evaluated their health as good even though almost all of the respondents admitted substance use.

The programme ‘Protect yourself’ was implemented in Cesis Correctional Institution, and designed to improve knowledge of pre-release juveniles on risk behaviour as regards HIV/AIDS, STI and substance use.

Description of the programme

The programme consisted of 12 lessons with one lesson lasting 90 minutes. Three introductory lectures were held in order to recruit three groups with

36 participants for the programme. The programme is provided by a psychologist (project leader), a medical doctor and 2 nurses.

The activities during the lessons took place as group activities of no more than 20 participants. Participants are motivated to uptake voluntary HIV testing and medical consultation. The programmes' activities covered to develop a handbook with methodological and theoretical information, to provide handouts in Latvian and Russian language, and to prepare participants for release through giving them informative material on infectious diseases and drug addiction. For release the juveniles also got condoms.

Access to the programme

The pre-release programme is directed to juvenile prisoners who reported an experimental use of substances. During the period from 10th November 2008 until 10th October 2009 a total of 62 prisoners participated in the training course "Protect yourself", and out of them 39 prisoners completed the training.

Evaluation

There is no outcome evaluation of the programme but a monitoring of the implementation of the programmes' activities. In the above mentioned period from 2008 to 2009 a total of 44 prisoners have received voluntary testing and counselling on HIV. 108 prisoners participated in the event "A day without drugs", and 37 released prisoners received a box with information material and condoms.

Table 44: Quality for "Road map for safer life"

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	9	Sum of points	2	Sum of points	2
Total Score	13	Quality level 2 – Good Practice			

3.3.3.2 HIV/AIDS Screening, Portugal

Since 1995, the GATO (Group of Support for Drug Users) has been developing projects in prison. Recently, the project "Rebuilding the Future" has been implemented in prisons in Faro, Olhão and Silves, which are in the south of the country. The Faro prison has the capacity of 120 inmates, placed in 30 cells and

14 dormitories. In 2010, there were 169 prisoners with about 31 prisoners who were in prison drug treatment, in particular in methadone treatment. The prison operates a nursing office, a medical office and a dental office. The Olhão prison is a preventive detention institution where more than 50 % of the detainees are foreigners, often from Spain, Romania and Morocco. The prison of Silves has an average occupancy of about 59 inmates.

The project is funded by the National Coordination for HIV/AIDS and includes five activities: individual psychosocial support, psychosocial support group, screening for HIV/AIDS, awareness actions, and recreational activities.

Table 45: Structural data on the programme “Rebuilding the Future”

Topic	Details
Starting and end date	1 January 2010 – 31 December 2012
Provider	GATO – Grupo de Ajuda a Toxicodependentes www.gato.org.pt/?page_id=191
Main type (s) of intervention	Prevention of infectious diseases among the prison population
Target group	Experimental drug users, problem drug users, former drug users and individuals suffering from an infectious disease, especially from HIV/AIDS
Staff	5 staff members: 1 coordinator, 1 psychologist, 1 social worker, 1 graduate in applied social investigation, 1 social educator
Budget and source(s) of funding	Annual budget: 59,601 Euro Sources of funding: National government and NGO
Evaluation	Yes, internal evaluation with the last carried out in July 2012

Background and objectives

The organisation has more than 10 years of experiences with prison programmes. During these programmes a needs assessment is continuously carried out in order to respond to the acknowledged needs of the prison population. In this respect, the lack of HIV screening measures in the prison as well as the lack of data on the HIV/AIDS prevalence was realised. Furthermore, it became clear that several recommendations of the Ministry of Health as concerns the prevention of HIV/AIDS in prison have not been implemented properly. The HIV/AIDS prevention programme “Rebuilding the Future” has been established to contribute to the prevention of HIV/AIDS and sexual infectious diseases through promoting healthy attitudes and behaviours among prisoners.

The specific objectives of the programme were to educate prisoners on the protection of HIV transmission, their human rights, and how they can protect themselves from infectious diseases. The overall aim was to reduce the HIV prevalence in the prison population by easing free access to condoms, (repeated) testing and treatment for infectious diseases and psychological support.

Description of the programme

As mentioned earlier, the programme consisted of five activities.

- Individual psychosocial support: Individual support was provided weekly, and focussed on enhancing a better self-esteem, a healthier lifestyle, and the development of personal and social skills. Methods of motivational interviewing and empathic listening were used for providing psychosocial support.
- Psychosocial support group: groups take place weekly, and psychosocial support included educational games, brainstorming on a variety of issues, and thematic debates on e.g. drug dependence, imprisonment, and reintegration. Within the groups techniques such as drama, thematic debate, group dynamics, role-playing, feedback, and positive reinforcement are used.
- Screening HIV/AIDS: part of the screening it to first watch a video on information about HIV/AIDS. This is followed by pre-test counselling and rapid testing, and finally post-test counselling. Inmates may choose only part of these procedures.
- Awareness raising: awareness raisings covers two main topics, HIV/AIDS and citizenship. With regard to HIV/AIDS prisoners were supported in developing skills to prevent the acquisition and transmission of HIV, and they were informed about relations between HIV infection and drug addiction, medications for treatment, labour etc. Citizenship and employment implied discussions about the concept of citizenship, its ethics, the rights and duties as a citizen, and the steps necessary to be integrated in the labour market.
- Recreational activities are offered such as sports, theatre groups, cinema sessions, and art.

The recreational and educational sessions were based on the methods of art therapy. These methodologies use artistic expression as tools for the personal and social development, through three levels: recreational, therapeutic and transformative. The themes were chosen by the participants and in accordance with the objectives of the Prison Direction.

Two specific sessions on burnout symptoms were organised for the prison staff and guards. The topic ‘burnout’ appeared to be a very important health issue for those working in the prison setting.

Access to the project

The programme can be accessed by all prisoners, including drug users. It is especially directed to prisoners at risk of acquiring HIV, viral hepatitis or tuberculosis.

Evaluation

The impact of the health promotion project is considered as positive. An increasing number of prisoners participated on the activities, resulting in an increase in screening for infectious diseases and in a higher awareness for and knowledge about HIV/AIDS among prisoners. Participants also benefited from the psychological support in terms of a better emotional and psychological stability, and the integration in therapeutic communities or “apartments of rehabilitation”.

Table 46: Quality for “Rebuilding the Future”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	11	Sum of points	6	Sum of points	3
Total Score	20	Quality level 2 – Good Practice			

3.3.3.3 Prison HIV and STI service, Ireland

A proposal to provide a consultant led service to Cloverhill and Wheatfield Prisons is in the context of the National Aids Strategy Committee recommendations that, where referral rates and numbers justify it, consideration should be given to the development of satellite clinics within the prison system. Due to the association between substance misuse, criminality, and prevalence of HIV and hepatitis, prisons have been responsible for a disproportionate num-

ber of referrals to HIV/infectious disease services. Requirements for STI services in prisons are disproportionately higher than in the general population (General Healthcare Study of the Irish Prison Population, 2000). GUIDE Clinic St James Hospital research has identified that one third of the HIV cohort attending can be linked to injecting drug use as the mode of acquisition. Prisoners requiring GUIDE Services attended the main clinics escorted by two or more staff, causing major disruption to the clinics operation. Such visits posed a significant resource implication for the Department of Justice and heighten the risk of incidents/escapes among prisoners.

The GUIDE Clinic, having consulted with IPS Healthcare Directorate, proposed the allocation of three clinic sessions per week. One clinic session each in Cloverhill Prison (Remand) and Wheatfield prison complex (sentenced) and one administrative session to treat HIV, infectious diseases and STD's. This allowed for the development of weekly clinics in both complexes and would provide considerable benefits both financial and operational for the prison services.

Table 47: Structural data on the programme “Prison In Reach HIV STI Service”

Topic	Details
Starting and end date	31 January 2007 – ongoing
Provider	Irish Prison Service
Main type (s) of intervention	Indicated prevention Service available to all prisoners who might be at risk for HIV or STI Early detection of HIV and other blood-borne viruses through screening
Target group	Experimental drug users, problem drug users, former drug users and individuals suffering from an infectious disease
Staff	2 staff members: 1 nurse and 1 consultant STI physician
Budget and source(s) of funding	Annual budget: 169,000 Euro Sources of funding: Prison service
Evaluation	Yes, repeatedly carried out in December 2011

Background and objectives

Prisoners coming into custody may or may not self-identify as being HIV positive or in need of STI services. A routine committal health screen was provided but many prisoners would not trust sufficiently in the system to disclose their status, unless they were on medication that they needed to continue. Issues regarding a perception of a lack of confidentiality etc. because attendance at outside hospital appointments would be known by prison officers because they had to escort them to the hospital in the community. For those who did opt to attend the community hospital there was up to a six week waiting list. Attendance at outside hospital services increased the risk of bringing in contraband.

The overall objective of the programme is to provide an STI/HIV inreach service at two prisons which will improve the existing service and increase accessibility. In addition, there is a number of specific objectives, which are the following:

- Prompt and timely processing of prisoner patients (i.e. the usual waiting time of six weeks would no longer apply);
- Implementation of internationally recommended standards of best practice for health care delivery to prisoners;
- Reduced cost of service provision for the Department of Justice & Equality;
- Develop vaccination and prevention programmes appropriate to this patient group;
- Eliminate risk of absconding, and eradicate the risk of transfer of illicit materials/substances through contact with general public.

Along with the programme on-site training is organized for existing medical support staff at each of the prisons. A consultant led diagnosis will facilitate a prompt response when in-hospital care is indicated. It is expected that earlier engagement of patients will result in decreased rate of complications and reduced risk of transmission.

Description of the programme

The development of the service was based on an evidenced needs assessment. There was pressure on prison officers to provide escorts to over 30 patients a month to specialist services. Staff shortages could often result in patients failing to attend specialist appointments. Complaints from physician regard-

ing continuity of care were becoming more frequent. The development of this service was grounded by effective clinical risk management principles.

The main programme activities are 1. Assessment; 2. Screening; 3. Treatment for all STIs and HIV; 4. medication monitoring and review; 5. Vaccination; 6. Phlebotomy and 7. Contact tracing.

Access to the programme

It had been identified by the Irish Prison Service that there were a significant number of prisoners in need of HIV and STI services. Approximately eight clients per week were attending St James Hospital.

Evaluation

The internal evaluation was carried out by medical student under the direction of the consultant. According to the results there was a better treatment access through this in-reach programme since patients could be seen on site and not have to wait for appointments and opportunities for escorts to be arranged. As part of the committal process, nursing staff are able to direct at risk prisoners to the in-reach service more effectively and quickly.

Patients who are on treatment regimes have better compliance since the opportunity to follow-up patients in non-compliance can be much more effectively achieved in a more timely manner through the regular in-reach clinics. In addition, the inmate Red Cross volunteers, linked to the in-reach service operating in the two prisons have a role in encouraging compliance through peer to peer support. The opportunity for prisoners to be seen on site by a sympathetic and dedicated team created patient satisfaction.

In terms of reduced stigma and improved vaccination coverage, there has been a significant increase in the number of prisoners being tested for HIV through a rapid voluntary HIV testing campaign in both Cloverhill and Wheatfield prisons. This has only been possible because of the links between the in-reach service and the Inmate Irish Red Cross volunteers. Their role has been one of advocacy to encourage fellow inmates to come forward for viral testing. The impact was that only 2 % of the prison populations were aware of their HIV status prior to this programme and raise to >50 % of the population in both prisons. Additionally, the advocacy work of the volunteers helped to reduce stigma and encouraged prisoners to talk about HIV. Qualitative evaluation indicated that prisoners had a new understanding of HIV

and AIDS affecting how they felt about others having the disease. There has also been an increase in the number of prisoners seeking out vaccinations for hepatitis because of the in-reach service available on site.

The in-reach service has had a significant impact on the number of prison officers having to be tied up in escort duties. On average there are around 10 prisoners per clinic seen with the inreach clinic which adds up to around 420 patients seen per annum. This works out at about 10 % of the prisoner population in Ireland.

Table 48: Quality for “STI/HIV Project”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	11	Sum of points	8	Sum of points	3
Total Score	22	Quality level 2 – Good Practice			

3.3.3.4 Hepatitis C guideline in detention, The Netherlands

As indicated by research, the prevalence of hepatitis C is relatively high in detainees. In 2008 and 2009 pilots were arranged in three prisons to learn about the best way of enlightenment, screening, treatment and continuity of care. Knowledge from these pilots together with experiences from a number of other prisons and knowledge of chain partners are used to establish a guideline for enlightenment, screening and treatment of hepatitis C in detention. This guideline is endorsed by the assembly of prison nurses and prison GPs. The implementation of the guideline runs from 1st quarter 2012 to the 3rd quarter 2012.

80 % of detainees in The Netherlands are staying in detention less than four months. Continuity of the treatment is mainly aimed at the policy of DJI for enlightenment and screening in detention. Treatment will only start within detention if delay is medically liable or if the detention is longer than the duration of the treatment. After detention detainees are transferred to community treatment.

Table 50: Structural data on the programme “hepatitis C guideline in detention”

Topic	Details
Starting and end date	January 2009 – ongoing
Provider	Dienst Justitiele
Main type (s) of intervention	Interventions at the stage of arrest Prevention of infectious diseases Testing, counselling, treatment for hepatitis C and transfer to health care facility after detention.
Target group	Experimental drug users, problem drug users, former drug users and individuals suffering from an infectious disease Groups of increased risk of hepatitis C such as HIV patients or MSM
Staff	8,000 staff members in all prisons in the Netherlands: nurses, doctors, psychologists, psychiatrists and executive staff
Budget and source(s) of funding	Annual budget: the budget for the 3-years pilot and development of the guideline was 600,000 Euro. The claim for evaluation of the guideline in 2013 is 40.000 Euro. Sources of funding: Prison service
Evaluation	Yes, completed evaluation. The pilots were evaluated in 2009 and 2010. The evaluation of the guideline is planned for the end of 2013.

Background and objectives

Research showed that the population in detention had a much higher prevalence of hepatitis C compared to the general population. Before the start of the project professionals were not aware of the need in terms of information, detection and treatment for hepatitis C. The main objective of the HCV guideline in detention was to ensure good and unambiguous care to the detainee, to contribute to healthy work and life, and finally to contribute to public health. A structured approach to hepatitis was necessary as an estimated 2-10.7 % of the detainees are infected with HCV.

Description of the programme

Pilots were realised in two prisons – in Veenhuizen for longstay detainees and in Arnhem for shortstay detainees – to test the best practice for HCV testing and treatment of detainees. Later on a third pilot was conducted in an

Amsterdam prison for longstay detainees. The guideline for hepatitis C was developed for a target group that is often not considered eligible for treatment in community services. The pilot prison staff was trained in hepatitis C screening and treatment. The pilots were the basis for the official directive to screen for HCV and treat a hepatitis C infection in detention.

Access to the programme

All detainees with risk behaviour such as drug use, injecting drug use, or MSM as well as HIV patients have access to the programme.

Evaluation

The evaluation of the pilots showed that training on HCV is improving the knowledge of the nurses. Furthermore it became obvious that clear agreements and specified tasks and roles of the medical staff are important. To raise awareness and to conduct screening for hepatitis C takes more time than the medical duties needed before. Finally the testing results demonstrated that in addition to HCV cases also cases of STD were found.

Table 51: Quality for “Hepatitis C”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	6	Sum of points	2	Sum of points	4
Total Score	12	Quality level 1 – Promising Practice			

3.3.3.5 TB screening in detention, The Netherlands

Tuberculosis (TB) is a bacterial infection. It is spread through inhaling tiny droplets of saliva from the coughs or sneezes of an infected person. TB mainly affects the lungs. However, the infection can spread to many parts of the body, including the bones and nervous system. Typical symptoms of TB include coughing, weight loss and night sweating.

Since 1994, all newly arrived prisoners in the correctional institutions in the Netherlands were screened for tuberculosis through research in the mobile X-ray units. Based on the opinion of the Commission for Practical Tuberculosis (CPT which represents the TB doctors in The Netherlands) the Agency of Correctional Institutions (DJI) decided in 2010 that from 2011 on the screen-

ing procedures for TB among entering detainees will be changed. Since then a chest X-ray is only made after a standardised risk assessment. If according to the risk assessment there might be an infection with TB, X-ray will be done.

A new guideline on the modified method of TB screening in detention was developed in 2010, and piloted in three prisons. The preconditions for screening changed, training for medical staff was recommended, and a number of implementation meetings took place for the staff of the management, policy and prison nurses.

Table 52: Structural data on the programme “TB screening in detention”

Topic	Details
Starting and end date	1 July 2008 – 1 March 2011
Provider	DJI (Dienst Justitiële Instellingen), Agency of Correctional Institutions info@kncvtbc.nl
Main type (s) of intervention	After care Indicated prevention
Target group	Individuals suffering from an infectious disease, in particular those who were suspected of TB (born outside the Netherlands, homeless, drug users, former TB patients, HIV positive, stay in foreign prison)
Staff	5000 staff members, covering all prisons in the Netherlands: nurses, doctors, and people working at municipal health, department tuberculosis control
Budget and source(s) of funding	Annual budget: no information Sources of funding: Prison service
Evaluation	Yes, current. Period which was evaluated: February 2011 – September 2011, external Evaluator

Background and objectives

According to the Law on Population (WBO) screening for TB is only permitted in case of an infection risk. The purpose of TB screening is the detection of active TB. Prisoners who are infected with TB will be treated in order to avoid transmitting the bacteria to others. Until 2008, TB screening was conducted by the GGD Flevoland and GGD Hart van Brabant. Since 2008, the screening of prisoners is executed by GGD Netherlands and eight back-office health centres. Since 2009, there is a national coverage of TB screening, meaning that in all 48 detention centres weekly screening for tuberculosis performed by the mobile X-ray unit.

From the intake screening it is known that the number of TB cases among detainees in correctional institutions was declining, and since 2005 TB infections fell below the national standard. Research showed that most of the people who were born in the Netherlands were TB negative. Against this background the main purpose of the new screening procedures is to reduce the number of chest X-rays and at the same time to increase the percentage of completed TB treatment. Detainees are provided appropriate care which implies not exposing them to X-rays if this is not indicated by risks of TB infection.

Description of the programme

The DJI was examining whether the current tuberculosis prevention is sufficiently effective and efficient and whether this policy complies with laws and regulations. In October 2007, the CPT was requested to evaluate the procedures of an effective tuberculosis screening among detainees, and in April 2008 the CPT recommended a TB screening after risk assessment. Accordingly in 2010 a new directive on TB screening was developed which came into practice in 2011.

Access to the programme

Screening for TB is accessible for all prisoners who are exposed to risks of an infection with TB. If TB has been detected, treatment is initiated. Treatment often includes a long-term intake of antibiotics which usually lasts for at least six months. However, TB infection can usually be cured with treatment.

Evaluation

First data from the external evaluation showed that there is a reduction of 45 % in indicated chest X rays. Most people carry out the triage as it should be. However, the new procedure is expected to fail the detection of 2-4 cases of TB.

Table 53: Quality for “TC screening in detention”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	11	Sum of points	10	Sum of points	6
Total Score	27	Quality level 2 – Good Practice			

3.3.4 *Structural Responses to Prison Health Care*

3.3.4.1 Community based health in Irish prisons, Ireland

Ireland was the first country in the world that introduced the Community Based Health and First Aid in Action (CBHFA) programme through the special status Irish Red Cross Volunteer Inmates in Wheatfield Prison Dublin in June 2009. Following the success of this pilot, in 2010 to 2012 this approach was extended to five other prisons and it is anticipated that it will be operating in all fourteen prisons in the Irish State by 2014. The programme was developed by the International Federation of the Red Cross (IFRC) and operates under a partnership between the Irish Prison Service, Irish Red Cross and Vocational Education Committee. It uses a unique approach to raising community health and hygiene awareness and first aid in prison communities through peer to peer education.

Prisoner volunteers are trained as peer educators, and the quality of their interventions are overseen by the project manager. A key feature of peer education is drug addiction awareness, harm reduction, infectious diseases such as HIV/AIDS, hepatitis, TB and other infections prevalent in closely confined communities such as prisons. Volunteers learn about and carry out landing level awareness about hygiene, cleanliness and disease prevention. This includes proper hand washing techniques and ongoing TB awareness/vigilance campaigns that include sneeze/coughing etiquette and stigma reduction. CBHFA nurse/health & fitness teachers and Irish Red Cross facilitators work with the CBHFA inmate volunteers who in turn act as peer educators with the rest of the prison population. Prisoners self select to gain entry to the programme. If they are motivated and committed to complete all the modules of the programme, they will be certified as Special Red Cross volunteers. Volunteers work closely with the addiction counsellors in each prison assisting in clinic management and encouraging inmates into the programme. Action learning projects include teaching first aid management of drug overdose and a particular campaign aimed at warning inmates of the dangers of overdose associated with release from prison. Whilst needle exchanges are not available in prisons, the information is passed on about safer practices for when prisoners are released.

Table 55: Structural data on the programme “Community Based Health & First Aid in Action in Irish Prisons”

Topic	Details
Starting and end date	30 June 2009 – 31 December 2014
Provider	Irish Prisons, Red Cross
Main type (s) of intervention	Assistance and aftercare for prisoners with drug use problems is provided by Red Cross peer educators Tuberculosis awareness and symptom recognition/ prevention of spread. Encouragement with Direct Observation Therapy (DOT). Drug Counselling – involvement of volunteers in promoting the Counselling service Violence reduction
Target group	Drug users, including problem drug users and former drug users who mainly used cocaine, methadone, amphetamines or benzodiazepines Prisoners suffering from an infectious disease, mainly from HIV/AIDS, TB, infected leg ulcers, flu (seasonal/ swine flu), hepatitis, and STI's
Staff	2 core staff who travel to all six prisons 1 nurse manager and 1 Red Cross project manager Additionally in each prison site there is a specified nurse, teacher and interested prison officers
Budget and source(s) of funding	Annual budget: 100,000 Euro Sources of funding: Prison service, non-governmental organisation, Community Foundation for Ireland
Evaluation	Yes, completed internal and external evaluation in November 2010

A partnership developed between a local hospital and the project facilitated a mass voluntary HIV rapid testing campaign in two prisons which resulted in an increase of known viral status from only 2 % to over 50 % of the prison populations. Qualitative evaluation also indicated that there was a significant reduction in stigma and prisoners willingness to talk about HIV/AIDS as a result of the engagement of the prison community in this project. The programme also targets violence in prisons with a key project on a weapons amnesty and awareness to reduce or remove cutting weapons from prisons linked to advocacy around the seven Red Cross humanitarian principles. This

is important because of the links between illicit drugs and the potential for violence.

Background and objectives

Health Care in prisons has been going through a change in philosophy from being reactive to a proactive, preventive culture and this project has been key to moving this forward at community level. Prior to this project there was no prisoner peer to peer health awareness which appears to be a driving force to making a difference in prisons. Within the course manual, a needs assessment is conducted as module 3 of the programme.

The overall objective of the project is to create a cadre of inmate Irish Red Cross volunteers as peer to peer educators in all 14 prisons in Ireland to promote health education/awareness, first aid and Red Cross humanitarian principles advocacy. Further, there are a number of specific objectives which include:

- At least 10 volunteer inmates in each prison are trained in the Community Based Health and First Aid in Action approach to community health awareness and first aid.
- Volunteers identify, in collaboration with healthcare personnel, the main health problems in specific prisons.
- Inmate volunteers carry out practical awareness about seven Red Cross humanitarian principles in the prison setting. These are: humanity, impartiality, unity, independence, voluntary service, neutrality and universality.
- There is an improvement in basic health, hygiene and safety within the prison environment including proper handwashing techniques and sneeze/coughing etiquette. There is evidence of changed thinking amongst inmate Irish Red Cross volunteers about their goals, identity, beliefs and values, capabilities, behaviours and living environment that indicate personal empowerment.
- Campaigns are conducted that increase awareness about the dangers of drug addiction, needle-sharing, tattooing/piercing, overdose risk on release from prison focusing on harm reduction.
- Projects are being operated in partnership with Merchant Quay Ireland (MQI) to assist in better access of the prison population to drugs counselling services.
- There is evidence of a sense of community being fostered through the Red Cross CBHFA in action approach within each prison. There is evi-

dence of a reduction in the number of prisoners smoking through the smoking cessation project run by the inmate Irish Red Cross volunteer facilitators. Inmate volunteers are promoting mental health first aid within the prison community.

- The inmate volunteers, in partnership with prison management, will advocate for a weapons amnesty linked to promotion of the Humanitarian Principles leading to a reduction in cutting weapons, thus leading to less cutting incidents within the prison.
- Women's health issues are promoted within the female prison.
- Projects are implemented that assist new inmates entering the prison to adapt more safely to their new environment of living, providing emotional and practical information support.

Description of the programme

Each prison is divided into sections called Divisions/Landings on which there are specific units containing cells that accommodate from one to three people and on occasions four people. For the purposes of this programme, which is a global Red Cross community programme designed for external communities, the following is defined: divisions/landings are like neighbourhoods, units are like streets, and cells are households.

Each prison has a prison school and classes for teaching CBHFA to inmate volunteers is sited here in each prison. The awareness campaigns/health education is carried out within the prison community on the landings, within the units and on a person to person basis at cell level. Some prisoners are on what is called 23 hour lock-up, which means they are not allowed or do not choose to associate with other prisoners for various reasons. In these cases, inmate Red Cross volunteers are permitted to visit them personally in their cells so that they are not disadvantaged. Other places for the promotion of awareness/information are recreational areas and within the school area.

Access to the programme

There are over 4000 prisoners in custody in Ireland within 14 state prisons. Whilst there is healthcare in each one of the prisons, it has been difficult until this project to make a real impact at prisoner community level in terms of basic health education/health awareness which includes drug awareness and harm reduction.

As described above, volunteers self-select into the programme. The average number of Red Cross Prisoner volunteers in one prison at any one time is 20. Peer educators have reached 2,056 prisoners who participated in the interventions.

Evaluation

There was an evaluation of the pilot project in one specific prison in the Irish Prison Service between September 2009 and September 2010. The programme is now available in six prisons and includes all elements of harm reduction that was limited in the pilot programme. The impact of the harm reduction elements of the project will be addressed in the 2012, and a 3-year evaluation was available in December 2012.

The main findings from the 2010 evaluation are:

- A formalized twice monthly hygiene and cleanliness audit system has been implemented throughout the prison. The Irish Red Cross inmate volunteer group has ensured that all equipment and materials needed for proper cleaning of the landings is now available. Consequently, hygiene and cleanliness has notably improved as shown by audits, prisoner community and staff comments.
- The known HIV status of the prisoner community has improved from only 2 % to 56 % through the HIV testing initiative as part of a CBHFA project. There has been a significant change in the way that the subject of HIV AIDS and PLWHV are accepted among the prisoners.
- A major health problem (smoking) is being addressed through a smoking cessation programme that is a partnership in which the Irish Red Cross inmate volunteers support community smoking cessation groups and the doctor prescribes medications for stopping smoking.
- Operational alliances between the Irish Prison Service and other relevant departments/organisations have been created such as with the Irish Red Cross, City of Dublin VEC, St James Hospital, Health Service Executive (HSE) Health Education in order to undertake special projects that serve all partner interests.
- Prisoners actively involved as Irish Red Cross Inmate volunteers in Wheatfield may be advantaged when it comes to seeking parole and later in securing jobs upon release. Irish Red Cross inmate volunteering is having a positive effect on improving interpersonal relationships in the prison and has the potential to install good citizenship for the future.

- IRC Inmate CBHFA volunteers work closely with, and sometimes as part of, other projects such as the Listeners Project (linked to the Samaritans) and the Alternative to Violence Programme in the Prison (AVP).
- Evaluation of the programme identified that despite very good senior management sensitization to the project, teachers and prison officers on the ground were not well enough informed and this needs to be addressed in future programmes.
- Fifty prisoners are successfully managing their own medications in a Medications In-Possession Project in which IRC inmate volunteers were supporting the community.

The IRC volunteer inmate group recognized the multi-cultural nature of some of their community and used their own linguistic assets (Russian bi-lingual CBHFA volunteer) to produce materials and messages in Russian. In general, there is good evidence that prisoners listen more to other prisoners than to medical or nursing staff about health matters.

The evaluation also identified some limitations in the programme implementation. The Community Tools module provided with the CBHFA Training Pack has been of limited use in a closed prison community. This is because there are different priorities in an all-male prison in western society. As recommended by the International Federation of the Red Cross and Red Crescent Societies, National Societies may need to create their own and this was successfully done by the volunteer group and produced by the prison print shop. Furthermore, the practice of first aid in the prison community was weak because of the difficulties of providing first aid kits in the prison community (security and self harm risks described in challenges section). Teaching about the use of condoms has been limited due to the reluctance for security staff to allow condoms to be freely available in the prison.

Table 56: Quality for “Community Based Health and First Aid Action”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	10	Sum of points	6	Sum of points	7
Total Score	23	Quality level 2 – Good Practice			

3.3.4.2 Community linking after release, Ireland

Table 57: Structural data on the programme “An exploration of the effectiveness of community linking for prisoners who are released from Mountjoy Prison on methadone maintenance”

Topic	Details
Starting and end date	1 January 2012 – 1 May 2012
Provider	Irish Prison Service
Main type (s) of intervention	After care in Mountjoy Prison Substitution/maintenance treatment or pharmacologically assisted treatment Detoxification or withdrawal treatment Reduction of overdoses
Target group	Drug users (e.g. frequent and persistent users of psycho-active substances) Main substances: Cocaine, Heroin, Misuse of tablets, Methadone. HIV and blood borne diseases
Staff	4 staff members: clerk on temporary release desk, medical clerk, 2 addiction nurse specialists
Budget and source(s) of funding	Annual budget: no information
Evaluation	Yes, internal evaluation completed in May 2012

The community linking after release was explored in a study with a small sample group in Mountjoy Prison with the aim to enhance seamless care for prisoners who are released from Mountjoy Prison on methadone maintenance. For data collection and analysis qualitative methods were used. The study involved six semi structured interviews with the Irish Prison Service staff, three interviews with community service providers, and a focus group with four prisoners in Mountjoy Prison. From the data gathered it was clear that there is effective community linking for prisoners who are released from Mountjoy Prison on methadone maintenance. Both prison and community staff saw the linking process as being effective and seamless. Exceptions to this rule were a rarity and both groups of staff saw these exceptions as resulting from external forces which the prison service has little control over. Participants in the focus group also stated that they had a seamless transition to the community with no impact on their continuing drug treatment. However all interviewees made suggestions on how improvements in the linkage between prison healthcare and community services could be made. Prison staff identified areas that needed to be addressed locally to ensure that all rel-

evant prisoners were effectively linked to community drug treatment and community staff also suggested ways where more effective networking and communication could take place to ensure seamless through care for all prisoners who are released. The focus group participants recommended local improvements that would ensure that all their medical needs were met on release.

Background and objectives

In order to review the community linking a study was conducted with the aim to explore the effectiveness of community linking for prisoners on methadone maintenance as perceived by the Prisoners themselves who have experience of the community linking system, and professionals/administrators within both prison and community health systems. Specific objectives of the study were to investigate the following: 1. whether everyone involved in the community link process was actually being connected in reality; 2. whether all prisoners in need of community linking were actually being linked effectively; 3. identifying how the process of community linking could be improved; 4. make recommendations for the improvement of the service.

Description of the programme

Mountjoy prison is a 700 bedded medium secure prison. The community linkage is generated out of the prison surgery of 30 staff of which six should be dedicated to Addiction Services. The aim is to arrange the transition of methadone treatment from the prison to the social environment by engaging the community services at the most appropriate time. This provides a continuity of care which should be seamless.

Access to the programme

Access to the programme is driven by the hypothesis that the more seamless the transition from prison to community with methadone treatment, the less risk there would be of overdoses following release. About 1,000 prisoners participated in the methadone treatment per year.

Evaluation

Overall the findings of the study were positive in that all of those consulted – prison staff, community drug service staff, and prisoners themselves – agreed that the issue of prisoner safety post-release had been clearly identi-

fied, and that community linking for prisoners being released from Mountjoy on methadone maintenance was reasonably effective. While many criticisms were expressed about the detail of prison-community linking, none of these criticisms were of a fundamental nature but were presented in terms of improving a situation which was generally deemed to be working well. Some of the criticisms related specifically to features of the prison system, such as unplanned temporary release which occurs at times in response to prison overcrowding but which make community linking difficult. Also there was a recognition that healthcare should have a role to play in discharge of prisoners ensuring that all relevant documentation and medication is arranged and that the prisoner has the necessary upcoming appointment date to facilitate continuity of care. To implement an effective discharge plan for every prisoner this would require further change and cross sector working. Further changes could be implemented to improve the transition process and notification.

Table 58: Quality for “Community linking for prisoners after release from Mountjoy Prison Methadon Maintenance Programme”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	10	Sum of points	4	Sum of points	5
Total Score	19	Quality level 2 – Good Practice			

3.3.4.3 Primary assessment at prison entry, Lithuania

The primary assessment is carried out by a physician when a new convict enters prison. In addition, a psycho-social assessment is made to evaluate individual characteristics and social and health problems, including drug dependence. In case of withdrawal effects the inmate is sent to the Prison Hospital psychiatric department for a 1-2 weeks detoxification. After detoxification the prisoner is transferred to health care and social rehabilitation services provided by physicians, psychiatrists, and psychologists. By the end of 2011, the Lithuanian prisons provided 36 different psychological programmes that focused on emotional management, conflict resolution skills, communication skills, the ability to resist drugs/alcohol, lessons on safe sex, etc.

Table 59: Structural data on the programme “The primary assessment”

Topic	Details
Starting and end date	1 April 2010 – 31 August 2012
Provider	Vilnius Correction House
Main type (s) of intervention	Assistance to drug users in custody and prison Evaluation of “new” prisoners as to their health, emotional well-being and need for dependence treatment
Target group	Drug users who use all kinds of substances, such as opioids, cannabis, cocaine, sedatives, stimulants and hallucinogens
Staff	30 staff members: doctors, psychologists and social workers
Budget and source(s) of funding	Annual budget: no information Sources of funding: Prison service
Evaluation	Yes, repeatedly carried out. Last evaluation was in August 2012

Background and objectives

The main objective of the primary assessment is to assess the health and emotional well-being of the prisoners. Professionals are conducting interviews and tests with each new convict entering prison. The assessment also covers the question of substance dependence and infectious diseases. In detention, those prisoners with drug use most often injected drugs (83 %), followed by inhalation (7 %) and sniffing (3 %). After the evaluation the main intention is to provide the necessary first aid, and in case of substance dependence to motivate the person to undergo for drug treatment.

Description of the programme

The initial assessment is carried out in correctional institutions. In the first week after prison entry the inmates are assessed by health, psychological and social rehabilitation services. The assessment is based on interviews, blood sampling, general health check, diagnosis for hepatitis A, B and C, HIV, AIDS, TB and other infections. A psychologist evaluates the emotional state, drug dependence, motivation for treatment, self-harm history, social relationships, communication skills, and the well-being. With regard to drug addicts the main purpose of assessment is to refer them to detoxification and drug treatment.

Access to the programme

In principal, all prisoners are assessed at prison entry. However, a main target group consists in prisoners with problem drug use and/or infectious diseases.

Evaluation

An initial evaluation of the programme only indicated that the assessment increased the motivation for drug treatment, especially among prisoners who were repeatedly imprisoned.

Table 60: Quality for “Primary Assessment Programme”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	8	Sum of points	2	Sum of points	2
Total Score	12	Quality level 1 – Promising Practice			

3.3.4.4 Drug-free zone, Slovakia

Table 61: Structural data on the programme “Drug-free zone”

Topic	Details
Starting and end date	27 March 2012 – ongoing
Provider	Corps of Prison and Court Guard
Main type (s) of intervention	Selective prevention Psycho-social intervention or drug free treatment
Target group	Former drug users and those prisoners who have not used drugs in the past
Staff	58 staff members: pedagogues, psychologists, social worker, medical staff, psychiatrists, prison officer, prison chaplain, prison pastor
Budget and source(s) of funding	Annual budget: no information Sources of funding: Prison service
Evaluation	Yes, repeated internal evaluation with the last evaluation carried out in January 2012

Drug-free zones were created as a space of higher protection for prisoners at risk of relapsing to drug use when staying in prison environment that increases the likelihood to use drugs or alcohol. In drug-free zones cell and

body searches for illegal substances, also with dogs, are carried out to ensure that there are no drugs in these zones. Prisoners in these zones have to agree with this procedures, and they are informed that they will be excluded from the zone and receive further sanctions if illegal substances are found. Drug-free zones are dedicated to prisoners who never used drugs and to those who had been used drugs but want to stay abstinent. In Slovakia, drug-free zones have been established in 13 prisons.

Background and objectives

In prisons there is the risk that prisoners who never used drugs in the past will initiate drug use while in prison due to the influence of other prisoners with drug use. There is also the risk that drug users who were in drug treatment while in prison will relapse if they are transferred back to the general prison unit. To prevent prisoners from initiating the use of drugs or alcohol and from relapsing to drug use, drug-free zones have been established. The main aim of these zones is to ensure optimal conditions for the mental, social and physical development of prisoner in terms of drug abstinence. Accordingly the main focus of the interventions provided in drug-free zones is on the prevention of drug use group counselling.

Description of the programme

Drug-free zones are a separate unit within the prisons. They are usually operated by two pedagogues who are working only in the drug-free zone, and additional part-time work of a psychologist, social worker, and medical staff. The staff is trained in working with drug-dependent clients. Other institutions (County office of labour, social affairs and family), voluntary associations, the church and charity institutions can cooperate with the staff of the drug-free zone.

Within the drug-free zone psychosocial treatment is provided which consists in group counselling, social learning, relaxation, cultural activities or sports. There are no strict rules on how often counselling must be provided, usually there is one group counselling session per week. In addition, the pedagogue or psychologist provides individual counselling upon the prisoners' request. However, counselling is focussed on improving the skills for an adaptation to the prison condition, rational problem solving, change in values and norms, reevaluation of attitudes to the committed crime and imposed sentence, and the change in drug use behaviour.

Access to the programme

Typically, in Slovakian prisons there are 35 places in drug-free zones. Access to drug-free zones is possible to prisoners with no drug use history and to drug dependent prisoners. Drug use covers all types of substances including alcohol and medicaments. Precondition for access is abstinence from any substance, compliance with formalities and rules and the motivation to stay abstinent from substance use.

Evaluation

The internal evaluation is to monitor processes and results of the programme. In this respect the number of prisoners included in drug-free zones and the type and number of activities performed in drug-free zones is recorded. Furthermore, results of drug testing, drug searches and seizures of drugs found through searches are monitored. The evaluation also documents the number of prisoners excluded from the drug-free zones and the reason for their exclusion.

Table 62: Quality for “Drug-free zone”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	9	Sum of points	2	Sum of points	4
Total Score	15	Quality level 2 – Good practice			

3.3.4.5 Alternatives to imprisonment, Italy

The project “Good Guys” (“Bravi Ragazzi”) was carried out by the Cooperative Lotta Control ‘Emerginazione Sociale Onlus, which is a social association working the Milan area. The project was addressed to the drug users in prison that may take advantage of the probation measures as an alternative to imprisonment. Probation measures are possible if the prison sentence is less than six years. On a voluntary basis prisoners could apply for probation measure which is to enter the Therapeutic Community “Addiction Center” at Lacchiarella, Milan. The residential treatment programme is based on a cognitive behavioural approach, aiming at relapse prevention as regards drug use and crime and social rehabilitation.

Table 63: Structural data on the programme “Good Guys”

Topic	Details
Starting and end date	1 September 2009 – 1 September 2012
Provider	Cooperativa Lotta Control Emarginazione
Main type (s) of intervention	Alternatives to prison Psycho-social intervention or drug free treatment Reduction of overdoses
Target group	Problem drug users of mainly heroin, cocaine, alcohol, cannabis and/or club drugs
Staff	58 staff members: pedagogues, psychologists, social workers, medical staff, psychiatrists, prison officers, prison chaplain, prison pastor
Budget and source(s) of funding	Annual budget: 45,000 Euro Sources of funding: Regional authorities
Evaluation	Yes, internal evaluation with the last one carried out in July 2012

Background and objectives

Therapeutic Communities may be the ideal drug-free environment for drug users on probation as this treatment is designed to promote changes in drug use and criminal behaviour. However, in Milan area only a few residential treatment units for detained drug users do exist. One aim of the project is to increase the availability of Therapeutic Communities for this target group.

The general methods of Therapeutic Communities include skill building, control training (regulation, control of affects, and role models). With regard to sentenced drug users the main emphasis is directed to reduce drug use, prevent recidivism, and to reintegrate in the work life.

Description of the programme

The residential drug treatment programme consists of five elements:

- behaviour management/shaping;
- emotional/psychological;
- intellectual and spiritual;
- vocational/survival skills;
- medical management;

Access to the programme

Since the beginning of the project 19 detained drug users entered the residential treatment provided by the “Addiction Center”. 12 drug users completed the treatment successfully.

Evaluation

There is an internal evaluation which was carried out in July 2012. At the time of reporting no evaluation results were available.

Table 64: Quality for: Programme “Good Guys”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	10	Sum of points	0	Sum of points	4
Total Score	14	Quality level 2 – Good Practice			

3.3.4.6 Alternative to imprisonment, Estonia

More than one fourth of all prisoners in Estonia are drug addicts, thus there are approximately 900 drug addicts in prisons and pre-trial detention. From the recidivism rate it is known that about 40 % of all released convicts will commit a new crime within a year after release.

In community drug treatment and rehabilitation services are available for people with drug dependence. However, there were no specific services for drug dependent offenders and no systematic referral system for drug-dependent offenders who were released from prison. Such a system was lacking because there was no regulation in place and there was only a limited number of places for drug treatment and rehabilitation. To fill the gap the Ministry of Justice prepared a semi-compulsory programme for drug dependent offenders with the aim to provide sentenced offenders with the opportunity to enter drug treatment. According to plans residential as well as outpatient treatment and rehabilitation will be an available option. The complete treatment period will be on average nine months, and offered in cooperation with some treatment centres in Tallinn and Ida-Viru County.

Table 65: Structural data on the programme “Treatment and rehabilitation of drug-addicted offenders”

Topic	Details
Starting and end date	1 August 2011 – 31 December 2014
Provider	Estonian Ministry of Justice info@just.ee
Main type (s) of intervention	Drug treatment as an alternative to imprisonment withdrawal from drug addiction reduction of recidivism
Target group	Drug addicts whose prison sentence has been replaced by a treatment programme Drug-addicts released from prison on parole
Staff	Staff members: 1 project leader and staff of rehabilitation centres
Budget and source(s) of funding	Annual budget: Approx. CHF 1,117,647 Swiss contribution 85%, and Estonian co-financing 15% Sources of funding: Swiss funding and Ministry of Justice
Evaluation	Yes, repeatedly internal evaluation

Background and objectives

According to police statistics, a substantial proportion of the offenses, in particular property offenses have been committed by drug dependent people. In order to reduce relapse to offending the current project is a key in creating a system for enabling convicted drug addicted offenders to receive drug treatment.

Based on the experiences with the project it is intended to amend the national guidelines for drug treatment and rehabilitation.

Description of the programme

Treatment and rehabilitation is provided outside prisons by community treatment centres that have fulfilled the necessary requirements. The quality of the treatment and rehabilitation is supervised by the Ministry of Justice and other relevant institutions. Treatment guidelines have been specified in cooperation with the National Institute for Health Development and the Estonian Society of Psychiatrists.

Psychiatrists, psychologists, and social workers provide a variety of services, ranging from methadone substitution treatment to long-term rehabilitation. Based on the individual needs different components of treatment and rehabilitation such as individual and group counselling, psychotherapy, social counselling, and social-skills development is offered.

Access to the programme

By the end of the project it is expected that at least 90 offenders have received treatment. The available figures show that in 2010 a total of 49 drug dependent prisoners were released from the rehabilitation unit and in 2011 this was the case for 66 prisoners.

Evaluation

The Prison Service collects monitoring data quarterly. According to the drug monitoring reports in 2012, the concept of drug rehabilitation works.

Table 66: Quality for “Treatment and rehabilitation of drug-addicted offenders”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	10	Sum of points	2	Sum of points	0
Total Score	12	Quality level 1 – Promising Practice			

3.3.5 *Drug Counselling, Treatment Services and Peer Education*

3.3.5.1 Alternative treatment-based intervention, England

In May 2011 the UK Government made a commitment to ‘explore alternative forms of secure, treatment based accommodation for mentally ill and drugs offenders’. This commitment was reiterated in the 2010 Drug Strategy which said “we will encourage those dependent on drugs or alcohol into recovery-focused services in the community by developing and evaluating options for providing alternative forms of treatment-based accommodation”.

A working group examined and considered current good practice around alternatives to custody and how best to deliver the key aspects of the commitment – security, treatment, and accommodation. Analysis suggested that exploring only residential provision would result in a limited approach, would not be cost effective, and was unlikely to provide the flexibility required to best meet treatment needs and deliver health and criminal justice

outcomes. It was therefore agreed that the word “secure” should be interpreted in its broadest sense and including security around the individual offender in non-residential settings. This would mean developing options aimed at ensuring that the offender complies and engages with the treatment programme most suitable for tackling their health needs and offending behaviour, delivered in community based accommodation if assessed as a requirement. This work incorporates 16 areas of England. Its purpose is to test alternatives to custody at the point of sentencing i.e. court-based activity.

Table 67: Structural data on the programme “Alternative treatment-based interventions”

Topic	Details
Starting and end date	1 April 2011 – 1 December 2014
Provider	Department of Health
Main type (s) of intervention	dual diagnosis / mental health interventions
Target group	Drug users and individuals with mental health problems
Staff	100 staff members: nurses, psychologists, psychiatrists, probation workers
Budget and source(s) of funding	Annual budget: £1,5M Sources of funding: central government
Evaluation	Yes, the external evaluation is a full impact study, and is about to be commissioned. It is scheduled for completion end 2014.

Background and objectives

The prison population in England and Wales has been rising steadily over the past ten years. A 2008 study of newly sentenced prisoners found that the majority of prisoners had used illegal drugs during the year before custody (Stewart, 2008). Over half had used cannabis and four out of ten had used heroin and crack cocaine. Use of heroin or cocaine was more likely to be reported by women, adult prisoners and those sentenced for less than one year. Heavy drinking, defined as drinking more than twice the recommended sensible daily limits, was reported by 36 % of the sample, and was more prevalent among short-term prisoners and men. The prevalence of mental health problems was high. Ten per cent of the sample was identified as likely to have a psychotic disorder and 61 % a personality disorder. Over a third of prisoners reported significant symptoms of anxiety or depression. Levels of psychosis, anxiety and depression, self-harm and suicidal attempts were considerably greater among women than men.

The increasing prison population and the high proportion of prisoners with substance misuse and mental health problems in England and Wales has led to a sense that more must be done to see that people who might be effectively treated in the community as part of a criminal justice sentence should be given this opportunity.

Description of the programme

In England and Wales there are sixteen sites which comprise courts services, probation centres, residential treatment, community treatment and quasi-residential treatment (combined community treatment with supported accommodation).

The main activities are as follows City of York. The York Drug and Alcohol Action Team (DAAT) is developing a quasi-residential abstinence programme that involves a three staged recovery pathway including mutual aid groups and mentor support (including evenings and weekends) over 48 weeks. Accommodation to support the programme will be provided to both men and women via an existing criminal justice accommodation provider; development of a private landlord scheme and via LA supported housing provision. The provider will introduce a day programme for offenders receiving a Drug Rehabilitation Requirement and Alcohol Treatment Requirement (DRR/ATR) as part of a community sentences, with an emphasis upon employability and up skilling of offenders. The use of a social enterprise to give real experience of employment and the city of Willowdene have also secured other funding to develop a community payback and restorative justice pilot project so there are links between these projects. Day programme will be one day per week for 12 months.

Surrey & Sussex Probation Trust: Development and delivery of a peer mentoring project across Surrey Probation Trust targeting DRR and other higher risk substance misusing offenders. This is to enhance the delivery of the existing groupwork interventions to substance misusing offenders subject to statutory offender management. Mentors will be recruited to provide both one to one and group work support to around 120 individuals participating in the groupwork project.

Wirral Women Together: The project will provide key working sessions with offenders with mental health and substance misuse issues, using a desistance framework model to support the offender. Offenders will develop and im-

plement their own personal life plan. The model includes face to face and monitored weekly group work interventions. Offender Managers will offer the model as a component of a supervision requirement within a community order.

The theoretical assumption is that effective interventions will help reduce re-offending among a cohort of offenders based on a range of factors that emerge from the evidence base of court-mandated treatment of offenders.

Access to the programme

The project is restricted to those offenders who have a substance misuse or mental health problem, or both (i.e. dual diagnoses) and whose index offence and risk of re-offending is of sufficient seriousness likely to attract a prison sentence of up to 12 months. The decision as to whether to send an offender to prison or to hand them a community sentence lies entirely with the judiciary (i.e. with a judge or magistrate). Offenders who qualify for the approach will be given enhanced support in the community as an alternative to prison.

Evaluation

There is a current evaluation, which is a full impact study, and is about to be commissioned. It is scheduled for completion end 2014 with an external evaluator.

Table 68: Quality for “Alternatives to prison”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	11	Sum of points	18	Sum of points	2
Total Score	31	Quality level 3 – Top Level Practice			

3.3.5.2 Drug treatment of juveniles, Slovakia

Voluntary drug treatment of juveniles with drug dependence is an alternative to the compulsory treatment ordered by court. The voluntary treatment is offered in a separate prison unit and the treatment programme follows the standards of psychosocial drug and alcohol treatment. Medical staff – clinical psychologist, psychiatrist, nurse – a pedagogue and a social worker provide the treatment. The intention of the treatment unit is to treat drug and alcohol dependence by means of medications, psycho-therapy and rehabilitation. The

clients should keep three basic conditions of the treatment: to comply with the therapeutic regimen, to take the prescribed medicines and accept the mental support provided by therapists.

Table 69: Structural data on the programme “Voluntary treatment of juveniles’ drug addictions”

Topic	Details
Starting and end date	1 March 1998 – ongoing
Provider	Corps of Prison and Court Guard
Main type (s) of intervention	Psycho-social intervention or drug free treatment Detoxification or withdrawal treatment
Target group	Juvenile prisoners with drugs problem or drug addiction
Staff	5 staff members: clinical psychologist, psychiatrist, pedagogue, social worker, nurse
Budget and source(s) of funding	Annual budget: no information
Evaluation	Yes, repeatedly through internal evaluation, the last evaluation was carried out in November 2011

Background and objectives

The prevalence of drug addictions and related criminality is increasing. Usually the court orders compulsory treatment, while voluntary treatment is an alternative option for juvenile prisoners without a court treatment order. Voluntary treatment of drug addictions is designed for juvenile prisoners who are motivated to undergo treatment in order to develop a life without drugs. Accordingly the overall objective is abstinence from substances and a change of values, attitudes and behaviour.

The specific objective of the rehabilitation programme for juvenile prisoners is to increase the awareness for a healthier behaviour and the benefit of abstinence through both psychotherapy and controls for substance use while in the treatment unit.

Description of the programme

The treatment unit provides psychotherapy, rehabilitation and re-socialization activities. The therapeutic staff is composed of a clinical psychologist, psychiatrist, pedagogue, social worker and a nurse. Each prisoner who enters the rehabilitation unit is examined by the psychiatrist, and the treatment is recorded in a patient file. The drug addicted juveniles also have to undergo

blood testing for HIV/AIDS, HCV and HBSAg, and if an infection is detected the juvenile will receive treatment.

All juveniles in the treatment unit are obliged to participate in the activities defined in the therapeutic plan. Treatment consists of group and individual psychotherapy, didactotherapy, bibliotherapy, ergotherapy, art therapy as well as in education, diaries, points system, and self-governed activities. Within the therapeutic programme, the juveniles can participate in education and job-training courses, cultural-enlightening activities, and sports. Part of the therapeutic regimen is that smoking is forbidden and that intensive drug searches take place. Juvenile prisoners are tested for drugs through urine screening, body searches and searches of personal things. If someone violates the therapeutic regimen, the head of the therapeutic group decides after consultation with the therapeutic staff on the stay in this unit. In case of repeated or serious violation of the therapeutic regimen (verbal or physical aggressiveness, theft, damaging of prison property) the prisoner is excluded from the treatment.

Access to the programme

Juveniles who do not realise the need for treatment and who do not accept the treatment regimen are not eligible to access the treatment unit. In the period from January 2011 to November 2011 out of 32 juvenile prisoners 13 completed the treatment. During this 10 month period from three prisoners were excluded from the treatment due to disciplinary reasons, and 29 disciplinary punishments were imposed.

Evaluation

According to the internal evaluation from May 2011 to November 2011 the number of juveniles taking heroin or methamphetamine has increased and their age has decreased when compared with previous results. With regard to educational sessions especially the topics of HCV infection and drug overdoses after prison release were discussed. The results of the antibody testing for HIV and hepatitis showed that among 10 prisoners, who were tested, one was positive for hepatitis B. From January 2011 to November 2011 a total of 140 urine screenings were conducted which were all negative. For statistic evaluation the results of the urine screening are reported regularly to the General Directorate of the Corps.

Table 70: Quality for “Juvéniles treatment for drugs addiction”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	6	Sum of points	2	Sum of points	4
Total Score	12	Quality level 1 – Promising Practice			

3.3.5.3 Rehabilitation programme, Lithuania

The rehabilitation programme corresponds with the Lithuanian Penal Code Article 137. In this respect the prison rehabilitation programme is aiming at supporting prisoners in respecting the law, human values and public safety, and to promote reintegration after prison release.

The rehabilitation is provided in a separate prison unit in the Vilnius Correction House. However, participants are not completely separated from other prisoners as the dining room and the gym is shared. Its treatment programme is designed for drug addicted inmates with a sentence of more than six months and who are motivated to receive treatment, and who have previously participated in the introductory group. Based on this admission criterion prisoners are selected for the programme. However, many of them are willing to enter the rehabilitation programme as there are better living conditions.

Table 71: Structural data on the programme “rehabilitation program”

Topic	Details
Starting and end date	1 May 2011 – 1 May 2012
Provider	Vilnius Correction House
Main type (s) of intervention	Psychosocial intervention
Target group	Experimental drug users, problem drug users
Staff	5 staff members: psychologists, social workers, addiction counsellors, clergy
Budget and source(s) of funding	Annual budget: no information
Evaluation	Yes, repeatedly carried out in April 2011; internal evaluator

Background and objectives

The rehabilitation programme has been established in response to the drug consumption which was observed in all correction houses and detention cen-

tres. The programme was implemented in collaboration with other institutions. Its main objective is to provide drug treatment during the prison stay in order to prepare prisoners with substance dependence for their reintegration after release. The rehabilitation programme applies the following methods: “Minnesota”, “Atlantis”, a bio-psycho-social model, and the AA 12-step philosophy.

The main objectives of the rehabilitation programme are to enhance behavioural changes in the prisoners as regards their social behaviour, problem solving strategies, criminal and drug use behaviour and relationships with family members or other significant persons.

Description of the programme

The rehabilitation programme is provided by psychologists, addiction counsellors and social workers. The main programme activities are educational sessions on addiction, therapeutic groups and individual counselling. Therapeutic groups are lead by the psychologists and addiction counsellor. The duration of the programme is 12 months, but if necessary, the treatment contract can be prolonged to continue treatment. The main focus of the programme is directed to maintain abstinence, avoid relapses to offences and to encourage spiritual development of the participants.

Access to the programme

As previously mentioned, eligibility for the rehabilitation programme requires participation in the introductory group and a prison sentence of more than six months. If both is given, the staff of the programme makes a selection among eligible prisoners which is based on their assessment of whether prisoner will comply to the treatment rules.

Evaluation

The evaluation demonstrated that out of 50 treatment participants no more than 10 participants completed the programme. Among the drop-outs the majority started to use drugs again while others have to leave the prison before completing the programme. Further difficulties in providing the programme result from the staff shortage.

Table 72: Quality for “Rehabilitation programme”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	7	Sum of points	2	Sum of points	4
Total Score	13	Quality level 2 – Good Practice			

3.3.5.4 Prison Drug Treatment, Bulgaria

The programme “Treating addictions in the system of Bulgarian prisons” was introduced in 2009 by the General Directorate responsible for the execution of punishments. The programme is based on the 12-steps Minnesota model and consists of 36 group sessions and a follow-up of 12 individual sessions. The programme aims to reduce criminal behaviour by supporting the participants in stopping or reducing the use of drugs and alcohol and improving their social adaptation.

Table 73: Structural data on the programme “Treating addictions in the system of Bulgarian prisons”

Topic	Details
Starting and end date	2009 – ongoing
Provider	General Directorate “Execution of Punishments” at the Ministry of Justice gdin@abv.bg
Main type (s) of intervention	Assistance to drug users in custody and prison Psycho-social intervention or drug free treatment
Target group	Drug users, including problem drug users
Staff	30 staff members: multidisciplinary team of professionals, who have passed special training such as social work, psychologists and probation officers
Budget and source(s) of funding	Annual budget: The program is funded through the overall budget of the social care system of prisons. It does not have a specific budget.
Evaluation	Yes, repeatedly by internal evaluation. The last evaluation has been conducted in 2011

Background and objectives

The programme was implemented to address the growing need for specialised treatment for drug users in Bulgarian prisons. In 2011, approximately

2,000 out of the total prison population of 10,000 were prisoners with a drug use history. Around 140 persons (7.1 %) of the drug users have passed through the drug treatment programme for prisoners. Major objectives of the programme are: to reduce crime relapses through the reduction of drugs and alcohol use or abstinence; to enhance social adaptation and conflict management skills through participation in groups sessions and individual follow-up sessions.

Description of the programme

The programme participants are placed in special premises that are separated from the other prison population. The programme consists of 36 group sessions with each lasting two hours. The sessions are realised within 12 weeks, which is three sessions per week. Each group is composed of 8 to 12 participants, and the sessions are focused on the control of emotions and drug use, and managing the risk of drug relapse. After this intensive phase there is a follow-up phase of 12 weeks in which individual sessions take place. The individual sessions are aiming at supporting relapse prevention and reintegration.

Access to the programme

As the programme is ongoing each prisoner with drugs problems can apply for entering the programme.

Evaluation

In 2010 six programmes have been implemented in different prisons in the country. According to the evaluation in 2010 all existing programmes have been completed by a total of 68 participants. In 2011, three programmes have been completed by 30 participants. The evaluation did not collect data on the number of drop-outs.

Table 74: Quality for “Prison drug treatment programme”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	8	Sum of points	4	Sum of points	2
Total Score	14	Quality level 2 – Good Practice			

3.3.5.5 Rehabilitation services for released drug addicts, Bulgaria

The NGO “Project Butterfly Sofia” initiated a small scale pilot project to implement rehabilitation services for drug users in Sofia. The project was realised with the support of the Sofia prison and addresses drug users who were are soon to be released soon and whose offenses were related to their drug use. The NGO visits drug users in prison with the aim to motivate them for a long-term outpatient rehabilitation after release.

Table 75: Structural data on the programme “Centre for rehabilitation and re-integration of people with addictions”

Topic	Details
Starting and end date	1 November 2011 – 28 February 2012
Provider	Association “Project Butterfly – Sofia” www.ppsbg.org/
Main type (s) of intervention	Assistance to drug users in custody and prison After care Psycho-social intervention or drug free treatment
Target group	Problem drug users
Staff	5 staff members: clinical psychologists, family counselors, addiction counsellors
Budget and source(s) of funding	Annual budget: approx. 1,750 Eur Sources of funding: National government, non-governmental organisation
Evaluation	Yes, internal evaluation, completed in February 2012

Background and objectives

In Bulgarian prisons a limited number of treatment and rehabilitation services are available. In addition there is no systematic transition into the community as regards ongoing treatment which results in a high rate of relapses. The small project provides psychological counselling with drug addicted prisoners who are going to be released. The aim of the counselling is to ensure psychological support for drug users and their families after release and to motivate them to enter community treatment.

Description of the programme

For counselling there is a separate consultation room in the Sofia prison. Individual counselling was to disseminate information and to conduct an as-

assessment of the needs and substance addiction. The counselling is based on motivational interviewing.

Those prisoners who accept treatment after release are allowed to enter the outpatient rehabilitation centre of the NGO Project “Butterfly Sofia”, which is located in the centre of Sofia. The monthly programme consists of group sessions (90 minutes), four individual sessions with a psychotherapist (45 minutes), four individual sessions with a case manager (45 minutes), and two family consultations (70 minutes). In addition, urine and saliva drug testing is performed. The interventions are based on a manual.

Access to the programme

All prisoners with drugs problems in the Sofia prison can participate in the project. However, only seven prisoners had been included in the prison counselling, and two of them entered the community rehabilitation programme.

Evaluation

A programme documentation was carried out by the project staff. From the documentation it was obvious that the intervention requires to be initiated at least three months before release with more intensive sessions. In addition, finances, housing, employment etc. are main issues in the pre-release period. However, the number of participants was low.

Table 76: Quality for: Rehabilitation centre for drug offenders

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	10	Sum of points	0	Sum of points	2
Total Score	12	Quality level 2 – Promising Practice			

3.3.5.6 Drug rehabilitation units in prisons, Estonia

Since 2008 in all Estonian prisons (except from Tallinn Prison) there are special Drug Rehabilitation Units. By 2012 four drug rehabilitation units had been implemented in three prisons with more than 200 places. These units are located in the prisons in Tartu, Viru, Harkuja Murru. In the Tartu Prison is the biggest rehabilitation unit with 174 places for adult men. In the Viru prison there are two separate units for drug rehabilitation: one for adult men

with 20 places and one for juveniles with 16 places. The Harkuja Murru Prison is a small unit with 8 places for women.

Diagnosed drug addicts in the Estonian prison system are divided into two groups. To the first group belong prisoners with an acute drug dependence, defined as being drug-free for less than one year due to being in an institution (prison, treatment). The second group is composed of prisoners, who are drug-free since more than one year and being either in freedom or in prison. Those drug addicts who are defined as being in an acute condition should enter the drug rehabilitation unit. The rehabilitation process is divided into three parts which are first the initial phase (adaption, motivation), second the main phase (different interventions) and third the post rehabilitation phase (retention). In the main phase the treatment duration varies from 9 to 12 months, depending on the unit.

Table 77: Structural data on the programme “Drug Rehabilitation Units in Estonian Prison Service”

Topic	Details
Starting and end date	1 January 2008 – ongoing
Provider	Estonian Ministry of Justice and Estonian prisonsinfo@just.ee
Main type (s) of intervention	Assistance to drug users in custody and prison Psycho-social intervention or drug free treatment Reduction of overdoses
Target group	Drug addicts
Staff	Staff members vary depending of the unit size. psychologists, social workers, contact persons, guards, medical stuff, nongovernment partners
Budget and source(s) of funding	Annual budget: not known Sources of funding: Prison service (which is financed by the Estonian Ministry of Justice)
Evaluation	Yes, repeatedly carried out within the internal Drug Monitoring Survey in the Prison Service. Data is collected quarterly. The last data is from 2012.

Background and objectives

Treatment and rehabilitation of diagnosed drug addicts is known to be most effective if delivered in special units. To raise the effectiveness and quality of drug rehabilitation for drug addicts the Drug Rehabilitation Units in Estonian Prison Service have continuously developed specialised treatment units. The

main aim of these units is to discontinue the link between drug use and offending, to prevent relapses after release and to promote reintegration. The rehabilitation is provided by a team of psychologists, social workers, contact persons, guards, medical staff, and partners from NGOs. In the rehabilitation unit different psychosocial interventions as well as medical treatment is offered. Both drug-free treatment and opioid substitution treatment (OST) combined with psychosocial interventions is considered to be the most effective treatment.

Description of the programme

Drug rehabilitation takes place in special units of the prisons. Participating inmates are informed about the aims and rules of the rehabilitation service. Part of the rules is not to smoke and not to take drugs, and to accept drug testing.

For admission to the rehabilitation unit an initial assessment is carried out to diagnose drug dependence and to evaluate the treatment motivation. Within the rehabilitation unit medical treatment usually includes medical monitoring, but also detoxification and in some cases OST. However, in general participants are not in substitution treatment. Depending on the rehabilitation unit the programme varies a bit. In general, psychosocial interventions, psychotherapy, psychiatric treatment, social activities, counselling, and work activities are provided. In addition, the programme includes an Anonymous Drug Addiction group, lifestyle training, social skills training, and anger management. The programme is based on motivational interviewing and the 12-steps-model.

Access to the programme

The main pre-conditions to enter to the rehabilitation units are that the prisoners is diagnosed for drug dependence and has a sentence of at least one year. In 2012, most of the 200 places for rehabilitation were occupied. In 2010 and 2011 altogether 49 and 66 inmates were released from the rehabilitation units.

Evaluation

The short-term evaluation is carried out on the basis of different data gathered from the prisons in order to assess the work of the units. There is also a drug monitoring for which data is being collected continually such as the number of diagnosed drug addicts in prison, the number of qualified staff, drugs found in prison, results of drug testing. Further the patients in detoxification, opioid substitution and drug rehabilitation are monitored.

Table 78: Quality for “Drug Rehabilitation Units”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	8	Sum of points	2	Sum of points	0
Total Score	10	Quality level 1 – Promising Practice			

3.3.5.7 Therapeutic Community in prison, Hungary

The so called drug prevention units operate since 1999 in the Hungarian Prison Service, and one of the firsts pilot projects started in the Budapest Central Prison (BCP) in Block “B” in a separated wing of the third floor. At the beginning the BCPs drug prevention unit was also accessible for vulnerable prisoners who need to be protected due to debts from card playing or being a sex offender. Now the unit works as a Therapeutic Community run by a social worker and a psychologist.

The admission to the Therapeutic Community (TC) is regulated in a decree of the Minister of Justice (6/1996). Accordingly the inclusion criteria are either drugs problems in the past or recent drug problems and offences that are related to the drug use. Participation in the drug treatment programme is voluntary. Another condition that has been set in place by the psychologist of the TC in 2009 is that participants have at least used drugs since two years. This change was necessary because drugs problems occur in about 75 % of the prison population.

Table 79: Structural data on the programme “Systematic psychological support for the therapeutic community in Budapest Central Prison”

Topic	Details
Starting and end date	1 June 2009 – ongoing
Provider	Budapesti Fegyházás Börtön, www.budapestifegyhazi.hu
Main type (s) of intervention	Assistance to drug users in custody and prison Psycho-social intervention or drug free treatment Prevention of violence
Target group	Drug users, including problem drug users and former drug users
Staff	6 Staff members: social worker, psychologist, prison officers
Budget and source(s) of funding	Annual budget: not known Sources of funding: Prison service
Evaluation	Yes, internal evaluation

Background and objectives

One special drug-related problem in the Hungarian Prison Service is the misuse of the anti-epileptic tranquillizer Rivotril and other benzodiazepines (Stöver/Thane 2011). Rivotril is a potent benzodiazepine which is a prescribed medication in Hungary. Inmates using non-prescribed Rivotril or other benzodiazepines often overdose the substance use, resulting in aggression, self harm, drug dealing and other security issues which impose disciplinary measures. Before starting the TC programme, there were no interventions to combat the Rivotril problem in the prison.

Before the TC programme started in the Budapest prison it has been a unit for psychosocial interventions which was also open to vulnerable prisoners. Since implementing the TC a new unit has been established for psychosocial interventions for vulnerable prisoners and prisoners with mental health problems.

The overall objective of the TC is to achieve and maintain abstinence from drugs. This also includes a change in the attitudes and values towards drug use and crime. Prisoners who are drug-free self-select into the programme, and partly their participation is motivated by the privileges they have in the TC unit. Part of these privileges is to spend leisure time which is extremely important in the prison setting. In addition, challenges of daily life and practical issues are discussed which are important for the life after release.

Description of the programme

The TC unit has 30 places in five cells. Different to other interventions, the therapeutic programme is provided by social worker and a psychologist who are qualified in addiction and social work. Usually social workers in the Hungarian Prison Service are prison officers or teachers who are not providing social work but have their focus in administration and disciplinary procedures. Within the TC weekly group sessions are provided by the social worker. The psychologist also runs weekly group sessions and offers in addition individual meetings. The group therapy includes art therapy, music therapy, bibliotherapy, assertive therapy, drama and poetry. The individual meetings address crisis intervention, case management and relationships and contacts to the outside world. TC participants have to define clear goals for their treatment process.

Randomised urine testing is obligatory. Acting against the rules of the TC results in disciplinary punishments and might cause to be expelled from the

treatment. Due to the high turnover rate in the prison, the programme has not defined duration.

Access to the programme

As described above, to access the TC there are specific criteria as to drug use and offenses. In addition, there are informal criteria for access which are related to ethnic conflicts. For instance, there had been pure “white” cells which were prohibited areas for Romani. The current practice is that the whole Therapeutic Community decides on the ethnic composition of each cell. Since the start of the programme in the Budapest prison 120 inmates participated in the TC.

Evaluation

Staff members of the TC continuously monitor the behaviour of the participants on basis of the following: results of urine tests; number of home leaves and family visits; number of disciplinary procedures; number of applications and activities during the group sessions.

Table 80: Quality for “Support for Therapeutic Community in Budapest central prison”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	6	Sum of points	0	Sum of points	2
Total Score	8	Quality level 1 – Promising Practice			

3.3.5.8 Therapeutic Community in prison, Greece

The Judicial Prison in Athens for male prisoners is the largest penal institution in Greece. According to the data of the Ministry of Justice the prison has a capacity for 1,000 inmates. However, there are 2,400 inmates and about half of them are imprisoned for drug offenses. Among them there are a high number of drug addicts who continue drug use inside prison. ENDRASI (Specialized comprehensive treatment network for interventions inside prisons and post release support) – which belongs to the organisation Kethea – runs counselling groups in this prison since 1985 with many referrals to Kethea therapeutic programmes after release. In 2009, the Ministry of Justice and Prison Administration have implemented an intensive prison drug treat-

ment programme which is based on the therapeutic community approach. Participants of the existing counselling groups were the first members of the TC, and they also contributed in the renovation of the rooms. A group of highly experienced counsellors in prison substance abuse programmes supervised the TC that has a special focus on physical and mental health problems and cooperated with the prison medical services. Those who successfully complete the scheduled prison treatment programme can be released earlier under the condition of participating in the after care programme. Early release for participation in after care requires a respective court order. In most cases early released prisoners are referred to the rehabilitation centres for ex prisoners (in Athens and Thessaloniki) or to other therapeutic programmes.

Table 81: Structural data on the programme “Therapeutic Community in Mens' Judicial Prison (Athens)”

Topic	Details
Starting and end date	1 May 2009 – ongoing
Provider	Therapy Center for Dependent Individuals, KETHEA admin@kethea.gr
Main type (s) of intervention	Assistance to drug users in custody and prison Therapeutic Community in Prison Reduction of overdoses Measures to combat violence Psycho-social intervention or drug free treatment
Target group	Drug Addicts Problem drug users
Staff	12 Staff members: sociologists, social workers, drug counsellors, 12 part-time/volunteers (medical doctors, trainers, educators etc.)
Budget and source(s) of funding	Annual budget: 152,135 € Sources of funding: National government
Evaluation	Yes, repeatedly carried out, last evaluation was in December 2011

Background and objectives

Greek prisons are holding a large number of drug offenders. According to the 2012 data of the Ministry of Justice the Greek prison population 12,479 inmates of whom 4,136 (33 %) are incarcerated for drug offences. In the Athens prison a significant number of illegal male immigrants is imprisoned who are

also drug addicts. The high number of imprisoned drug addicts made the implementation of drug treatment necessary. Treatment was decided to be delivered in a Therapeutic Community. The approach of the Therapeutic Community implies the participation in several self-help groups in order to develop a life different from being dependent on drugs. This includes taking responsibility for own actions and behaviours, developing trust, expressing own feelings, and establish relationships that are based on acceptance and respect.

Like in all Therapeutic Communities the main objective is to achieve abstinence from drug and alcohol use. Further objectives are to improve the physical and mental health status and the social skills and legal status of participating drug addicts.

Description of the programme

The Therapeutic Community is located in a separated prison wing providing a safe and secure environment. However, the lack of a separate drug-free unit is forcing members of the TC after completion of the daily program to return to their cells where they are together with other prisoners and which jeopardises their treatment success.

The daily programme includes work therapy, educational activities, group sessions (2 hours) and according to specific needs individual counselling sessions (1 hour). Furthermore educational and vocational activities (usually 3-4 hours) are provided. The main interventions during group and individual sessions are psychosocial therapy, relapse prevention, educational activities, vocational training, recreational activities, legal support, and physical and mental health assessment.

Access to the programme

Access to the TC requires to have a drugs problem but being drug-free at the time of admission. In 2012, the average number of TC participants was 23.

Evaluation

An internal evaluation is carried out by the ENDRASI Research Department. For the evaluation data is collected monthly and annually of the participants, the length of their stay in the TC, the number of completers and drop-outs, the number of counselling sessions and referrals. From 2009 to 2010 the number of participants has increased from 37 % to 55 %.

Table 82: Therapeutic Community in a men’s prison in Athens

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	10	Sum of points	2	Sum of points	4
Total Score	16	Quality level 2 – Good Practice			

3.3.5.9 Counselling at Athens juvenile court, Greece

The counselling centre for adolescent drug addicts at the Juvenile court in Athens has been implemented by “Strofi”, which is the oldest therapeutic programme for adolescents with drug addiction problems in Greece. The counselling service at the courts has several goals: First to inform juvenile delinquents about their options in dealing with their addiction problem and to provide them with legal support. A further aim is to motivate them for treatment and finally to refer them to therapeutic programmes. Another important objective is the establishment of a network between therapeutic services, court authorities, the police and probation officers. Networking includes seminar and training with judges, layers, police officers, social workers working in the criminal justice system etc. There is also a special focus on the family of the young delinquent.

Table 83: Structural data on the programme “Counselling Center in Athens Juvenile Court”

Topic	Details
Starting and end date	1 November 2011 – ongoing
Provider	Therapy Center for Dependent Individuals, KETHEA admin@kethea.gr
Main type (s) of intervention	Interventions at the stage of arrest Assistance to drug users in custody and prison Referrals to therapeutic programmes-alternatives to imprisonment Psycho-social intervention or drug free treatment
Target group	Experimental drug users, problem drug users Adolescents offenders who are drug addicts Individuals suffering from an infectious disease
Staff	3 Staff members: sociologists, psychologists
Budget and source(s) of funding	Annual budget: 3.122.187€ for the entire therapeutic programme of Strofi. Sources of funding: National government
Evaluation	Yes, repeatedly carried out through internal evaluation. Last evaluation dates from December 2011

Background and objectives

Adolescent drug addicts build a special group in the population of problematic drug users as from their age and their patterns of drug use special needs arise. Most of the adolescents are in an experimental stage of drug use, but a significant number already engages in addictive behaviour. When an adolescent becomes a criminal offender the situation turns into a high-risk scenario. The drug offences of adolescents include drug possession, drug dealing, theft and robbery, and rarely violent crimes.

Within the criminal justice system there are no special programmes for adolescent drug addicts. According to 2012 data of the Ministry of Justice 597 juvenile offenders are imprisoned in four correctional institutions for adolescents. Among them a significant number of immigrants have no or poor Greek language skills. The counselling centre in Juvenile court in Athens is aiming to promote an alternative to imprisonment for young drug addicts. Their work creates a link between penal authorities and treatment facilities or other supporting services. The objective of the court counselling is to support adolescent drug addicts during the court procedure, to inform them about alternative options such as drug treatment, to motivate them for treatment, and to cooperate with the police and the court authorities.

Description of the programme

In the premises of the Athens Juvenile Court there is also a social service and the probation service. Counselling at court usually implies that adolescent drug users receive one individual counselling session which is followed by referral to therapeutic or health services. In some cases – depending on their judicial procedure – there is a second counselling session. Counselling also might include family counselling.

Access to the programme

In 2012, a total of 22 juvenile drug addicts have received individual counselling by the centre.

Evaluation

An internal evaluation is carried out by the Strofi Research Department. For evaluation purpose data on juvenile clients and the number of counselling sessions and referrals are collected on a monthly and annual basis. The num-

ber of clients is constantly high. In 2011, out of 43 clients 29 clients have been referred to treatment facilities.

Table 84: Quality for “Counselling Centre in Athens Juvenile Court”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	10	Sum of points	2	Sum of points	4
Total Score	16	Quality level 2 – Good Practice			

3.3.5.10 Peer Training on naloxone, Scotland

The NHS Highland Naloxone Programme commenced in Inverness in July 2009, providing overdose prevention, intervention and naloxone training to those at risk of opiate overdose, family members and friends of those at risk and staff and services working with those at risk. Inverness (Porterfield) Prison covers the Highland area and also the Moray area which is part of Grampian Health Board. It is a relatively small prison with a maximum capacity of 130 and a sentence duration which must be three years or less.

Table 85: Structural data on the programme “NHS Highland Inverness Prison Peer Trainer (Naloxone)”

Topic	Details
Starting and end date	1 July 2012 – ongoing
Provider	NHS Highland www.nhshighland.scot.nhs.uk
Main type (s) of intervention	Assistance to drug users in custody and prison Indicated prevention Peer education and training
Target group	Problem drug users
Staff	5 Staff members: nurses and peer trainers
Budget and source(s) of funding	Annual budget: no information
Evaluation	Not yet evaluated, will be evaluated by internal and external evaluation

Naloxone is a non-addictive, non-arousing drug often used by emergency health professionals for opiate overdose reversal. It is administered by intramuscular injection via a pre-filled syringe. The Health Boards across Scotland now operate programmes where individuals likely to witness an opiate

overdose are provided with training by trained trainers and a “take home” supply of naloxone to use in the event of a witnessed overdose. Trainers do not need to be clinically trained staff; they can deliver all of the elements of the training programme once they have completed the Training for Trainer’s course. However, supplies of naloxone can only be made by clinically trained staff.

Background and objectives

Highland covers a large geographical area situated in the north and west of Scotland and has a population of around 308,790. The city of Inverness is the largest urban area in the region. Due to the geographical area and concerns due to lack of anonymity in rural areas, accurate prevalence of injecting drug use has always been difficult to obtain. The current estimate for the Highland area is 2,100 “problem drug users”.

In 2005, the Scottish Advisory Committee on Drug Misuse (SACDM) commissioned a Working Group on Drug Related Deaths which recommended that “those in a position to administer naloxone should receive appropriate training” to do so. This move came about due to legislative changes in June 2005 where the Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005 now contains provision for the administration of naloxone by anyone for the purposes of saving a life. In 2009, the Inverness pilot was carried out. The pilot in Inverness also included Porterfield Prison where those at risk were provided with training whilst in prison and a naloxone pack issued upon their liberation. Following the results of the Inverness pilot the Scottish Government announced its support for a National Programme and the Scottish National Naloxone Programme commenced in November 2010.

The NHS Highland Inverness Prison Peer Trainer was established in recognition that peer trainers can contribute hugely to the roll out of the Naloxone Programme. They have the ability to engage with and enroll those clients at risk, who would otherwise be extremely difficult to access. Peer trainers have the ability to engage with hard to reach individuals and have the personal knowledge and understanding required in order to address some of the barriers and therefore increasing uptake and engagement with the naloxone training programme.

However, there is a concern that the need to carry naloxone will be associated with criminal drug use. For those in recovery there is a concern that treatment services may withhold prescriptions as naloxone may be suggestive that the client is at risk of overdose therefore continuing to use illicit drugs. There can be inaccurate information and myths about the training, the product and effects of the drug. All of these issues are of particular relevance to those in prison. Release from prison is identified as a high risk time for opiate overdose for those at risk.

Description of the programme

There is an allocated space in Inverness prison which is used as the venue to link internal and external agencies. This is also used for training and as the venue for the peer trainers to deliver the overdose prevention, intervention and naloxone training. The aim of the training programme is to pilot a peer trainer role within Inverness Prison. This would be a dedicated role and part of the current working roles within the establishment. Part of the role would also include promoting the programme and encouraging those at risk to engage and attend.

One or more individuals who are identified as appropriate by Inverness prison staff, will be enlisted as peer trainers. The identified individuals are then trained as trainers and provided with the required training and support by the NHS Highland Clinical Harm Reduction Nurse Specialist and the Naloxone Lead so that they are able to provide all of the elements of the training programme to those at risk whilst in prison. Part of the peer trainer' role would also include promoting the programme and encouraging those at risk to engage and attend. The aim of this would be to increase the number of supplies being made; particularly to those who have not previously engaged.

Training is delivered by the peer trainer both in groups and 1 – 1 settings to those at risk. The training covers the following elements:

- Drug-related overdoses on national and local level.
- Risk factors, high risk times, signs & symptoms, myths of overdose.
- Calling 999.
- Naloxone kit assembly and administration.
- Basic Life Support and Recovery Position.
- Practice.

Training is usually delivered over one session. However it can be delivered over more if required. All of the required elements have to be completed as per training checklist that is used. The sessions are catered to individual needs and circumstances, and for this reason the duration of sessions can range from 15 minutes to two hours.

Following training provided by the Peer Trainers, supplies of naloxone will be made by the trained healthcare staff and will be placed with the trainee’s belongings upon their release. At the day of release trainees were provided with a “take home” supply of naloxone which they could then administer in the event of witnessing and overdose, whilst waiting for the arrival of emergency services. There is also the opportunity for the peer trainers to get a supply of naloxone upon their own liberation. Peer trainers can continue to provide training in the community with support of the NHS Highland Clinical Harm Reduction Nurse Specialist and the Naloxone Lead.

Access to the programme

The national programme was rolled out so that all health boards across Scotland could provide training and supply to those at risk and those likely to witness an opiate overdose. This also included involving the rest of the prisons across Scotland. Until 2012, over 3,000 kits have been supplied throughout Scotland. In Highland, over 750 supplies have been made with over 140 recorded successful uses to date. However, despite the high number of supplies, barriers can still remain in place which deter those at risk of opiate overdose in coming forward to receive the training and naloxone supply.

Evaluation

At the time of reporting there was a current internal and external evaluation. No results have been available at the time of reporting.

Table 86: Quality for: Inverness prison peer training on naloxone

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	11	Sum of points	2	Sum of points	4
Total Score	17	Quality level 2 – Good Practice			

3.3.5.11 Peer education, Romania

Before the methadone substitution programme and the syringe exchange programme had been initiated, in all Romanian prisons peer educators have been trained to provide other prisoners with information on safer sex, sexually transmitted infections, methadone treatment and the syringe exchange programme.

Table 87: Structural data on the programme “Peer educators”

Topic	Details
Starting and end date	1 June 2006 – 1 December 2008
Provider	Romanian Harm Reduction Network www.rhrn.ro
Main type (s) of intervention	Assistance to drug users in custody and prison Psycho-social intervention or drug free treatment Education Reduction of overdoses Prevention of infectious diseases Measures for safer tattooing and piercing
Target group	Experimental drug users, frequent drug users, problem drug users, former drug users
Staff	150 staff members: nurses, medical doctors, psychologists
Budget and source(s) of funding	Annual budget: no information Funding: non-governmental organisation
Evaluation	Yes, internal evaluation, completed in 2008

Background and objectives

Until there was no harm reduction implemented for drug users in prisons, peer educators were the most important group in all national prisons. Their role was to stimulate the communication between the prison staff and other inmates. Peer educators facilitated the utilisation of a range of interventions, covering voluntary counselling and testing for HIV and hepatitis B and C, condom distribution, information, syringe exchange programme etc. The main objective of the peer education activities was to increase the prisoners’ access to all harm reduction measures available in prison.

Description of the programme

Peer educators were identified according to their motivation to act as peer educator, their abilities to ease communication with other prisoners and their willingness to complete the training. Peer educators received a specific training until the end of 2008. In order to assess the knowledge gained from the training as pre- and post-training evaluation was carried out. After successful training the peer educators were responsible for disseminating information about STD, voluntary counselling and testing for HIV and hepatitis, and for the distribution of sterile insuline type syringes, alcohol pads and condoms.

Access to the programme

In the 38 Romanian prisons about 800 inmates were trained as peer educators. More than 300 prisoners participated in the activities provided by peer educators.

Evaluation

In 2008 the internal evaluation was completed. However, no results from the evaluation have been reported.

Table 88: Quality for “Peer education”

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	5	Sum of points	4	Sum of points	4
Total Score	13	Quality level 2 – Good Practice			

3.3.5.12 Peer education, Portugal

Peer education was implemented in the prison population of Guarda by the Van Guarda Project with the aim to prevent drug misuse and to promote healthier life styles for drug users. This project is promoted by APDES (Agência Piaget para o Desenvolvimento) with the co-funding of IDT, the National Institute of Drugs and Drug Addiction. The first phase of peer education was performed from 2008 to 2010. The second phase was implemented in 2010 for a period of almost two years. The first and the second phase differed in the activities which were carried out. One most important activity was a training course on peer education to promote health in the prison context.

Table 89: Structural data on the programme “Van Guarda”

Topic	Details
Starting and end date	1 November 2010 – 31 October 2012
Provider	APDES – Agência Piaget para o Desenvolvimento
Main type (s) of intervention	Assistance to drug users in custody and prison Prevention for all prisoners in this prison Reduction of overdoses Prevention of infectious diseases Measures for safer tattooing and piercing
Target group	Experimental drug users, problem drug users Former drug users Prisoners suffering from an infectious disease
Staff	14 Staff members: 1 project coordinator, 2 psychologists, 1 social worker, and trainers with different professional backgrounds (psychology, social work, nursery, economy, sociology, nutrition science)
Budget and source(s) of funding	Annual budget: 19.472,49 Euros Sources of funding: National government and non-governmental organisation
Evaluation	Yes, internal evaluation

The project is implemented in the prison Guarda which has a maximum capacity of 175 prisoners. In most of the time the occupancy rate exceeds the capacity. For this reason the space available for the peer activities is insufficient. The activities take place in different spaces, depending on the nature of the activity and on the rooms available.

Background and objectives

In Portugal, the prison occupancy is much higher than its capacity (122 %). The vast majority of the prisoners are men between 25 to 39 years old. About 65 % of the prisoners have or had a drug problem. Due to the increase of the penal sanctions for drug related crimes the number of prisoners increased.

The 2008 assessment revealed that in the Guarda prison there is a

- high level of risk behaviours regarding sexual practices, injecting drug use, piercings and tattoos, share of hygienic materials;
- high prevalence of psychiatric co-morbidity such as personality disorders, mood and anxiety disturbances;

- high level of the use of psychotropic medicines (benzodiazepines) and other psychoactive substances among non-drug users;

Against this background specific interventions became necessary to promote the adoption of a healthier life style and to support the development of personal and social skills in term of relapse prevention. Specific objectives of the peer education were to improve the prisoners' knowledge about drugs and relation harms and about infectious diseases. Further a variety of health issues was addressed ranging from a self-determined sexual life to physical exercise and healthy food.

Peer education is based on the method of participation which includes the prisoners, the prison staff and the community services in the assessment, design and implementation of the activities provided by peer educators. The dimensions addressed with peer education are primarily prevention and harm reduction. The project intended to promote an integrated and systemic intervention, working not only on an individual level but considering also the impact on the dynamics of the prison system.

Description of the programme

For any activity in the prison there are six class rooms with the capacity for 10 persons, two outdoor playgrounds, two multipurpose spaces and a few rooms for individual counselling. These different spaces have to be managed for all the activities and events being conducted in prison (visits, training courses for prisoners and for staff, regular school, professional courses, cultural activities, sports, information sessions, cinema, etc).

For health promotion and prevention the peer educators provided group activities as well as individual information. They disseminated information and implemented cultural and recreational activities. Through these activities peer educators promote healthier life conditions in prison, healthier life styles and the development of personal and social skills such as in decision-making, problem solving and dealing with anxiety and frustration.

Access to the programme

During the project period 16 persons participated in the training course for peer education. Out of them nine persons concluded the training with success and got a pre-professional certification. Altogether 38 prisoners were contacted individually by the peer educator.

Evaluation

Because of its certification the training course was evaluated before and after the training. Furthermore, the interventions carried out by the peer educators was monitored weekly. After one year of the project a process evaluation took place and the final evaluation in November 2012 is based on the assessment of the individual contact by the peer educators. Until mid 2012 a total of 141 individuals were contacted by peer educators and a total of 169 different interventions were provided.

Table 90: Quality for: HIV prevention through peers

Logic model	Points	Evaluation	Points	Additional information/deliveries	Points
Sum of points	12	Sum of points	2	Sum of points	3
Total Score	15	Quality level 2 – Good Practice			

3.3.5.13 Peer education, Italy

The project “The Health Does Not Know a Border” (“La Salute Non conosce Confini”) has been carried out by the Italian Penitentiary Medicine and Health Society (SIMPSE) and the Italian Society of Infection Diseases (SIMIT) with support of the Italian Ministry of Health. It was implemented in 20 Italian prisons.⁴

The project was addressed to the general prison population including drug users and it involved peer educators. The project has three steps: The first one is that the peer educator informs a group of prisoners about defining someone among them as leader who informs about health and social problems associated with infectious diseases. The second step is to disseminate information (flyers and brochures) to the leaders who will then disseminate the information to the other prisoners. The third step is to collect data on the main risk behaviours associated with infectious diseases. The project had an emphasis on the prevention of infectious diseases through information on and screening of HIV and hepatitis and respective treatments.

4 The 20 Italian prisons were Roma Regina Coeli, Viterbo, Genova, Torino, Verona, Padova Reclusione, Padova Circondariale, Cagliari, Sassari, Napoli Secondigliano, Napoli Poggioreale, Catania, Palermo, Bologna, Bari, Catanzaro, Reggio Calabria, Firenze, Perugia and Roma Rebbibbia.

Table 91: Structural data on the programme “The Health Does Not Know A Border”

Topic	Details
Starting and end date	1 September 2011 – 1 September 2012
Provider	The Italian Penitentiary Medicine and Health Society sanitapenitenziaria@gmail.com
Main type (s) of intervention	Peer Education Selective prevention Psycho-social intervention or drug free treatment Prevention of infectious diseases
Target group	all prisoners, including drug users
Staff	5 Staff members: 3 medical doctors, 2 peer educators
Budget and source(s) of funding	Annual budget: 20,000 Euro Sources of funding: Non-governmental organisation
Evaluation	Yes, internal evaluation, carried out in May 2012

Background and objectives

Peer education is considered as one of the most effective and empowering methods in working with drug users. Also prison settings benefit from peer educators who communicate a range of social issues such as drug prevention, crime and violence. The literature and the experience suggest that peer education is a very effective method for sharing information and knowledge. Prisoners are more likely to listen to people like them. Consequently, the peer education approach may modify a person's knowledge, attitudes, beliefs and behaviours.

Peer education drew special attention to infectious diseases as regards to obtain data on the prevalence of HIV and hepatitis, raise awareness of risk behaviour and the prevention of infections, and finally to increase the number of treatments for infectious diseases.

Description of the programme

Educational information about social and health problems is disseminated to the identified leaders in prisoners' groups. Knowledge on the main risk behaviours associated with the infectious diseases is achieved.

Access to the programme

During the first six months of 2012 in sum 32 psycho-educational interventions were performed in the 20 prisons with the involvement of 1,546 prisoners. Preliminary results from nine prisons suggest that screening for the infectious diseases could be increased to 59 % of the whole prison population.

Evaluation

There is an internal evaluation, covering the screening rate for infection diseases and the number of patients in treatment for infectious diseases. When reporting about the project, results of the evaluation were not available.

Table 92: Quality for: Peer Education “The health does not know a boarder”

Logic model	Points	Evaluation	Points	Additional information/ deliveries	Points
Sum of points	11	Sum of points	4	Sum of points	2
Total Score	17	Quality level 2 – Good Practice			

Summary of findings

Experts from 15 European Union Member States have been appointed to collate most recent examples of good practice which are targeted to drug users in the criminal justice system. The collation of good practice is complementary to the systematic review of effective interventions in the criminal justice system and the inventory of available harm reduction and drug treatment service in prisons in European Union. The main aim of the collation of good practices was to learn about details of the implementation of current harm reduction services and drug treatment programmes in prison or other criminal justice settings.

Examples of good practice refer to the broad definition as specified by the EDDRA best practice portal, provided at the EMCDDA website (<http://www.emcdda.europa.eu/themes/best-practice/examples>). According to this definition good practices are an attempt to better understand what works, how and why it works and under which conditions. However, good practice follows the general principle to respect human rights and evidence based research. In general the assessment of good practice can be done by using different methodologies with varying degrees of complexity and rigour. For the present research two standard documents for reporting on good practices were applied; one for describing the intervention systematically and one for the quality assessment.

Depending on the assessment criteria that are fulfilled by an intervention the quality has been determined. The lowest quality level ‘Promising Practice’ requires that an intervention has clear objectives, a sound theoretical basis and has proved its ability to engage the target group. The quality level ‘Good Practice’ is achieved if – in addition – an intervention manual is used and at least a process evaluation is conducted. Criterion for the ‘Top Level Practice’ is that the intervention has been evaluated validated instruments as to its outcome.

All 15 experts reported on three “new” interventions which comply with one of the quality levels. The term “new” refers to interventions which have been implemented in prison or in community during the period from 2008-2012. With this approach the recent developments in the health care of prisoners with drugs problems are traced. Within the ACCESS Project only a limited number of countries could be involved in collating examples of good practice. The selection followed the intention to cover a variety of European Member States from West to East and North to South. However, this approach also implies some limitations as not all Member States are covered and as the collated examples of good practices demonstrate a selection of what is provided to prisoners in a country. On the other hand the selection of intervention programmes allow to spotlight innovative approaches or evidence based approaches.

The findings of the reports of the 15 experts show that most of the newly implemented interventions refer to the area of drug counselling and drug treatment as well as peer education provided in the criminal justice setting. Out of a total of 38 reported interventions 13 interventions are related to Therapeutic Communities, rehabilitation programmes and peer approaches (34 %). The majority of these interventions is implemented in prisons and is targeted at prisoners with drug problems in general or at specific subgroups such as individuals with mental health problems (England) or juvenile drug addicts (Slovakia). In addition, a few initiatives focussed on the period before or after prison release. For instance, in Sofia, Bulgaria, a small pilot project was initiated to support drug users who were soon to be released and whose offences were related to their drug use. In Athens, Greece, a court counselling service has been implemented to provide legal support to juvenile delinquents with drug problems. With regard to the peer approaches the education of prisoners as peers is focussed on risk behaviour associated with blood-borne diseases, sexually transmitted infections and overdose; overdose prevention with naloxone is part of a peer training in Scotland.

Out of the 13 interventions eight of them are still ongoing while five interventions have already been terminated. The majority of the 13 drug treatment, counselling and peer approaches meet the quality criteria for Good Practice (n=8). Another four interventions, being implemented in Eastern European countries, achieve the level of Promising Practice. The Top Level Practice is reached by one comprehensive intervention from the UK which aims at alternative forms of secure, treatment based accommodation for

mentally ill and drug offenders. This programme is implemented in 16 sites, comprises courts services, probation centres, residential treatment, community treatment and quasi-residential treatment, and is evaluated by a full impact study.

Second most often medication-assisted treatment has been implemented in the criminal justice system (n=8; 21 %). In five cases pharmacological interventions consist of methadone maintenance treatment in prison and in two cases the provision of naloxone on release is involved (England, Scotland). Furthermore in the Netherlands therapeutic GHB is provided for detoxification purposes to GHB addicts arrested at the police station. With the exception of the GHB intervention all other intervention programmes are ongoing. In Romania methadone maintenance treatment has been enlarged with funding of the UNODC to nine prisons until the end of 2011. Since 2012 the National Administration of Penitentiaries had to ensure methadone treatment through their own funds, meaning that treatment access might be reduced. Six of the pharmacological interventions achieved the Good Practice quality level. In Poland, methadone maintenance treatment in prisons is limited to one detention unit and for this reason it is assessed as Promising Practice. In England, the impact of the prison initiated opioid substitution programme on post-release outcomes is being evaluated on a national level. In order to investigate the effectiveness of OST on the reduction of fatal overdose, offending and the treatment engagement a control group design is applied. Given the rigour in methodology used for the OST evaluation this programme is assessed as Top Level quality.

In the third place of the reported interventions rank behavioural interventions (n=6) and structural responses to prison health care (n=6). Behavioural intervention programmes consist of psycho-education for health, legal and family problems, brief intervention for treatment motivation and cognitive-behavioural skill training. In general, behavioural interventions are usually delivered in group sessions and aim at changes in drug use behaviour and delinquency, health promotion and to engage prisoners with drugs problems in drug treatment. However, these interventions are rarely evaluated, instead monitoring data such as on number of participants and group sessions are collected. For this reason four of the behavioural interventions are assessed as Promising Practice, and out of them two intervention programmes have already been finalised. Furthermore two interventions meet the quality criteria for Good Practice; one is the cognitive behavioural programme for drug

using offenders provided in one city in Bulgaria, and the second one is the brief intervention which has been introduced in a number of detention and prison units in Poland.

Structural responses to prison health care comprise alternatives to imprisonment (Italy, Estonia), the creation of drug-free zones (Slovakia), the assessment of the physical health and emotional well-being of the prisoners at prison entry (Lithuania), and community based health programmes in prison and after release (Ireland). Alternatives to imprisonment consist of residential drug treatment which is offered to drug addicted offenders sentenced to prison who comply with conditions related to their offense or prison sentence. The two health programmes implemented in Ireland are rather different. One of these initiatives has been implemented in one prison and aimed at arranging most effective community linkages to ensure a seamless transition of methadone treatment from the prison to the community. In a defined period of time the most effective ways of community linking after release were explored in a small scale study. The results demonstrated that the community linking for prisoners being released on methadone maintenance was effective. The other programme consists of the implementation of a comprehensive community based health approach in five Irish prisons. This programme comprises of peer education in harm reduction and prevention of infectious diseases, addiction counsellors, interventions for violence prevention, mass voluntary HIV rapid testing campaign etc.

Three of the six programmes on structural responses to prison health care ended; this was the case for the Irish evaluation of community linkage, and the programmes from Italy and Slovakia. With respect to the quality levels of the six programmes two of them were assessed as Promising Practice while four programmes meet the criteria of Good Practice.

Finally five different interventions in the area of prevention of infectious diseases were reported by the experts. Two of these interventions were related to the implementation of guidelines in detention in the Netherlands; one guideline for the detection and treatment of HCV in prisons, and one new guideline on indications for TB screening of prisoners. Furthermore, the prevention of infectious diseases covers the implementation of specialised HIV and STI services (Ireland), HIV screening in prisons in combination with psychosocial support (Portugal), and motivation of juvenile experimental drug users for HIV testing and medical consultation in prison (Latvia). At the time of reporting three of the programmes already ended; the one from Latvia, Portu-

gal, and the guideline for TB screening. With one exception all programmes achieved the quality level for Good Practice.

In conclusion, experts from 15 European countries reported on 38 intervention programmes which have been implemented in the criminal justice setting since 2008. Two third of these programmes were still ongoing in 2013, and many of them will continue in the near future. The main focus of the collation of recent intervention programmes was to identify examples of Good Practice. With regard to the quality level, a total of 24 programmes achieved the Good Practice level (61 %). 12 of the reported programmes showed Promising quality, and two programmes from England met the criteria for Top Level quality.

Good quality models can be regarded as intervention programmes that have somehow demonstrated through data or evaluation to be effectively working in their defined setting. However, initiatives in practice do not always follow the evidence base even though evidence is a precondition for complying with the standards for good practice. The systematic literature review, which is part of the present book, is a compilation of the current evidence for effective interventions and hence acts as a measure for further assessment of the programmes implemented in the criminal justice system. There is unique evidence for the effectiveness for prison-based opioid maintenance treatment and Therapeutic Communities which are effective in any prison setting. Furthermore testing and treatment for HIV and HCV has shown to be feasible, and cost-effective for drug dependent prisoners. Ambiguous or limited evidence exists for drug-free zones, cognitive behavioural therapy, pre-release treatment with naloxone, and peer education. However, at present only a few studies with methodological rigour are available which evaluated the effectiveness of these approaches. Furthermore research might prove the effectiveness of overdose prevention with naloxone or peer education if implemented properly and integrated in a comprehensive health care for prisoners. A number of the interventions reported by the experts are currently under evaluation, and results will be available in 2014. It can be expected that in particular the research on methadone treatment and naloxone from England and the research on community linkage from Ireland will contribute to the increase of evidence.

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