



SUBSTITUTION TREATMENT IN EUROPEAN PRISONS

A study of policies and practices of substitution in prisons
in 18 European countries

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Executive Summary

Aims

Compared to services offered in the community, access to substitution treatment in prisons is inadequate in many countries across Europe. This study uncovers obstacles to the introduction of substitution treatment and explores limitations that prisoners encounter when attempting to access services. The objectives of the research were (i) to conduct a literature review on substitution treatment in prisons, (ii) to elaborate an inventory of substitution policy and practice in prisons, (iii) to provide an overview of the national and regional developments of health care standards (iv) to raise issues related to the interruption or continuation of substitution treatment from the community into the prison setting, (v) to initiate an exchange of information between medical doctors and health care workers in prisons (vi) to identify 'good practice' in the field of substitution treatment.

Methodology

Research was conducted over 18 months, from December 2002 to May 2004. This involved: (i) The collection of general data at the national level (through literature review, library searches, consultation of ministerial documents) and (ii) field trips in which interviews were conducted in two prisons per country with prison staff, doctors, nurses and focus groups of prisoners. As an explorative study, qualitative methods were employed, providing in-depth insights into individual experiences and sensitive areas. Prisoners' views on service provision constitute a major element of this study. Prison visits took place in 33 prisons in 17 countries (15 EU-Member States, as of 1st May 2004, except Luxembourg, plus Czech Republic, Poland and Slovenia) with 184 prisoners (132 men, 52 women) in 33 focus groups.

Results

In common with the evolution of substitution treatment in the community, the service was first made available in prisons for inmates with HIV/AIDs, other infectious diseases and, in the case of women, those who were preg-

nant. Though these constraints have largely vanished, with substitution treatment now offered to a broad cross-section of prisoners, provision still lags behind the standards of substitution treatment in the community. A treatment gap persists between those requiring substitution treatment and those receiving it and, in most of the countries studied, coverage is patchy. Heterogeneous and inconsistent regulations and treatment modalities appear throughout Europe, sometimes even within one country. Nevertheless, compared to previous research, this study illustrates that the scope of substitution treatment has extended across Europe: it is now only Greece and Sweden who do not offer treatment in prisons.

In most countries, substitution treatment is most likely to be discontinued when entering prison. The reasons for this include: (i) a basic drug free orientation in prison, (ii) the perception of methadone (or any other substitution drug) as a psychoactive drug that is unsuitable for therapy, (iii) a lack of understanding of dependence as a chronic disease, (iv) limited resources and expertise. Prisoners also demonstrated resistance due to: (i) a lack of understanding of the nature of substitution treatment; prison sentences are often viewed as a drug free time with an expectation of withdrawal and subsequent relapse upon release, (ii) prisoners want to hide their drug use (one reason being that they fear prejudice and disadvantageous treatment if seen as a drug user), which is an impossibility if they are receiving treatment.

Across the board, a consensus surrounding the need to continue substitution treatment that had already been started in the community was apparent. However, this depended on the time spent in treatment in the community and the length of sentence that the prisoner faced. The initiation of substitution treatment within prison proved much more problematic. When it occurred, treatment arranged immediately upon admission or in the run up to release.

In some countries, substitution treatment is formally limited to a period of between 6 to 12 months. Elsewhere, such restrictions apply informally but are not codified in official guidelines or regulations. In other countries, no time limits exist and substitution treatment is offered on an individual basis. In Spain and Austria, substitution is standard practice. Psychosocial care is seen as an integral part of treatment and a vital compliment to medical care. However, such support is rarely provided.

As much variety exists in relation to methods of detoxification, both across Europe and within individual countries. Reductions in dosage tend to fluctuate from prison to prison with schemes lasting from between 7 days and four

weeks. The use of benzodiazepines is beginning to enter the prison system and constitutes an additional problem due to the intensified dependence, severe syndromes and difficulties in detoxification involved.

Research indicated that the average substitute dose varied considerably in prisons (from 30 to 70 mg). In contrast to community practice, many believed that low doses were sufficient on the basis that 100% intake was guaranteed and that the amount of other drugs used is significantly lower in prison.

The provision of information concerning substitution treatment, drug-use and prison policy was seen to be lacking in many prisons. Frequently, prisoners didn't understand the goals being pursued through substitution treatment, nor why specific drugs or treatment methods (exclusion criteria etc.) were employed. This raises serious issues about the extent to which prisoners can be said to have given informed consent.

Although it is hard to secure anonymity and confidentiality within the prison context, attempts have been made to administer substitution drugs in a way that protects prisoners, either by putting all patients together in one wing or delivering substitution drugs discreetly with other pharmaceuticals. Exceptions were found in which prisoners complained of public identification of those on treatment.

In several countries, specific training for doctors is not required, preventing professionals from responding to a fast changing treatment environment and making necessary improvements. With most staff learning on the job, additional training would be welcomed. It was reported that some training programmes focus on drugs and drug treatment in the community and are not targeted towards the prison setting.

Conclusions

Prisons systems were found to be slow in responding to epidemics of viral infectious diseases (such as HIV and Hepatitis) and injection drug use. Substitution treatment was seen as a response to the dangers encountered by opiate dependent inmates as it can reduce (i) heroin use, drug injection and needle sharing, (ii) participation in the prison-based drug trade, (iii) opiate related mortality soon after release from prison. It can lead to (iii) increased participation in drug treatment following release from prison, (iv) a significant reduction in serious drug charges. Offenders participating in substitution

treatment displayed lower readmission rates overall. More broadly, the prison system benefits through a reduction in withdrawal symptoms upon admission, a restricted drug trade and increased productivity among prisoners. The existing studies indicate that continuity of care is required to maintain any benefits acquired.

In order to ensure universal levels of care (i) a major expansion of maintenance is needed in many countries to meet the needs of prisoners (ii) substantial efforts have to be made to improve the quality of services and (iii) better links and continuity of care are needed between prisons and the range of community based services.

The research indicates that the goal of achieving a drug free state for all patients jeopardises the achievement of other important objectives – HIV/Hepatitis infection, prevention of overdose, relapse after release etc. – which should be afforded greater priority as policy objectives.

Low and high threshold programmes should be considered, emphasising harm reduction goals (e.g. prevention of relapse after release, prevention of infectious diseases), where high threshold programmes would be equipped with additional means and resources (e.g. psycho-social care and support) and would require greater commitment and engagement. The specific treatment needs of women must be met according to the complexity and severity of the drug use of women admitted to prisons.

Ongoing contributions from patients are valuable in order to improve the quality of health care; most prisoners have had previous, personal experience of prison health care and substitution treatment inside prison and in the community (either detoxification or maintenance). They are willing and able to make substantial and valuable comments on the service delivery.

In many countries, health care is not monitored adequately; only rough estimates on the scope and quality of substitution treatment are available. In almost all countries visited, there was a lack of evaluation in which the needs of the patients were taken into consideration as well as the views of the service providers. For any improvements to be seen, additional work must be done on patients' needs, service provision and enhanced links with community services.

On a positive note, examples of good practice were found in relation to (i) guidelines on clinical management and the treatment of substance use, (ii) structures for substitution treatment e.g. regular meetings between social

workers, nurses, doctors and psychologists, (iii) networking with community substitution treatment services. On the basis of these findings, recommendations for improvements in the quality of substitution treatment have been elaborated.

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Introduction

Forty years after the introduction of substitution treatment for opiate dependent persons its implementation is often far from adequate. Especially in prison settings in Europe the availability, the implementation, clinical management and the evaluation of substitution treatment for opiate dependent persons are often deficient. This is one of the reasons why this study of the situation in prisons in 18 European countries is important. As there is a wealth of scientific evidence that shows effectiveness of substitution treatment both in the community and in prison, we are focusing on the obstacles to introduce this treatment and the limitations of its access for prisoners, so that this group can benefit from medical and social improvements adequately.

We would like to stress two peculiar aspects of the study right from the start. First, although in almost each of the eighteen countries two prisons were visited, it is not a comparative study. The inmates and the substitution treatment for opiate dependent persons differ not only from one country to another, but also from one region to another, from one prison to another and from one prison physician to another. It is therefore not really possible to compare the collected data on a country level or any other level. What we tried to do is to involve as much as possible different settings (such as male and female prisons, youth prisons, prisons in big cities and in small communities, etc.) in order to be able to describe the very different ways of functioning in relation to substitution treatment for opiate drug users in a prison setting in a reasonable number of European countries.

Secondly, the most original aspect of the study is the fact that, besides official data and interviews of key persons, inmates themselves were interviewed in focus groups. We consider this as an often forgotten sound in the concerts of policy, practice and research.

Our report starts with the objectives of the study, followed by a chapter on basic terminology and the applied methodology. Then the results of the study are summarised in the literature review, the country reports presented in alphabetical order, followed by emerging issues, conclusions and recommendations and ending up with a reference list and some relevant appendices.

This study is only a first general overview, a kind of base line study realised in a very short time. For all of these reasons it calls for further in-depth research in the future.

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PART I :
Review oft the Situation

A. General Introduction

1 Background information

There is a consensus among many experts and committees (Gezondheidsraad 2002, 22) that the greatest possible use can and must be made of detention periods to motivate drug users to continue or start to work on their drug use and dependence. The central aims of detention are to enable inmates to increase their social and individual competence in order to overcome either the drug dependence or to develop coping strategies which are harm minimized either in an individual or social meaning. The prison service can support this process by offering (new) opportunities. The provision of health care, either a continuity of care or the initiation of treatment, which can be continued following the individual's release are central elements in the recovery and stabilization process. We know that while many drug users get into contact for the first time with health services while in prison, others try to continue their treatment started outside. However, it should be recognized that the opportunities for treating drug users with the aim of cure and causal therapy are very limited in penitentiary settings. The limitations are inherent to the nature of detention, the dominance of security aspects, the duration of detention, the scope and accessibility of treatment facilities, the coercive and control oriented setting, and the nature of dependence itself.

So, any opportunities should be fully exploited. In most countries the penitentiary and treatment policies are primarily focussed on abstinence so that not all opportunities (e.g. harm reduction and stabilization) are exploited adequately.

Substitution treatment is a treatment which unifies cure and care elements. It is a cure for opioid dependence in that it blocks the craving and allows drug dependents to lead a normal life with a substitute drug. The treatment is a care for those not yet or not at all capable and willing to pursue the goal of abstinence, but who try to avoid the damaging effects for themselves and their social environment deriving from their drug dependency. Stabilisation and improvement of the individual's health and quality of life is one key element in the treatment with substitution treatment within the wider concept of risk reduction.

Substitution treatment is one of the most widespread drug treatments for opiate dependent persons in the EU and Norway. According to the EMCDDA

(2003) the substitution treatment has seen a 34% increase in availability. Some 400,000 people now receive substitution treatment in the 16 countries. Over 60% (around 250,000) of these treatments places are found in Spain, France and Italy.

But still access to substitution treatment for opiate dependent prisoners is very limited and it is clear that in many countries prisoners do not have the same or even similar health services available as those outside the prison system. So, experts are analysing a special need for further development of substitution services within the prison system of different countries (Farrell et al., 2001, 31; Casselman, Meuwissen, Opdebeeck, 2003) and demanding extra efforts to attain this objective of equivalent health care (Buning, 2001, 216).

This study “Substitution Treatment In European Prisons” looks at the procedures and problems of substitution treatment in prisons. It acknowledges that there is an overall need to bring about consistency in the management of inmates who are on substitution treatment when admitted to and released from prison in order to strengthen their health, and to ensure that the provision of substitution programmes is managed safely, securely and continuously.

Substitution treatment in prison can only be understood in the broader sense of the treatment facilities outside in the community and in the light of regional and/or national law and regulations. Prison medical services and consequently substitution treatments reflect the legal and professional situation outside within their organizational boundaries. Substitution treatment in Europe is a very heterogeneous issue. There are many different views of the impact and the value of substitution treatment, the way it is integrated in the drug treatment services (detoxification and/or maintenance), the way it is used as baseline for ongoing treatments. Furthermore, medical care in prison is provided by many different agencies and systems and approaches (either under the auspices of the Ministry of Health or the Ministry of Justice). Different values and concepts make it difficult to compare the provision of substitution treatment in Europe. We are far from giving advice or recipes for substitution treatment in prisons. But on the other hand, substitution treatment has been well analysed in the research and over a period of time, has been well-documented and international bodies have formulated their views both of prison-based medical services in general and substitution treatment specifically (see the chapter ‘literature review’).

2 The principle of ‘equivalence’ in international guidelines and recommendations

While the United Nations has stated that persons “deprived of liberty” have all other rights retained, and most countries are signatories to this convention¹, the realities of prison life, and death, are grim. Disease transmission in prison, and the impact on the general community provides ample reason to consider the public health implications of mass incarceration. A number of studies have identified disparities between services inside and outside of prison, in the fields of diabetes (MacFarlane, 1996), mental health (Hargreaves, 1997) and drug and alcohol treatment. There are a variety of international recommendations that include the principle of equivalence as a basic supposition for the treatment and care of drug using prisoners. This principle means that prisoners should have access to the same medical and health care services as outside prison, and that the professional standards of care and cure provided outside should be applied in prisons. Prisoners and all detained persons have the right to the highest attainable standard of physical and mental health. They are not sentenced to insufficient medical care, but to a loss of freedom. The principle of equivalence serves as a baseline in discussing health care services for drug users in prisons, either for treatment of their drug use or for the prevention of drug-related harm, such as infectious diseases.

The Joint United Nations Programme in HIV/AIDS (UNAIDS) clearly states: ‘With regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community. But in reality, few prisons provide adequate HIV/AIDS prevention and care programmes comparable to the outside situation. Neither prisoners nor prison staff are provided adequate information and education concerning how to avoid becoming infected. Nor do prisoners have the access to the means of prevention that are available on the outside. This would include condoms, bleach for disinfecting needles, and needle exchange programmes, which are available in the community.’

The European Council also clearly stated for HIV/AIDS policy that all political actors regarding AIDS should be in alignment with the guidelines of the WHO as well as with the principle of equality along the recommendation No. R (93) 6 by the European Council (see Appendix A5): prisoners should

1 Standard Minimum Rules for the Treatment of Prisoners:
http://www.unhchr.ch/html/menu3/b/h_comp34.htm

be offered the same medical treatment and psychological care as other members of society.

Although in some countries the principle of equivalence of care and provision for the continuity of care is explicitly formulated in official government papers (for Ireland, Department of Justice 1994, in: Dillon 2000, Irish Prison Service 2000), in practice health care provision equivalent to that available in the community is hardly achieved – at least for drug using inmates (for Ireland: Dillon 2000; for the UK: Turnbull 2000, 102). O’Brien & Stevens (1997) found in their European study on the ‘Implementation of International Guidelines on HIV/AIDS in Prisons of the European Union’ that WHO guidelines on HIV/AIDS in prisons (1993) are not being uniformly applied in prisons in EU member states. “In general, the principle of equivalence between HIV services in prison and in the community is not applied. In particular, many of the WHO recommendations on HIV/AIDS in prisons are not implemented”.

One reason for that, according to Dillon (2000, 38), is that different government departments are responsible for the care of drug users in the community and for drug users in prison: ‘This situation creates inherent problems for the continuity of care of drug users. Despite on-going commitments, the principle of equivalence does not prevail within the Irish prison system in its care of drug users.’ Furthermore, some HIV-prevention measures are highly politically loaded, cannot be introduced due to resistance of staff, or are perceived as inadequate for the prison setting (e.g. needle exchange).

In the European Union there appears to be gaps in adequate provision of treatment, care and prevention as Stevens (1998) and Bollini (1997)² point out. WHO/UNAIDS (1997) confirmed this in a study of 23 prison systems in 20 European countries, representing 387 000 prisoners. It was pointed out that:

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

- in most prisons, information is provided for prisoners and staff;
- condoms are distributed in 18 of 23 systems;
- disinfectants are available in 11 systems and methadone treatment in one way or the other in only 9 systems.

3 Substitution treatment as acknowledged and effectively proven therapy

Substitution treatment in its different forms has established itself as a widely accepted harm reduction and treatment measure for opiate dependent individuals in the community (Council of Europe, 2001). Its effectiveness in terms of desirable treatment outcomes can be concluded from a decisive body of research (Farrell et al., 2001; see also the chapter ‘Literature Review’).

If methadone is perceived more as a “psychoactive drug” than as a “therapeutic drug” as it is the case in some countries and settings (e.g. prisons), this view and perception causes consequences in terms of general acceptance and understanding of substitution treatment as a therapy. Viewed as a ‘psychoactive drug’ it can more easily be subordinated under public order policies. Taking comparably the acknowledged treatment against diabetes, nobody would doubt the usefulness and continuation of proven therapies like giving insulin while the concerned are at the admission to prison. As substitution treatment varies considerably throughout European prisons, problem areas need to be identified, such as

- Different concepts of substitution treatment,
- Different medications,
- Different forms of psycho-social care, etc.

4 Increase Access to and Availability of treatment for drug users

The EU Action Plan on Drugs 2000-2004 (CORDROGUE 32 7/6/00) calls on Member States to find strategies to increase access to and availability of services for drug users who are at risk of severe health damage, drug-related infectious diseases and deaths, in order to reduce individual and public health risks. One of the priorities of the work plan 2003 of the Programme of Community action in the field of public health (2003-2008) (2003/C 62/06, Decision No. 1786/2002/EG) is to develop strategies to reduce health inequalities in the Community (2.1.2). Taking prisons as part of the community inequalities can clearly be identified. The questions are:

- How can more drug users benefit from new treatment options?
- What are 'Good Practice' models that could be identified?
- Which problems at the interface of community/prison can be solved and in which way?

B. Basic Concepts and Definitions

Within the context of the activities of the 'European Network on Drug Services in Prisons' (ENDSP), Cranstoun Drug Services has managed a research project on 'Substitution Treatment in European Prisons' over a period of 18 months in 18 countries (the 15 EU Western countries, the Czech Republic, Slovenia and Poland) starting in December 2002 and finishing in May 2004.

The study results will be presented at the 8th European Conference on Drug and HIV/AIDS Services in Prison in July 2005 in Budapest, Hungary.

The researchers were Dr. Heino Stöver (University of Bremen, Germany) and Laetitia Hennebel (ENDSP/Cranstoun Drug Services, U.K.). Professor Joris Casselman (Catholic University of Leuven, Belgium) acted as scientific peer-reviewer.

The study was carried out with the support of the ENDSPP's national contacts (see acknowledgments).

1 Objectives

The *general objective* of the research was to conduct a study of substitution treatment in prisons in 18 European countries.

The research had the following *specific objectives*:

- Conduct a literature review on substitution treatment in prisons;
- Elaborate an inventory of the substitution policy and practice in prisons;
- Provide an overview of the national and regional developments of health care standards with regard to substitution treatment in prisons;
- Point out issues related to cessation and continuation of substitution treatment prescription from the community into the prison setting;
- Initialise an exchange of information of medical doctors and health care workers in charge of prison health care services; and
- Identify 'Good Practice' of substitution treatment offered in prisons.

2 Structure of the report

The *Executive Summary* is presented at the very beginning of the report.

The *first PART* includes 3 chapters. The first chapter introduces the research by stating the rationale behind conducting such a research project, the context of the research, as well as its objectives. The reader will find information and feedback all through the report on the different set objectives. The second chapter presents the large literature review that was conducted. Basic concepts (and definitions) that are used throughout the report, are presented in the third chapter.

The methodology is covered entirely in the *second PART*.

PART three presents the findings. Country reports for the 18 countries are presented in an alphabetical order in the first chapter, followed by emerging issues in the second chapter. This latter presents important issues shared in the various visited countries. In a third chapter we are stressing the need to treat women separately in substitution treatment.

Conclusions and recommendations are presented in the *fourth PART* including an outline on prevention and treatment of blood-borne-viruses (HIV and Hepatitis) within substitution treatment in prisons.

Although each country report has a list of *references* referring to the country described, all references, across all the chapters, are presented in alphabetic order at the end of the report.

C. Literature Review

1 Introduction

In its different forms, substitution treatment has established itself as a widely accepted harm reduction and treatment measure for opiate dependent individuals in the community (Council of Europe 2001). In terms of desirable treatment, its effectiveness in outcomes can be concluded from a decisive body of research (Farrell et al. 2001). Most of the scientific research work has been done on methadone; newly authorized substitution substances, like buprenorphine, have only been studied in the last years.

A different situation is encountered when looking at substitute prescription in penal institutions: Different goals are formulated (e.g. abstinence-orientation vs. harm reduction); different values and characteristics are connoted to substitution drugs (methadone within a hedonistic rather than pharmaceutical concept), security aspects have to be acknowledged (supervision of intake to avoid selling the substitute), the different doctor-patient relationship has to be recognised (namely, the loss of free choice of the doctor) and, finally, structural conditions of the prison setting as such have to be looked at (such as the impossibility of escaping the prison drug scene). Finally, opposing arguments are to be found among the views of professionals, prison health authorities and politicians. In 1996, DeClerck, the Belgian Minister of Justice, summed up the grounds for a negative position on substitution treatment in prisons:

- “Methadone treatment should have diminished criminal behaviour. The fact that the user ended up in prison is proof that his treatment failed;
- The supply of heroin in prison is limited and irregular, therefore use will diminish anyway;
- Users of other drugs (cocaine, amphetamines) also have to detoxify. To offer substitution to one group, but not to another would be unfair;
- The large numbers of heroin users entering the prison system preclude the necessary psychological and social follow-up;
- In society, methadone is being used as a tool to lower the threshold of treatment. In prison, there is no need for such a tool”.

In many countries, the issue of substitution treatment in prisons remains highly controversial. As it is practiced in only a very limited number of prisons over the world, the amount of research conducted in this area is also of a very limited nature.

Programme. As most of the research has taken place in the United States, it is problematic to adapt the results and conclusions to European conditions. Even in the case of successful treatment programmes, the positive effects seem to disappear over the longer term if they are not succeeded by adequate follow-up care. But, methadone maintenance programmes in penal institutions which are intended to prevent addicts from relapsing to the use of illegal drugs and/or consequently to crime are promising (Gezondheidsraad 2002).

2 Results of previous literature review

The existing investigations on substitution treatment in prisons comprise: a small number of controlled trials (Dolan et al., 2002); evaluation studies of the provision in prisons (Schultze, 2001; McGuigan, 1995; Boguna, 1997; Keppler, 1995); feasibility studies and reviews (Dolan and Wodak, 1996; Pearson and Lipton, 1999); examinations of the different modes of substitution treatment found in either individual or in a number of prisons (e.g. detoxification, pre-release, short-term and maintenance) (Michel and Maguet, 2003) studies on the diverse criteria relevant to evaluating the quality of the outcomes/the national protocols (Hannifin 1997) or highlighting certain aspects of ST (for instance “overdose”, see Tracqui et al. 1998).

One of the most important reviews of existing literature has been done by Kate Dolan and Alex Wodak in their ‘International review of methadone provision in prisons’, (1996). Here they reviewed the ‘rationale, current international implementation and evidence of the effectiveness of methadone provision to inmates’ (p. 85). Our review focuses on data that was generated after their review process but, nevertheless, it is worth presenting some of their key findings in brief:

- Significant reductions in sharing injection equipment have been documented for among a group of incarcerated intravenous drug users in Spain who, along with a control group, participated in a prison based methadone programme (Marco, 1995).

- In an array of studies, correctional staff perceived prison methadone maintenance treatment (PMMT) to have reduced anxiety amongst prisoners, causing inmates in PMMT to be less irritable, anxious and easier to manage (Gorta, 1992; Herzog, 1993; Magura et al., 1993).
- Participants of a drug reduction scheme in Scotland, involving prescription of opiates, including methadone, who were accommodated in a separate unit were seen to have used fewer drugs than a control group (Shewan et al., 1994). However, since only two thirds received methadone it is not possible to single out its specific impact.
- No conflicts between treated and untreated were reported by Herzog explicitly (1993).
- Inmates in PMMT in New South Wales reported decreases in drug use, drug-related prison violence, crime following release (Bertram & Gorta, 1990a) and considered PMMT to be more effective at preventing HIV in prison than in the community (Bertram & Gorta, 1990b).
- Methadone based detoxification of heroin dependent prison entrants in Switzerland was found to reduce tension and facilitate custodial management (Herzog, 1993).
- In several studies (Bertram, 1991; Gorta, 1987; Wale & Gorta, 1987), negative side-effects of PMMT often feared by prison staff, such as stand-over tactics or a black market for methadone, were reported not have occurred.
- Herzog (1993) found that 7% of urine samples of PMMT receiving inmates in Switzerland tested positive for heroin and 20% for benzodiazepines. Bertram (1991) reported positive urine samples from inmates in New South Wales to be more likely to contain benzodiazepines than morphine whilst Gorta (1992) found the majority of samples (90%) to be clear of non-prescribed drugs.
- Sometimes correctional staff were found to feel ambivalent or negative towards PMMT (Magura et al., 1993). Sometimes this was also the case for inmates (Rosenblum et al., 1991). In New South Wales, prison staff frequently lacked an understanding of the aims and objectives of PMMT (Hume & Gorta, 1988).

3 Most recent review

Taking the review from Dolan & Wodak (1996) as a basis to 1995, an extensive literature review has been carried out of studies appearing between 1995 and 2003. These studies, on the effects of the divergent practices of substitute prescribing in penal institutions, also reflect the development of ST in prisons since the mid-nineties:

- ST has become more widespread in many countries,
- Prison policy and administration are looking for standards and protocols and are reviewing the progress
- Access and treatment modalities have changed substantially,
- Additional substitution drugs are prescribed (buprenorphine etc.).

We have accessed an array of sources, such as libraries, internet, experts and data bases. In the following, the core findings of the revised studies will be structured and presented according to the criteria described below whilst considering the scientific integrity, validity and impact on practical discussions.

4 Literature review of substitution treatment in prison

In the following, the existing literature on substitution treatment in prisons is examined and divided according to the following criteria:

- A) Patterns of drug use and related risk behaviours (e.g. needle sharing)
- B) Social status related issues (e.g. housing, education/qualification and employment) and treatment outcome and development on and after release
- C) Inmates' subjective perspectives and experiences towards prison based substitution treatment (e.g. prisoners' perception of treatment)
- D) Issues associated with control of inmates (e.g. management of opiate dependent inmates)
- E) Pharmacological Studies

A) *Patterns of drug use and related risk behaviours*
(e.g. needle sharing)

1) On the basis of retrospective reports, Dolan et al. (1998) investigated whether methadone maintenance treatment (MMT) reduces injecting risk behaviour and, consequently, the transmission of blood-borne viral infections among inmates in prisons in New South Wales (Australia). For this purpose, in 1993, structured interviews were carried out with 185 injecting drug users who had been imprisoned in New South Wales within the last two years and had recently been released. Participants were recruited at different drugs treatment agencies and services dealing with injecting drug users. According to the type of drug treatment received while in prison, respondents, who shared corresponding demographic variables, were allocated to group I-III as follows: 105 to the 'standard care group' (I: Drug and alcohol counselling), 32 to the 'time-limited methadone group' (II: Prescription of methadone on a restricted level regarding dose and duration) and 48 to the 'methadone-maintained group' (III: Prescription of doses of methadone over 60 mg for the whole duration of imprisonment). The results revealed that, significantly, members of group III were least likely to report injecting heroin, sharing syringes and scored lowest on the HIV Risk-taking scale whilst imprisoned. Even though, non-significantly, they were also least likely to have injected any drug in prison. The present study is the first to provide evidence that MMT can reduce injecting risk behaviour in penal institutions. However, Dolan et al. stress the crucial point that, for MMT to be effective, a moderately high dose of methadone, prescribed for the entire period of imprisonment, is decisive. Consequently, and with regard to the known impact of adequate MMT on HIV incidence and prevalence rates among injecting drug users in the community (Ward et al., 1992), the authors draw the conclusion that the risk of the transmission of HIV and other blood-borne viruses amongst prisoners might also be attenuated. Along these lines, the authors strongly emphasise the fundamental role of prison MMT Programmes, particularly when considering the extreme lack of other harm reduction measures across penal institutions, such as syringe exchange programmes. Concerning the limitations of their study – differing doses of methadone prescribed in group III, retrospective reports, no randomised allocation of participants to the three groups and lack of equal group sizes – Dolan et al. (1998) recommend future research into the form of prospective, randomised studies with objective outcome measures, to optimally evaluate the effectiveness of MMT in prison.

2) According to the recommendations (discussed above), Dolan et al. (2002) measured the impact of prison based methadone maintenance treatment on prevalence and frequency of heroin injecting, incidence of HIV and hepatitis C and the shared use of injecting equipment. They conducted a two-group, pre-post randomised controlled trial with 382 inmates in a New South Wales prison in Australia. Both groups, the MMT and the control group, consisted of 191 inmates. The results of this study demonstrated that MMT provision in a prison healthcare setting was effective in reducing heroin use, drug injection and syringe sharing among incarcerated heroin users. There were equal numbers of hepatitis C Virus (HCV) seroconversions (four subjects in both groups seroconverted to HCV; no one seroconverted to HIV). The authors recommend that PMMT should be made available to all prisoners with heroin use problems throughout their period of imprisonment. These results are consistent with the methadone literature on prison-based substitution treatment in other countries (Johnson et al. 2001).

3) With the aim of comparing the prevalence of drug use and injection risk-taking amongst incarcerated and community methadone maintenance patients in New South Wales, Australia, Darke et al. (1998) conducted structured interviews with 100 prison inmates and 183 community methadone maintenance patients. Inmates were recruited in two urban and three rural prisons and had to be enrolled in a prison MMT programme for at least six months. The comparison group was recruited in the community and also had to have taken part in a community methadone maintenance programme for six months or longer. Drug use and injection behaviours were examined with regard to the 6 months preceding the interview. According to the results, community participants were significantly more likely than their prison counterparts to have injected a drug (84 vs. 44%), to have used heroin (72 vs. 38%) and to have done so more regularly (20 vs. 4.5 days median). Even though the frequency of heroin use and drug injecting amongst the prison group was decisively lower, incarcerated patients were significantly more likely to have engaged in highly risky injecting behaviour, e.g. to have borrowed (32 vs. 15%) and lent (35 vs. 21%) injecting equipment. The differences in drug use patterns between the two groups were explained in terms of the widespread access of community drug users, not only to drugs but also to sterile injecting equipment, and the scarcity of both in prisons. The authors emphasise that they had not intended to evaluate the effectiveness of prison methadone maintenance prescription (regarding the reduction of injecting and injecting risk behaviours), which had been done elsewhere

(e.g. Dolan et al., 1996), but to demonstrate the impact of the setting, i.e. the peculiarities of the prison environment compared to the community environment. They point out that, in prison, and even more so in the community, methadone substitution can be expected to solve the problem of drug use and injecting risk behaviour but could certainly attenuate both. They highlight the need for a harm reduction combination, i.e. methadone maintenance and injecting equipment exchange, to be available in prisons. The advantages of this study were that it dealt with participants who were still incarcerated rather than using retrospective reports and that it included control group interviews.

4) On the basis of the conviction, that methadone maintenance treatment represents an adequate treatment option – especially for individuals with certain physical and psychological indications – and that MMT started in the community should not be interrupted at the point of incarceration, the Catalan (Spain) Ministries of Health and Justice initiated a pilot programme of methadone maintenance prescription in a male prison in Barcelona. The intention was to evaluate the efficacy of programmes of this sort; their ability to prevent MMT interruption, the transmission of infectious diseases and the reduction of opiate use. The findings were presented in a report by Mourino (1994), Generalitat de Catalunya (Ministry of Justice): 123 incarcerated opiate users participated in a 5month methadone maintenance programme in the Barcelonan prison. Included were: Opiate users already in MMT prior to incarceration (the majority of participants); users who, due to psychotic conditions, were not able to withdraw and those with infections, such as HIV and AIDS. All participants were male, most of Spanish and some of other Caucasian origin, on average 30 years old and all opiate users since the age of 17. The average prison methadone dose was 58 mg. Over the course of the programme, the incidence of sharing syringes, as well as injecting in general, reduced significantly. However, it is crucial to emphasise that this trend was only marked when the entire treatment duration exceeded six months. 15 participants had concomitant use of drugs, mostly of heroin. Concomitant opiate use was significantly more frequent among individuals who were prescribed less than 50mg than those who received more than 50mg, pointing to the importance of a sufficiently high dosage. Both inferences, the necessity of a sufficiently high dose of methadone and an adequate length of treatment, have also been emphasised by Dolan et al. (1998). The programme was completed by 60 participants. No one finished prematurely voluntarily; only due to release, transferral or death. According to the author, the high retention

rate offers the possibility of getting inmates in touch with general medical services. Moreover, he points to the value of therapeutic outcome studies in the context of 'daily treatment' rather than under 'controlled laboratory conditions'. Still, Mourino criticises the limited duration of the programme, as reducing the possibility of generalising the findings, as opposed to programmes which are not time limited (e.g. Magura et al., 1993; KEEP on Rikers Island, New York/United States of America, see B2). Finally, regarding the social and health related aspects of the findings, he argues for substitution treatment to be accompanied by psychosocial care.

5) With the purpose of evaluating the efficacy of prison based MMT, and ultimately to inform policymakers, the Addiction Research Centre, a research branch of the Correctional Service Canada, compared the release outcome of offenders who participated in a prison based MMT programme with the outcome of inmates who did not. (Lists of offenders receiving MMT were obtained by relevant health care representatives in different Canadian prisons). The experimental group was comprised of 303 inmates who were included on the basis of having received prison based MMT between 1996 and 1999. The 215 controls were matched in most key characteristics but were slightly older and had a slightly lower criminal history risk. The inclusion criterion was being a known heroin user, which was measured using urine analysis and through a questionnaire that offenders had to complete upon admission to prison. In order to be in the position to carry out a follow-up, only people who were released were included. Release outcome measures were: Time spent in the community before readmission to jail and institutional misconduct before and after MMT initiation, at a rate per month for the experimental group, and before and after the positive urine analysis for the control group, also at a rate per month. The analysis of the results revealed a significant reduction in 'serious drugs charges' when comparing 'before and after MMT initiation'. Even though it was found that MMT participants were readmitted at a lower, more gradual rate, than the controls, this difference was not statistically significant. The authors recommend additional research to address issues such as continuation of treatment in the community and other community safety benefits.

B) Social status related issues (e.g. housing, education/qualification and employment) and treatment outcome, development on and after release

1) Johnson et al. (2001; see also D1 below) analysed the effects of institutional methadone maintenance treatment on release outcome and institutional behaviour, especially regarding drug offences, in Canadian prisons. The study compares PMMT participants to a group of incarcerated heroin users. Amongst other things the readmission rates of the two groups were examined. Offenders participating in PMMT had lower readmission rates and were readmitted at a slower rate than the Non-MMT group. Within a 12 month period, the Non-MMT group was 28% more likely than the MMT group to be returned to custody. "In terms of institutional behaviour, the MMT group had a reduced rate of serious drug related institutional charges following initiation of the MMT. This likely indicates a decrease in drug seeking and drug taking behaviour among MMT offenders in comparison to Non-MMT offenders after MMT initiation" [*Reference needed?]. This study clearly indicates that participation in an institutional MMT programme had a beneficial effect on outcome after release.

2) To evaluate the effectiveness of KEEP, an MMT programme for inmates at Rikers Island prison in New York, Magura et al. (1993) used a longitudinal follow-up design. They compared post-release outcomes of KEEP participants and inmates, who had detoxified from heroin at Rikers. Effectiveness was defined in terms of whether the programme led heroin dependent offenders into long-term community drug treatment, thus breaking the cycle of illicit drug use and criminal recidivism. Similar to the Catalan programme (Mourino, 1994, A4) described above, KEEP represents an opportunity to prevent the disruption of methadone substitution treatment initiated prior to incarceration. The inclusion criteria for KEEP were to be medically diagnosed as a narcotics addict and to be serving a sentence not longer than a year. The experimental group consisted of 308 randomly sampled, predominantly black and Hispanic heroin users, who had not already received MMT in the community. They were maintained on a daily methadone dose of 30 mg. Most participants, of whom a significant majority was male, were daily heroin and/or cocaine injectors. The 138 systematically sampled controls matched the study group in most characteristics and differences were statistically adjusted. Of the total participants, 250 were re-interviewed at a median of 6.5 months after release from prison. The dependent variables

were represented by “show” and retention rates at community drug treatment programmes after release. 85% of KEEP participants, versus 37% of controls, had applied for some sort of drug treatment after release, both primarily for MMT. At the time of the follow-up interviews, 27% and 9% respectively were still enrolled, again, mainly in MMT programmes. Both group differences were significant. Consequently, the authors concluded that KEEP has been proven to have a modestly beneficial impact on routing untreated, criminally involved heroin dependent individuals into community drug treatment. However, administrative and organisational as well as individual obstacles should also be considered as barriers to treatment. Regarding relapse into drug use and crime after discharge from prison no group differences were found – 88% of KEEP and 85% of control participants returned to heroin and/or cocaine use. Consequently, the authors point out, the frequently concurrent crack and cocaine use of many diagnosed opiate addicts is not addressed sufficiently with MMT and thus reduces success outcome rates. As before, one obstacle to success may be the comparatively low methadone dose (see, for example, Mourino, 1994, B3; Dolan et al., 1998, A1; Bellin et al., 1999). Moreover, in order not to relapse into crime, people need both alternative financial sources to survive on and appropriate accommodation options. Overall, the authors suggest considering long-term drug treatment, instead of incarceration for drug dependent offenders, for at least the duration of the respective prison sentences.

3) Bellin et al. (1999) identified inmates accepting high dose (median dose of 70 mg; 1,423 inmates) and low dose methadone therapy (median dose of 30 mg; 1,371 inmates) between 1996 and 1997 in New York’s Correctional system. In order to assess the impact of dosage on the criminal recidivism rate, the duration between release to the community and re-incarceration was measured. They found that individuals discharged on high dose methadone were less likely to return to jail than those on low dose, with a median re-incarceration time of 253 and 187 days respectively. While a fixed higher dose demonstrably reduced recidivism, the authors recommend routine methadone plasma level monitoring to adjust doses to achieve “blocking dose plasma levels” both in the community and in prison.

4) Sibbald (2002) evaluated the effects of expanding methadone maintenance inside federal Canadian prisons. The Canadian prison policy regarding methadone prescription developed from 1998, when all those prisoners receiving methadone in the community were permitted to continue the treat-

ment, to 1999, when under certain circumstances severely addicted prisoners were prescribed methadone, to 2000 when MMT was offered to any prisoner with an opiate addiction. It was found that, after a year, 41% of inmates who were receiving MMT were readmitted to prison, compared with 58% of addicted inmates who were not on the programme.

5) In France, this result was confirmed by Levasseur et al. (2002), who showed that re-incarceration is less likely among inmates who receive maintenance treatment while incarcerated. Inmates who received maintenance treatment while incarcerated had less than half the likelihood of re-incarceration than those who only detoxify (19% vs. 39%).

6) Crowley (1999) analysed the drug detoxification unit at Mountjoy Prison in Dublin/Ireland. Detoxification consists of a 10-day methadone detoxification programme and a 6-week intensive rehabilitation module. Approximately 67% participants were drug free in the training unit and, in addition, an estimated further 35% remained drug free in the community or in another prison. In a follow up, after 12 months, the relapse rate was 78% compared to approximately 90% in other in-patient detoxification programmes. The author reports a high death rate after release (3 out of 4 deaths after release have been drug related). Crowley suggests that it is likely that many on the detoxification programme would have been treated more appropriately under a maintenance programme. The survey showed that 87 out of 479 committals were receiving methadone maintenance in the community, with treatment stopped on admission.

C) Subjective experiences of inmates participating in a substitution programme

1) In his qualitative retrospective investigation Hughes (2000) explored drug injectors' views and experiences of substitute prescribing inside English prisons. Besides 17 in-depth interviews small group discussions with a further 7 participants were conducted. Of the total 24 participants, 6 were female and 18 male with a mean age of 27 and 23 years respectively. Respondents were recruited in two North Eastern English cities with the aid of drugs agencies and snowballing. Participants had previously injected drugs – mainly heroin – for between nine months and 19 years and had spent time in custody on between one and 18 occasions. As a key finding, Hughes identified the heterogeneity of experiences that participants reported regarding substitute prescribing in prison; highlighting the inconsistencies in prescribing

ing practices. The inconsistencies ranged from no treatment, over the prescription of painkillers and sedatives, to the prescription of methadone and lofexidine and were understood to depend on prison specific practices rather than on injectors' self-identified treatment needs. Even though many participants regarded receiving no treatment as problematic, especially regarding withdrawal effects, advantages were also mentioned such as much shorter withdrawals and not having to withdraw from methadone subsequently. The sole prescription of psychotropic drugs was commonly perceived as being inadequate in managing withdrawals. Short courses of methadone detoxification were frequently experienced as too short, with doses reducing too quickly. More adequate prescribing practices were reported when respondents had been detoxified with lofexidine. None of the interviewed drug users had had experiences with methadone maintenance in prison. According to participants, the frequently experienced disruption of methadone maintenance treatment, initiated in the community, not only resulted in physical and psychological problems and risks but also in increases in intravenous drug use, sharing of injecting equipment and, subsequently, in the spread of infectious diseases. In the concluding discussion, the author emphasises the crucial contribution of qualitative research. Hughes points to the views and experiences of those affected as representing useful and reliable accounts (Neale, 1998), offering a rich source of data from which policies and practices can be examined. Furthermore, he regards respondents' statements regarding inadequacies in substitute prescribing treatment in prisons as evidence for both the self-identified needs of imprisoned drug users' and 'Health Care Standards' (HM Prison Service, 1996; Reed and Lyne, 1997) often not being met. Restrictive prescription, leading to an increase in infection-related risk behaviours, has also been reported in quantitative studies (e.g. Shewan et al., 1994). Finally, he highlights the fact that the views of some drug injectors concur with national (HM Inspectorate of Prisons for England and Wales, 1996) and British Medical Association, 1997) and international (World Health Organization, 1993 and Council of Europe, 1995) recommendations that promote consistent health care policies and practices including methadone maintenance treatment inside and outside prison.

2) In a study of drug use and treatment in prison after release, BMRB International (2001), 227 men were interviewed who had recently been released in England and Wales. 22% were placed on a substitution detoxification programme during their last sentence (approximately 2/3 said that the detoxification programme they have been in lasted 1-2 weeks). The views of the

prisoners indicate that the detoxification programmes could be improved in so far as “it could last longer” (most frequently mentioned suggestion by 36%) and “should give sleeping tablets” (21%). 18% rated their programme participation as ‘very beneficial’. 39% as ‘fairly beneficial’, 24% as ‘not very beneficial’ and 18% as ‘not at all beneficial’.

D) Control related issues

1) As already described in B1, Johnson et al. (2001) investigated the impact of prison-based methadone maintenance treatment on release outcome and institutional behaviour, especially regarding drug offences, in Canadian prisons. PMMT participants were compared to a group of incarcerated heroin users. As well as outcome results, the institutional behaviour of the two groups has been studied, i.e. whether MMT while incarcerated resulted in any desirable effects. Offenders involved in PMMT showed a decrease in drug charges over time, while offenders in the comparison group showed an increase. With regard to segregation periods, the MMT group spent less time in involuntary segregation than the Non-MMT group, both before and after the initiation of MMT. The authors conclude, cautiously, that methadone serves to calm disruptive institutional behaviour (p. 30). “More importantly, it was demonstrated that there was a decrease for MMT offenders, relative to Non-MMT offenders, in behaviours related to activity in the drug subculture.”

Johnson et al. (2001) looked at the impact of PMMT on institutional behaviour explicitly, i.e. inmates’ behaviour while incarcerated. However, some studies, which focused on other variables associated with prison-based methadone maintenance treatment or on institutional behaviour, also found a desirable impact of PMMT on the “management of inmates” as outlined below.

This favourable impact was also reported by Mourino (1994), in the study described above (see A4), of a 5 month, PMMT programme in a Barcelona prison. Contrary to expectations, the programme did not cause any pressure within the prison social structure nor did non-dependent inmates demand access. Quite the reverse was the case; prison officers reported a reduced rate of conflicts amongst participating inmates.

Similar results were found by Magura et al (1993) in their evaluation of KEEP, a MMT programme for inmates at Riker’s island prison in New York (see B2). Neither the diversionary effects of methadone, violence and secu-

rity breaches, which the prison personnel anticipated as negative side effects of KEEP, took place. Quite the opposite was reported, prison staff even perceived KEEP participants to be easier to handle than non-participants.

Kaufmann et al. (1998) evaluated the project KOST, which is concerned with the prescription of heroin rather than methadone, in a Swiss prison. However, it is still worth mentioning that, throughout the study, neither medical and social complications nor security related problems, such as violence or stealing of heroin, were registered.

E) Pharmacological Studies

1) With the aim of comparing the effectiveness and suitability of methadone with lofexidine in prison based opiate detoxification treatment, Howells et al. (2002) conducted the first, and to date, only randomised double blind controlled trial in this area. In the UK, many of the 30,000 detoxifications from opiate dependence per year are methadone assisted. However, the disadvantages of methadone are the potentially fatal outcome of overdoses, which have occurred a few times in prison settings (Cairns et al., 1996; Dyer, 1999) and some prisoners' dislike of it as a detoxification medication (e.g. Hughes, 2000; Dolan & Wodak, 1996). According to the authors, Lofexidine – an alpha2-adrenergic agonist – as opposed to methadone – an opiate derivative – is less dangerous and causes fewer side effects (Washton et al., 1983 and Cairns et al. (1996). The study was carried out in accordance with GCP (Good Clinical Practice) and ethical standards. The investigated variables were the relative efficacy, side effect profiles and participant acceptability. 68 inmates, recently admitted to a southern English prison for male remand and short-term prisoners, who met the DSM-IV criteria for opiate dependence and induced withdrawal and were younger than 55 years old, were randomised to receive either methadone or lofexidine for 10 days. 36 patients were allocated to the methadone group and 32 received lofexidine. Recent typical daily drug use corresponded between the two groups. Regarding the outcome measures, neither withdrawal severity in the beginning and over the course of the trial nor the number of treatment completers resulted in significant group differences. Nonetheless, it is worth mentioning that 87.5% versus 70% completed the methadone and the lofexidine detoxification respectively. Moreover, more lofexidine than methadone patients showed a hypotensive side effect: Whereas 12.7% of the lofexidine group showed a sitting systolic blood pressure below 90mmHg this applied to only 8% of the

methadone group. The authors recommend future research into the optimal treatment duration for both medications in terms of highest retention rates. In this context, the reasons for the longer retention rates within the methadone group should also be examined. While the authors view lofexidine as a suitable alternative detoxification medication, the subjective preferences and self-perceived needs of dependent opiate users detoxifying from drugs in a prison setting are crucial in this context (e.g. Hughes, 2000 described below).

F) Organisation of care in substitution treatment

Michel/Maguet (2003) looked at substitution treatment modalities in French prisons. Their starting point was the observation that care practices vary considerable from one institution to the other and that both patients and teams of healthcare professionals have frequently expressed their dissatisfaction with the way substitution treatment is organised. Alongside their literature review, they assessed practices of health care with regard to substitution treatment in 22 institutions (that were representative, at a national level, in terms of size, type and geographical distribution). Furthermore, they interviewed prison staff in 3 penal institutions (10 people in each, from prison governor to prison guard) and prisoners in 7 prisons.

They found a varying practice in substitution treatment; commenting that each prison has a different scheme and that the organisational choices that have been made are due largely to the capabilities of the healthcare teams and material circumstances rather than the needs of the prisoners. They also discovered misunderstandings of substitution treatment, which were often being linked to detoxification treatments.

With regard to access to care, or day-to-day organisation of treatment provision, the prisoners reported perceiving substitution treatment as arbitrary. In addition, they express their dissatisfaction with the lack of confidentiality.

Finally, the authors elaborated recommendations for the improvement of treatment programmes and modalities.

5 Conclusions

Regarding the variety of substitution drugs appropriate for the treatment of opiate dependent individuals, research is carried out on the type of drug (either methadone, lofexidine and buprenorphine) most suitable to the different needs of the patients. At this moment, it can only be concluded that more research is needed into the advantages and disadvantages of different medications with regard to dosage, treatment duration and retention rate of patients.

Studies focussing on drug use and related risk behaviours (e.g. needle sharing) showed that methadone maintenance treatment (MMT) can reduce injecting risk behaviour in penal institutions. One crucial point is that, for MMT to be effective, a moderately high dose of methadone must be prescribed and the prescription must last for the entire period of imprisonment. Moreover, MMT provision was shown to be effective in reducing heroin use, drug injection and syringe sharing. A sufficiently high dosage (more than 50 mg) also seems to be important for an increase in the retention rate, which then can be used for additional health care services. The initiation of MMT also contributes to a significant reduction in serious drug charges and in behaviour related to activities in the drug subculture. Offenders participating in MMT had lower readmission rates and were readmitted at a slower rate than Non-MMT patients. There is evidence that continued MMT in prison has a beneficial impact on transferring prisoners into drug treatment after release.

Research into the subjective experiences of inmates participating in substitution programmes reveals the heterogeneity of prescription practices in prisons. In particular, short courses of methadone detoxifications were frequently experienced as insufficient and inadequate. Most striking was the inconsistency in methadone maintenance prescription inside prison compared to the community. Notably, the disruption of treatment when entering the institution often leads to physical and psychological problems and increases the risk of intravenous drug use and sharing of injection equipment. Finally, more research is needed into prescription practices in European prisons.

PART II:
Methodology

General

This chapter presents the methodology that was used to collect information on substitution treatment across prisons in 18 different countries. It is intended to be as clear and concise as possible so that other researchers can replicate the same research with the same methodology.

This chapter contains the following:

1. The identification, role and importance of national contacts;
2. The procedure adopted to conduct the literature review;
3. The methodology used for collection of national data;
4. The process of conducting the qualitative study (via field visits);
5. Analysis and report writing
6. Ethical issues;
7. The role of the Scientific Committees.

The research project was conducted over a period of 18 months, from December 2002 to May 2004. The study was divided into 3 parts, each lasting approximately 6 months: the first part focused on the identification of the national contacts, preparation of the methodology and undertaking of the literature review; the second focused on the field visits and the third focused on data analysis and report writing.

Please note that all information in this report is presented in alphabetic order by country.

1 National Contacts

The first step of the project was the identification of national contacts. Since mid 1990s, Cranstoun Drug Services has been managing the European Network of Drug Services in Prison (ENDSP)¹. Within that context, key indi-

1 Cranstoun Drug Services has managed the European Network of Drug Services in Prisons (ENDSP) thanks to funding from the European Commission to carry out activities throughout the European Union. ENDSP, along with its more recently established sister network, the Central and Eastern European Network of Drug Services in Prisons (CEENDSP, January 2003), have been leading activities in the promotion of drug and infection prevention services in prisons within the enlarged European Union. As of July 2004, the two networks

viduals working in governmental and/or non-governmental institutions have been involved in the network. The majority of national contacts were ENDSP (and CEENDSP) representatives as well as key individuals working in the national prison service.

These individuals were contacted and were asked if they were interested and would like to be involved in the ‘Substitution Treatment in European Prisons’ research project. They were asked to:

- Collect comprehensive information on substitution treatment in their respective countries (at the general/ community level and at the prison level).
- If requested, provide support to the researcher to enable them to understand key information in languages they do not speak.
- Identify national experts, NGOs, and others to be interviewed during the qualitative part of the project (via the field visit).
- Facilitate the organisation of the field visit, further to the field visits’ requirements and proposed agenda as sent in an appendix to the national contact.
- Assist the researcher during the field visit.
- Provide availability and support for issues that may arise during the research.
- Prior to publication, provide comments and feedback on the country report.

Each national contact had a direct contact with the designated researcher. Each researcher was appointed 9 countries.

National contacts provided key support by advising on the procedures needed to obtain official authorisation to conduct the research in the various prisons and in underlining cultural issues.

Thanks to their role and important involvement, authorisation for the research was obtained in all countries but Luxembourg, where a national contact was not identified successfully and where direct contact with the Ministry did not result in authorisation.

will join with the European Network on HIV and Hepatitis Prevention in Prison to undertake an ambitious three-year work plan throughout the 27 European countries.

The following national contacts confirmed their interest, involvement and provided great support with the research project. It must be underlined that it is likely that, without their contribution, the research project could not have been carried out.

Table 1 List of National contacts used as facilitators and advisors for the research

Austria	Alfred Steinacher, <i>Ministry of Justice, Prison Director</i>
Belgium	Sven Todts, <i>Ministry of Justice, Drug Coordinator</i>
Czech Republic	Jan Sochurek, <i>Ministry of Justice, coordinator for Prison Service of the Czech Republic</i> Jiri Richter, <i>NGO Sananim, Director</i>
Denmark	Alette Reventlow, <i>Ministry of Justice, Senior Advisor</i>
Finland	Leena Arpo, <i>Ministry of Justice, Chief Medical Officer of the Prison Administration</i>
France	Saadia Yakoub, <i>Centre Hospitalier Sainte-Anne, Maison d'Arrêt de la Santé, Psychologist</i>
Germany	Heino Stöver, <i>University of Bremen, Researcher</i>
Greece	Anna Tsiouboukli, <i>Educational Psychologist, Kethea, Director</i>
Italy	Dario Foa, <i>ASL Ministry of Health, In charge of the operative unit in Prison</i> Susanna Falchini, <i>ASL Ministry of Health, in charge of the operative unit in Prison</i>
Ireland	Enda Dooley, <i>Irish Prison Service, director of prison health care</i> Francis Nangle-Connor, <i>Co-ordinator of Nursing – Health Care Directorate</i>
The Netherlands	Jan Flikkema, <i>Ministry of Justice, Senior policy advisor prison policy-development</i>
Poland	Marek Bujak / Marzena Ksel, <i>Healthcare Department, Polish Prison Service</i> Maria Salivonenko, <i>International Projects' Co-ordinator, MONAR NGO</i>
Portugal	Maria Estrela da Graça de Pinho Campinos Poças, <i>Prison administration Service, Ministry of Justice, Director of Health Care Office</i>
Slovenia	Joze Hren, <i>Ministry of Health, Government Office for Drugs, Counsellor to the Director</i> Borut Bah, <i>Association for Harm Reduction Stigma, Director</i>
Spain	Graciela Silvosa Rodriguez, <i>Delegation to the Government for the 'Plan National on Drugs', Director of the Service for Prison Programmes</i> Julian Sanz Sanz, <i>Ministry of Interior, Directorate General of Prison Services, Head of Drug use service</i>
Sweden	Åke Farbring, <i>Swedish Prison and Probation Administration, Programme Inspector</i>
U.K., Scotland	Karen Norrie, <i>Scottish Prison Service, Addictions Advisor</i>

2 Literature review

The literature review focused on peer-reviewed journals and published reports from all over the world. Different forms of studies have been integrated into the study and analysed:

- (Randomized), controlled trials,
- Evaluation studies of the provision of substitution treatment in prisons
- Feasibility studies and reviews, examining the different modes of substitution treatment (e.g. detoxification, pre-release, short-term and maintenance) found in either individual or in a number of prisons,
- Studies concentrating on the different criteria relevant to evaluate the quality of the outcomes/the national protocols or highlighting certain aspects of ST (for instance “overdose”).

Following the review of Dolan, Wodak & Hall (1996) of substitution treatment until 1996, our review focuses on data that has been generated after their review process.

3 Collection of national data

The research involved collecting national data and qualitative data. The methodology used for the qualitative data is described below.

National data was collected with the support of the national contact and ongoing examination of research reports, national governmental and non-governmental websites. This included general information on substitution treatment, in the community and prisons, as legislation, protocols, agreements, and procedures of the treatment itself. The national Reitox reports, from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) website, were used widely.

4 qualitative methods (field visits)

Qualitative data was collected through interviews conducted during the field visits and organised with the support of the national contact.

a) Interests of qualitative methods

Staff involved in and prisoners receiving substitution treatment were interviewed using qualitative methodology: this provides in-depth insight into

individual experiences and views in sensitive areas. Qualitative methods have proven to be suitable to public health studies and complex contexts as well as to charting the differing views of those involved. The researchers believed that qualitative methods were the most suitable for this explorative study. The choice of a qualitative approach reflects the fact that substitution treatment in prisons is a controversial issue in many countries and requires a sensitive approach. Indeed, qualitative methods are a relevant and useful research tool to reach a deep understanding of the phenomenon of substitution treatment in prisons, as well as to evaluate it from the perspective of those involved in it. By using qualitative methods, the researchers felt able to immerse themselves in the context and to understand participants' experiences, views and opinions better. Researchers felt that experiences, perceptions, attitudes and suggestions of all groups involved in substitution treatment (patients/inmates, professionals and individuals in charge of substitution treatment at the prison administration) should be given an adequate forum for discussion.

Importantly, the application of qualitative methods to this area of research and the scope of the study is unprecedented.

This research is not comparative or representative in any way. Instead, we used qualitative data to look at the subjective experiences of a limited number of individuals interviewed on a specific date.

We used several forms of interviews:

- qualitative one-to-one in-depth interviewing; a key means of carrying out research on sensitive topics (such as illicit drugs), with professionals and some prisoners who had refused to attend a focus group
- focus group, non-directive (free associations) and stimulated by open questions, resulting in narrative statements from prisoners
- group discussions, stimulating an open debate about various aspects of a specific topic (i.e. substitution treatment) with professionals .

The interview setting differed according to the venues available. In each case, the researchers gained assurance that the venues were suitable for the interviewees. When meeting prisoners, prison officers remained outside the room to ensure confidentiality. Anonymity was also ensured. No record of the names of the prisoners or the staff was kept. The researcher tried to maintain a balance between facilitating the emergence of new themes and insights whilst ensuring that the interview schedule was covered. During

focus groups or group discussions, the group dynamics were managed and kept in mind. Prisoners tended to use the interview situation to refer to their own cases and interests. Again, this had to be balanced with the interview schedule and the interest in raising new themes.

The researchers were not concerned with testing pre-existing hypothesis: the focus was put on gaining new knowledge, experiences and perceptions of different groups involved in specific health interventions. The aim was to compose a broad view of different professionals and people concerned with substitution treatment.

Prison visits took place in 33 prisons with 184 prisoners (132 men, 52 women) in 33 focus groups out of 17 countries. But, within these 17 countries there is a total of 1,318 prisons with a total population of 435,202 prisoners. Taking this background into consideration, it becomes evident that this study only offers snapshots of the modalities of substitution treatment in European prisons. Considering the heterogeneity of substitution treatment programmes across European prisons, the findings provide a limited basis for comparison. Clearly, due to a limitation in resources, all the prisons in each country could not be visited.

Moreover, the descriptions obtained during the field visits do not generate a generalised picture of a country. Instead, they reflect the subjective experience of some individuals involved with substitution treatment and reflect some specific practices in different prisons and countries. Prisoners' participation was selective and arbitrary. Therefore, conclusions in terms of possible generalisations must be drawn very carefully. With this in mind, key problems and issues have been identified in several prisons, allowing for conclusions and recommendations which, hopefully, can be used to improve treatment access, modalities, and public health across the prison sector.

b) Procedure

(i) Interview schedules

Prior to any interview or focus group, the researcher briefed each participant on the goal and expected outcomes of the research as well as the ethical issues involved.

Two lists of interview schedules (composed of open-ended questions) were drawn and used: one with the prisoners and one with professionals. (see Appendix 1+2 for the interview schedules)

(ii) Pilot study

To ensure the validity and reliability of the interview schedules, a pilot study was organised and conducted in a prison. The researchers discussed and revised the interview schedules further to this pilot study. As a result, alterations were made to apparatus used. No findings from this pilot study were integrated in the final report; the pilot study was used only for methodological purpose.

(iii) Tape-recorder

In the majority of the countries, interviews with prisoners were tape-recorded having obtained authorisation from the prison or relevant Ministry and the responsible staff members. Interviews with other participants were either tape-recorded or notes were taken. Any names of participants, as well as other data that may lead to their identification of, have been left out in order to avoid retrieval of information given.

(iv) Linguistic issues

Researchers conducted interviews and focus groups mainly in English but also in the language of the interviewees. The researchers carried out interviews in German, French and Spanish but used neutral and freelance interpreters for countries in which they did not speak the native language. Neutral, freelance interpreters were used in Italy, Poland, Portugal, the Czech Republic and Slovenia.

c) Time

The field visits, across 17 countries, were conducted between March 2003 and May 2004. Each visit lasted for between 3 to 7 days, depending on the geographical location of the prisons and the agenda prepared by the national contact. The field visits extended to 7 days in Eastern European countries where a double research agenda was conducted (as explained under 'Scientific Committees' below).

d) The Setting

(i) The countries

The research took place in 18 different countries: the 15 Member States of the European Union, Poland, the Czech Republic and Slovenia. The countries, 15 Western European member states and three Eastern European countries, were chosen on the basis of the

national contact's involvement in Cranstoun's networks as well as the interest they expressed for the research project.

Each researcher was in charge of 9 countries. The distribution of the countries between researchers was made according to linguistic knowledge as well as previous experience in and knowledge of the country and prison system.

Dr. Heino Stöver was in charge of and conducted the field visits in Austria, Denmark, Germany, Greece, Ireland, The Netherlands, Poland and Sweden and supervised the visit in Finland, which was conducted by Ms. Jutta Engelhardt (Mainline, Amsterdam/The Netherlands).

Laetitia Hennebel was in charge of and conducted the field visits in Belgium, the Czech Republic, France, Italy, Portugal, Slovenia, Spain, and the United Kingdom. Luxembourg was not visited (due to the lack of authorisation) but a country report was drawn up on the basis of national data. Hence, the methodology used for Luxembourg was altered in order to include information on that country and to write a country report.

(ii) Prisons

Two prisons were selected in each country, with the exception of Sweden and Greece where, as no substitution treatment is available in the prison setting, the researcher chose to visit only one prison.

The prisons were chosen on the basis of discussion and advice from national contacts.

Requirements for the field visits included visiting two prisons in each country (resources and time constraints prevented researchers from visiting more prisons), visiting prisons that differ in their geographical location, their type (remand/sentenced, men/women, juvenile/adults) and their approach and practise of substitution treatment.

Table 2 Prisons Visited for Research

Country	Prison	Number of prisoners interviewed	Number of prisoners reported at the time of the visit	Characteristics
<i>Austria</i>	Josefsstadt/Vienna	4 men	1,100	Located in Vienna (male remand prison)
	Stein	4 men	677	Located 50km north-east of Vienna (closed prison for male sentenced prisoners)
	Hirtenberg	No focus group	329	
<i>Belgium</i>	Jamitoux Prison	3 men	400	Located in French speaking area of Belgium, male and remand prison.
	Ghent Prison	1 woman and 6 men	315	Located in Flemish speaking area of Belgium, male and remand prison.
	Opava Prison	8 men and 6 women	365	Located in Opava, 5 hours drive from Prague, young offenders, female, and male sentenced prisoners.
<i>The Czech Republic</i>	Pribram Prison	8 men	596	Located 30 minutes drive from Prague, male sentenced prisoners.
	Vaestre Faengster	4 men	530	Central prison #
	Vrids/øselille	2 men	249	State prison. Out of the centre of Copenhagen #
<i>Finland</i>	Vantaa prison	4 women 1 man	155 men 12 women	Closed prison mainly for male remand prisoners with a few places for women and some sentenced prisoners. The average population in 2002 was 155 men and 12 women. Situated just outside of Helsinki's city boundaries.
	Hämeenlinna Prison	1 man 3 women	81 men, 113 women	Main institution for women prisoners. Closed prison, in which both remand (female) prisoners and sentenced prisoners are held. It is close to the city of Hämeenlinna, some 100 km from Helsinki.

Country	Prison	Number of prisoners interviewed	Number of prisoners reported at the time of the visit	Characteristics
<i>France</i>	Prison des Yvelines (Bois d'Arcy)	5 men	850	Located in the South of Paris, close to Versailles. Remand, male prison (with around 40% of sentenced prisoners).
	Prison de Lyon	2 men	900	Located in the centre of Lyon city. Remand, male prison (with 40% of sentenced prisoners).
<i>Germany</i>	Women's prison of Vechta/Lower-Saxony	6 women	186 women	Closed prison 50 km north-west of Bremen (female, young offenders, sentenced and remand) (Lower-Saxony)
	Men's prison of Lingen/Dpt. Gross Hesepe/	4 men	350	Closed prison 70 km west of Oldenburg near the Dutch border (Lower-Saxony)
<i>Greece</i>	Eleonas, Thiva	2 men	Capacity: 300 men, occupancy 45	70 km from Athens
<i>Italy</i>	San Vittore Prison	5 women and 15 men	1321	Located in the centre of Milan, closed prison for remand male prisoners with a wing for female (126) prisoners.
	Solliciano Prison	8 men	850	Located in Florence, closed prison for remand male prisoners (with 25% of sentenced prisoners) with a separated wing for female prisoners.
<i>Ireland</i>	Dóchas Centre, Mountjoy Prison – Dublin	5 women	90 women	Closed women's prison in the centre of Dublin
	Cloverhill, Wheatfield,	4 men	380	Closed prison for sentenced men in Dublin
<i>Luxembourg</i>	/	None	/	/

<i>The Netherlands</i>	Penitenciaire Inrichting Over-Amstel (PIOA), Amsterdam	4 men	144	The Amsterdam prison "Penitenciaire Inrichting Over-Amstel (PIOA)", here "Het Schouw" is a remand prison for males with a total amount of cells of 144 on 6 floors, structured in 12 sections, each section has 12 cells (single cell occupancy)
	Stadsgevangenis, Rotterdam	2 men	192	Stadsgevangenis Rotterdam introduction). It is a men's prison with two units a regular unit (120 places) and a treatment unit "SOV" with 72 places.
<i>Poland</i>	Sluzewiec/Warsaw	5 men	858	Closed prison for sentenced and pre-trial male prisoners
	Montelupich/Krackow	5 men	815	Closed prison for sentenced and pre-trial male prisoners with prison hospital.
<i>Portugal</i>	Lisbon Prison	6 men	1100	Located in the centre of Lisbon, male remand prison with sentenced prisoners too.
	Tires Prison	9 women	600	Located 40 minutes drive from Lisbon, female prisoners.
<i>Slovenia</i>	Ljubliana Prison	7 men	223	Located in the capital, male remand prison.
	Dob Prison	5 men	364	Located in the countryside, male sentenced prison.
<i>Spain</i>	Madrid IV	6 men	1200	Located in Madrid's suburbs, closed prison for male prisoners.
	Madrid I	8 women	350	Located in Madrid's suburbs, prison for female prisoners.
<i>Sweden</i>	Österåker prison,	2 men	209	Closed prison with motivation (43 places) and treatment unit (68) located 3km from Akersberga, 30km north of Stockholm
	HMP Shotts	9 men	516	Closed prison located around 30 minutes drive from Edinburgh, maximum-security prison for male adults who have a sentence of over 4 years.
<i>United Kingdom: Scotland</i>	HMP & YOI Cornton Vale	5 women	240	Closed prison located in Stirling, female and female young offenders.

d) The Sample

The sample was made up of *sample A*: prisoners and professionals working in prison, and *sample B*: key individuals within governmental and non-governmental institutions located outside of the prison.

All participants in the study volunteered to take part. An explanation of the study's approach to issues of confidentiality, anonymity, informed consent and the right to withdraw were presented to participants (as stated in Appendix 3 Research Protocol and ethical issues). The ethical code of conduct was consistently and rigorously adhered to.

Sample A

Researchers interviewed prisoners with a history of illegal drug use (any drugs, poly-drug use being frequent) and professionals working in prison and concerned with substitution treatment. National contacts invited prison staff and prisoners to take part in the research.

Usually, the national contact identified a key individual in each prison to take charge of organising the visit for the research. The researchers had previously provided the national contact with the field visit requirements and criteria to follow when inviting professionals and prisoners to take part in the research. It was underlined that the participation was on a voluntary basis. The confidentiality and anonymity aspects of the participation were also underlined.

(i) Prisoners

The research focused on prisoners with a history of illegal drug use and experiences in substitution treatment, inside prison and/or outside in the community. They were identified by the prison staff.

Prisoners were, in general, approached by a member of staff from the psycho-social-medical team. According to the researcher's criteria, prisoners were contacted who (i) were on a substitution treatment, (ii) had been on a substitution treatment, and/or (iii) could have benefited from a substitution treatment but for various reasons, never received such treatment. Researchers underlined that the ideal was to have a group with prisoners with different experiences. Once identified, prisoners were invited to take part in the focus group on a voluntary basis.

Prisoners were interviewed through focus groups (i. e. a group interview) that lasted for approximately 60-90 minutes. Permission to conduct focus

groups was obtained from the prison governor and/or the Ministry of Justice. One focus group with 2 to 8 prisoners was conducted in each prison with the sole presence of the researcher (accompanied by an interpreter when applicable).

Prisoners expressed no objections to taking part in a focus group except in France where, apart from 2 prisoners, the others wished to be interviewed alone. The methodology was thus adapted in that country in order to respect the cultural differences and to give a voice to French prisoners even on one-to-one basis.

In total, 33 focus groups in 33 prisons across 17 countries were conducted, reaching a total number of 184 prisoners.

(ii) Professionals working in prison

On the basis of the researcher's requirements, the national contact identified and invited professionals working in the prison and concerned with substitution treatment. Like prisoners, participants were briefed on the research goals and outcomes and ethical issues were underlined.

Information from prison staff involved in substitution treatment was obtained through interviews (on a one-to-one basis or with several individuals). This method was chosen because it elicits subjective opinions, allowing respondents to speak in their own words, covering issues that may not have been covered in a more pre-structured way (such as through written questionnaire) and thus providing added insight and depth to the data obtained.

Those prison staff interviewed in each prison were the drug treatment team (medical doctor, psychiatrist, nurse) the psycho-social team (psychiatrist, psychologist, social worker, pedagogue, ...), guards, management team and the governor and/or deputy governor.

The staff concerned with substitution treatment were interviewed for approximately 30 to 60 minutes, mostly on a one-to-one basis or in a group according to their preference and to the situation.

Sample B

In each country, key individuals within governmental and non-governmental institutions, located outside of the prison, were also interviewed. National contacts provided advice and guidance to the researchers as to who they should interview at the national level. They also facilitated most of the interviews.

In order to acquire a more general picture of substitution treatment in each country, researchers interviewed the Ministries in charge of the prison system (Ministry of Justice or of Interior) as well as, when applicable, the Ministry of Health. Various key individuals from ministries or other bodies concerned with substitution treatment in prisons (like health care management, training management, probation service, through care service, judge) were thus interviewed to gather information on the national procedure of substitution treatment in prisons.

Some key national experts on substitution treatment in prisons, as well as key NGOs representatives, were also interviewed to collect national information on substitution treatment in prisons.

Participants were interviewed for approximately 30 to 90 minutes, on a one-to-one basis or in a group according to their preference and to the situation.

5 Analysis and report writing

Analysis was conducted using quotations in order to generate categories (for the findings chapter), which serve as a differentiation of broader topics already set up in the interview schedules. This was intended to create a structure that would provide a better explanation of substitution treatment from various perspectives. As a contents analysis, it aims at bringing together the different subjective views of those involved in the study. The categories were identified inductively, through a process of reading and re-reading interview scripts, allowing careful understanding of interviewees' quotes, excerpts of which are used throughout this report as examples of the themes and patterns that emerged through the analysis process (Dillon, 2001). On the basis of this analysis, the findings are presented in Part III in two chapters. Chapter one presents (in alphabetic order) a country report for each visited country. Laetitia Hennebel, with the support of respective national contacts, wrote the country reports on Belgium, Czech Republic, France, Italy, Luxembourg, Portugal, Slovenia, Spain, and United Kingdom. Heino Stöver, with the support of respective national contacts, wrote the country reports on Austria, Denmark, Finland (via Jutta Engelhardt), Germany, Greece, Ireland, the Netherlands, Poland and Sweden.

Chapter two covers emerging issues across the 18 countries.

The analysis and findings are further presented in the conclusion and recommendations chapters in Part IV of the report.

6 Ethical Issues

Throughout the conduct of the research study, the ethical code of conduct for the completion of social science research was vigorously pursued.

Researchers explained the purpose of the research to each participant and stated participants' rights: participation was voluntary, confidential, anonymous, and participants had the right to withdraw from the research at any time. (see Appendix 3 for Research Protocol and ethical issues).

7 Scientific Committees

The 'Substitution Treatment in European Prisons' (STEP) Scientific Committee was made up of Joris Casselman, acting as the scientific peer-reviewer and as chair of this Committee, and the two researchers, Dr. Heino Stöver and Laetitia Hennebel.

The Scientific Advisory Group (SAG), see below, was an extension of the research Committee. The STEP research team worked closely with Dr. Morag MacDonald (UCE, Birmingham, England) who had carried out studies, on behalf of CEENDSP and Cranstoun Drug Services, in 10 Eastern European countries on the 'Provision of Services in prisons'¹. As well as a general cooperation and an exchange of information on drug services in prisons, a close collaboration between the two research projects was developed for the three countries that both research projects shared: the Czech Republic, Poland and Slovenia.

The STEP researchers conducted the field visits in these three common countries for STEP, and also on behalf of CEENDSP/ Dr MacDonald's research, using the list of open-ended questions for both. A pilot study and various meetings between the three researchers, with their respective scientific peer-reviewers, were held to ensure the validity and potential for replication of the methodology and to test the research instruments.

A scientific advisory group (SAG) for both research projects (STEP and CEENDSP) was set up as an important prerequisite for the success and scientific quality of the whole study. This involved: the three researchers

1 This research, published in July 2004, is entitled "A Study of Existing Drug Services and Strategies. Operating in Prisons in Ten Countries from Central and Eastern Europe".

(Hennebel, Stöver and MacDonald), Professor Joris Casselman, Roy Walmsley, Dr. Karlheinz Keppler and Professor Johannes Feest.

Meetings with Professors Casselman and Walmsley were held regularly with the three researchers (Hennebel, Stöver and MacDonald) to discuss the researchers' progress and the scientific validity of their findings.

Professor Joris Casselman was designated as the scientific peer-reviewer and co-author of the STEP research. Although he did not conduct any field visits himself, he was present and involved in the research project intensively throughout the project.

Roy Walmsley, from the "International Centre for Prison Studies", King's College London (England), was designated as the scientific peer-reviewer and general advisor for the CEENDSP research, conducted by Dr. MacDonald.

Two additional experts from the field of substitution treatment in prisons were part of the SAG, in the capacity of scientific advisors. They did not take part in any meetings but were consulted:

- Dr. Karlheinz Keppler, medical doctor in the Women's prison of Vechta in Lower-Saxony (Germany), acted as a medical advisor for all relevant questions of medical details on substitution treatment.
- Professor Dr. Johannes Feest, criminologist from the University of Bremen (Germany) and director of the "Archive for Penal Studies in Bremen, Germany", provided support by making contacts and delivering relevant literature for the research.

PART III:

Findings

A. Country Reports

Austria¹

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users (EMCDDA data)

In Austria, the number of “problematic drug users”, defined as those who frequently use “hard drugs” (predominantly opiates and cocaine) with polyvalent drug using patterns, is about 20-30 000 (ÖBIG 2003). This marks a slight increase over the last ten years.

Spirig and Ess-Dietz (2001) point out that there is no systematic data collection about drug use in Austrian prisons. The profile and drug use of inmates has changed over the years. During the mid 80s, the number of people physically dependent on opiates, at the time of incarceration, was approximately 10%. Today, a prudent estimate would be around 20%. The result of the last representative survey (Spirig and Schmied, 1999) revealed that: 15% of men, 6% of women and 8% of juveniles were found to be consuming intravenously during their sentence. During their sentence, 3% of both women and men as well as 25% of juveniles consume intravenously for the first time during their sentence. If the numbers of regular users and occasional users are aggregated, the total is estimated at 50%. If the consumption of other psychotropic substances, such as medicine or alcohol, is taken into consideration, the majority of inmates are supposed to be drug users. The patterns of use are changing over time, polyvalent drug use is widespread.

1 The field visit, conducted by Heino Stöver, was facilitated by Alfred Steinacher, Ministry of Justice of Austria, who also provided national-general information and support with the finalisation of this country report.

1.2 Substitution treatment

1.2.1 Historical and legal background

In 2003, 6 423 persons were in substitution treatment 891 for the first time (ÖBIG, 2003), of whom were 68 receiving substitution treatment for the first time. In general, the number of patients in substitution programmes is constantly on the rise (ÖBIG, 2003, 25).

WHO guidelines and European Council Recommendation (No.R(93)6)² provide the basic principles on which the Austrian prison health care system is based. The principle of equality must be followed: inmates should be offered the same medical and psychological treatments that are available to other members of society. In the Austrian penal system, this principle is only partially fulfilled.

The medical care of inmates in prison is organized by The Ministry of Justice and provided by internal medical services. Needs assessments for drug users are done, by a doctor, upon their admittance to prison. The guidelines for this assessment are provided by both the Ministry of Justice (e.g. substitution programmes) and individual prison guidelines and concepts. According to Spirig and Ess-Dietz (2001) the structure of drug services is divided into three main areas:

Abstinence Oriented Care

The court can order appropriate measures of care to be given to dependent delinquents (§ 22 StGB (Strafgesetzbuch)). The measures can also be executed upon the request of the inmates, on a voluntary basis (§ 68a Strafvollzugsgesetz/StVG). There are specialized areas for these treatments in five prisons. In Vienna, the Favoriten Prison specialises in caring for addicts.

Substitution

Spirig and Schmied (2003) point out that, according to the decree of The Ministry of Justice, substitution treatment must be available, as standard practice in every prison. “The decision is made by the prison doctor. It is recommended to maintain an existing substitution but at the same time a step by step reduction. In special cases it is also possible for the inmates to get

2 „Gefängnis und kriminologische Aspekte der Kontrolle von übertragbaren Krankheiten inklusive AIDS im Gefängnis.“

into a substitution programme during the sentence or before release.” (Spirig and Schmied, 2003, p. 25)

Drugfree wings

Drug free zones have the dual purpose of providing treatment to dependent inmates as well as to protecting non-dependent inmates. After positive results from the ‘Drugfree Zone’ in the Hirtenberg Prison (piloted since 1995), other drug free wings were created in four additional prisons. According to the Ministry of Justice, today about 600 places in controlled drug free areas are available. (Bundesministerium für Justiz, 2001)

The concept is based on voluntary cooperation: by signing a contract, through which the inmates commit themselves to follow certain rules (e.g. alcohol and drug abstinence, regular urine testing), they can enter the drug free zone. Violations (e.g. positive urine testing) or non-conformation to the rules is sanctioned with the removal of certain privileges (having cell doors opened during the day, having access to a telephone, reduction of controlled visits, permission to go out of the prison, etc.). (Spirig, 2000)

Drug treatment targets all three of these methods with varying degrees of cooperation from external institutions.

Substitution Treatment in general³

In 1987, guidelines for substitution treatment were laid down for the first time in the “Decree on Oral Substitution Treatment of Intravenous Drug Addicts” (“Substitution Decree”), based on the Narcotic Drugs Act (NDA). In 1998, a decree was issued by the Federal Ministry of Labour, Health and Social Affairs (FMLHSA)⁴, in which guidelines for substitution treatment in Austria were specified, and, in the revised Narcotic Substances Act (NSA) of January 1998, the legal admissibility of substitution treatment was made explicit. The ‘ultima-ratio-principle’, stating that substitution drugs could only be prescribed on medical grounds and if other drugs were not sufficient for the intended purpose, was no longer binding. As substitution treatment had

3 The following chapter is based on: Sabine Haas, Klarissa Guzei, Elisabeth Tüscherl, Marion Weigl., Austrian Health Institute (ÖBIG), Report on the Drug Situation in Austria, Vienna, 2001.

4 Erlass des Bundesministeriums für soziale Sicherheit und Generationen, Orale Substitutionsbehandlung von Suchtkranken, GZ 21.551/6-VIII/B/12/98, Wien, June 1998.

become an important form of therapy, it was included in the range of “health-related measures” targeting drug misuse as defined in the Act (Art 11 of the NSA).

When the NSA entered into force, the “Substitution Decree” (see above) was also amended on according to the experience and knowledge gathered which enabled relevant indicators to be specified more easily.

All over Austria, substitution treatment has become an integral part of available drug services. The indicators for substitution treatment have been changed over time. Under the amended version of the “Substitution Decree”, issued in 1998 by the Federal Ministry of Labour, Health and Social Affairs (FMLHSA), pregnant women, patients with HIV infections and people addicted to opiates for over one year have been included in the primary target groups for substitution treatment.

In the decree, with the exception of pregnant women, methadone continues to be defined as the substance of choice. In recent years, a diversification in prescribed substitution drugs has occurred: prolonged-action morphine and buprenorphine are used as well. In 2003, an analysis of substances used for first-time substitution patients showed that prolonged-action morphine was the drug most often prescribed followed by methadone and, shortly after, buprenorphine⁵. The decree also remarks that substitution treatment for people under 20 should be administered sparingly, with the option of abstinence treatment considered thoroughly.

Regarding organisation and monitoring, the decree stated that:

- The relevant diagnosis shall be made by doctors familiar with the problem of addiction, i.e. psychiatrists (and neurologists) or other physicians with special experience or knowledge in the field of addiction treatment.
- Generally, the substitution substances will be available on submitting a long-term, narcotic drug prescription, valid for a maximum period of one month.
- In the course of substitution therapy, the head physician must carry out regular examinations such as health checks and urine analyses.

On the basis of these general prerequisites, a number of organisational structures for substitution treatment were developed by the Provinces.

5 Personal communication with Dr. Sabine Haas, ÖBIG, Vienna, Austria.

1.2.2 Substitution treatment in prisons

On 28th of February 2002, 531 prisoners were in substitution treatment. This is approximately 7.5% of all inmates. 410 detainees received methadone, 115 received retarded morphine and 6 others were given oral opiates. This marks another increase in comparison with recent years (i.e. 335 detainees, or 5% of all inmates, in 2001. Spirig & Schmied, 2003, p. 11).

According to the Ministry of Justice (Bundesministerium, 2002, p. 28), substitution treatment is available in all prisons in Austria and is not limited to the length of the sentence. With regard to prisons, the Federal Ministry of Justice issued a decree stipulating that it will be possible for prisoners in any penal institution to continue substitution treatment initiated before imprisonment. Now, it is solely up to the physicians or psychiatrists to decide whether or not to continue the substitution treatment of a prisoner whilst, in the past, this decision also depended on the term of imprisonment. In individual cases, inmates may also start a new substitution therapy during imprisonment or before they are released (Melnitzky et al., 1998). Prisons focusing on substitution treatment include the Penal Institutions of Josefstadt (Vienna, see field visit), with a capacity for 100 patients, Innsbruck, Favoriten (Vienna) and the prison of Eisenstadt. In this prison, a special unit for methadone patients was opened for 15 inmates. Its aim is to reduce the methadone dosage step by step, but this is not a prerequisite. Participation in individual or group therapies is obligatory. Having reduced the methadone dose, a transfer to other prisons with more specific drug therapeutic resources (Wien Favoriten, or drug free zone) is possible and planned.

Random urine analyses and alcohol control tests are taken. The advantages for the inmates are that the cell doors are left open more often, with access to tea kitchen and other rooms, which in turn plays a role in facilitating and accompanying the steps to release (Bundesministerium für Justiz, 2002, p. 13).

As of 1 June 1999, substitution treatment was complemented by support from the penal Institution of Stein with a special ward for a maximum of 50 patients. The number of prisoners undergoing substitution treatment has risen continuously, from approximately 50 persons in 1990 to more than 500 in 2002. In most cases, methadone is administered. "The substitution programmes must be handled by medical doctors who are trained in drug treatment. Additional specialists are consulted when needed. The costs of

(external) medical care are paid by the Ministry of Justice because inmates are not insured.” (Spirig and Ess-Dietz, 2001).

According to the Ministry of Justice (Bundesministerium, 2002, p. 28), substitution treatment focuses mainly on HIV-positive inmates, those with a serious opiate case history and some inmates with a high risk of overdose on release.

1.3 Prison Population

Table 3 Data on the prison situation in Austria. (Source: King’s College London, International Centre for Prison Studies, Prison Brief for Austria)

Country	AUSTRIA
Ministry responsible	Ministry of Justice
Prison administration	Prison Administration
Contact address	Museumstrasse 7, A-1016 VIENNA, Austria
Telephone / fax / website	tel: +43 1 52 152 2216 fax: +43 1 52 152 2727 or 2822
Head of prison administration (and title)	Michael Neider Director General
Prison population total (including pre-trial detainees / remand prisoners)	8,114 at 10.11.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	100 based on an estimated national population of 8.09 million at November 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	26.8% (1.9.2003 – national prison administration)
Female prisoners (percentage of prison population)	5.7% (1.7.2003)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	2.5% (1.7.2003 – under 18)
Foreign prisoners (percentage of prison population)	33.0% (1.9.2002 – Council of Europe Annual Penal Statistics)

Number of establishments / institutions	29
Official capacity of prison system	8,022 (10.11.2003)
Occupancy level (based on official capacity)	101.1% (10.11.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 6,913 (87) 1995 6,180 (77) 1998 6,962 (86) 2001 6,915 (85)

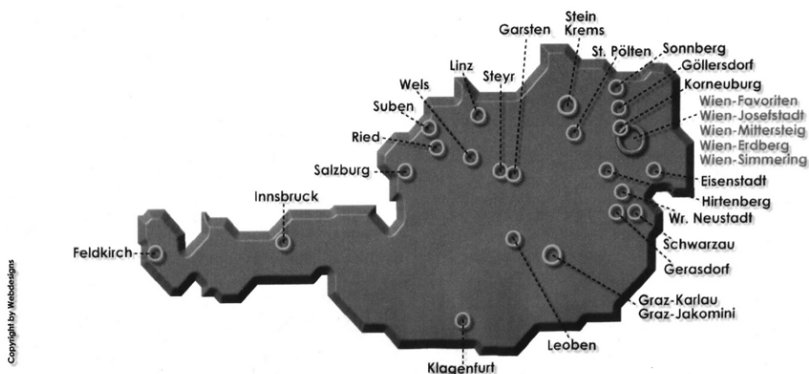
2 The field visits

2.1 Prison of Hirtenberg

2.1.1 *Description of the prison*

The prison of Hirtenberg, some 30 m southwest of Vienna, is a prison for sentenced prisoners and holds 329 inmates, of which approximately 30 were in substitution treatment at the time of the visit. The prison drug service became well-known when the first drug free-zone was established in 1995 (Steinacher, 2000; Bundesministerium für Justiz, 2002). Today, about 65-80% inmates participate in the programme.

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2.1.2 Goals and practical procedures of substitution treatment

Substitution drugs are allocated by nurses and by prison officers during the week-end. The intake is supervised and the drug is diluted in water. In most cases, the initial dosage of the substitution drug is set by remand prisons (e.g. Vienna Josefstadt, see below) and is adopted in the prison setting.

According to the psychologist, some prisoners wish to change their substitution drug from methadone to retarded morphine (e.g. Substitol®). Those who await a longer sentence often wish to reduce their dosage (down to 10 or 20 mg), but stop at this certain stage. This minimal dosage is often perceived as a form of security.

Patients in substitution treatment are led to the medical ward in the morning where they give their names. The nurse confirms the identity against a photograph of each patient before allocating the monthly prescription. Substitution treatment is oriented towards the specific needs of the patients and whether they want to stay on the treatment or reduce it. At the time of the visit (July 2003), The average dosage was 70 mg and urinalyses were taken once a month. The results are not communicated to the security staff of the prison and the medical unit does have access to the results of the urinalyses

conducted by the security staff (e.g. before leave). No connection has been made between cannabis use and substitution treatment.

The prison offers work for almost 90% of the inmates in 14 undertakings (e.g. market garden, waste separation; locksmithery). The exception for inmates being undergoing substitution treatment is that they are not allowed to work machines (for which they need a special machine license). This is the only work area that substitution patients are excluded from.

The prison staff expressed that there is a changeover possible from the methadone programme to the drug free zone, which is talked about during the admission interview. The drug free zone is supposed to be a protected zone, in which inmates can get distance from drug related talks and habits. According the external psychologist, being in substitution treatment is not a taboo but is perceived to be normal treatment for sick people.

Psychosocial care is provided, within a methadone group that meets every Wednesday, with a psychologist from a therapy institution near Vienna (Schweizer Haus Hadersdorf). The group is attended by 7-8 inmates regularly. Following this, a group is offered for those having problems with co-medication (e.g. benzodiazepines). The external psychologist offers one-to-one interviews. The person in charge of psychological care within the prison stays in close contact with the external psychologist.

The social worker of the prison hosts a monthly group on the topic “Imprisonment and Addiction” which, according to her, is attended by more participants from the drug free zone.

Once a month, everyone involved in the substitution programme meets (psychiatrist, external psychologist, social worker). This has to be seen as a central forum in which case studies are discussed. This meeting is confidential and all views are brought together to avoid playing the prison staff off against the external psychologist. From the beginning, conflicts have been overcome and a cooperative atmosphere has developed.

2.2 Prison of ‘Wien Josefstadt’ (Vienna)

2.2.1 Description of the prison

The prison of ‘Wien Josefstadt’, located in the centre of Vienna, is the central remand prison (also sentenced prisoners) in Austria and holds approximately 1 100 inmates, of whom 130-150 are in substitution treatment. On

average, the inmates stay in remand for between 3 and 4 months. Care for the drug users is provided by the Forensic Drug Ambulance of the University Clinic for Psychiatry of the General Hospital in Vienna (AKH Wien).

2.2.2 *Goals and practical procedures in the provision of substitution treatment*

According to a physician, substitution treatment was introduced in 1991, mainly as a continuation of the treatment in the community. The nurses see the connection between the increase in people on prescription outside and the number of inmates being admitted to prisons within a programme of substitution treatment.

Nurses report that substitution treatment is no longer a topic of conflict among the personnel. Only a few staff do not like to work with inmates in a substitution programme. The nurses feel there has been a remarkable process of normalisation in the last few years but that additional education remains necessary for the staff members.

“... we had a lot less then, ... about 50 or 60 people who’d been put on substitution treatment outside, and we continued it here. Of course, not everyone thinks its a good idea. We still get that today, not many, but there are still some who’re against it. Well that was worse then, especially when it came to letting them have jobs.” (A nurse)

For the staff especially, the nurses’ substitution treatment contributes to a quieter everyday life in prison and enables the prisoners to lead a normal life:

“The nights quietened down right away ... The sick bay was really quite at night and we just had the three in, the first ones were all admitted. But when it started escalating on the outside, we got more and more coming in here. Now, I’d admit I’m for methadone ... It makes the mornings that much easier, – I wouldn’t have thought so before, but now I always tell our staff: the ones on methadone can work just like normal. They get their tranquilisers and other stuff as well. You can treat them as normal” (A nurse)

The nurses had to gather experience in finding a mode of delivery that satisfied all needs:

“... We used to get them all over to the sick bay, and they all got their methadone at the same time. They were all swapping and changing – like a mad-house, it was! Oh, and we had Heptadone-cubicles set up, to supervise them

better, but that didn't help, so then we got a trolley with locking compartments for all the different units. And a registered nurse goes round early to all the different units, with a warder, and dispenses it in the medical room." (A nurse).

The staff of the medical unit emphasized how important it is to provide sufficient supervision:

"On average, there are 150 people in the programme. The warder comes with the methadone, then they all come in here and bring something with them to drink. ... They're very well behaved, you know, I'm always amazed how good they are here. ...Last year we had a lot who were vomiting afterwards in the cells. You do need to keep an eye on them." (Two nurses)

Substitution treatment is seen by the physicians as a crook to enable patients to participate in life. But, some of the patients think that they do not need a crook any longer and experience relapses because they want to get rid off the support too early or too fast.

"You always have to bear in mind that methadone is a medicine, a substitute. If you're doing it right, it's a support, – a support you don't want to let go of while you still need it. That's my way of thinking. But you always get a lot of people, methadone users included, who think: first I'll switch to methadone, then I won't take anything, then I'll get a completely new life and then I'll be fine. And when it doesn't work, because they haven't learnt to cope with frustration, then they crack up. If they can't cope with boredom, or hassles, or anger – how are they going to stay clean?" (A doctor)

Furthermore, substitution treatment is acknowledged as having stabilizing effects; the physicians stress the fact that drug users are experiencing often extreme fluctuations between drug consumption and withdrawal. This is seen as a "yo-yo-effect", which is seen as problematic for the users in terms of a negative health impact.

In the beginning, with little experience, prescriptions were simply continued. But, through the use of methadone, and its use to combat withdrawal ache, the nights in the admission unit became calmer. The nurses report "horror nights" from before the introduction of methadone due to inmates having pain on withdrawal. Since the mid 90s, nurses see an increase in inmates being admitted with a multiple drug use (including benzodiazepines and alcohol).

The details of the continuation of the prescription are discussed with the external pharmacy on the basis of what the inmate said:

“When the prisoner gets here he simply tells us he’s on methadone maintenance, or whatever. Then we get the details from the chemist where his prescription is registered, because they’re the ones who know the details.”

The reduction steps are taken in 5 mg steps. The dosage has to be confirmed in the pharmacy where the monthly prescription has to be placed. According to physicians, the dosage reported by most inmates is correct.

For various reasons, the strategy of the physicians is to change-over from retarded morphine (Morphine hydrochlorid) to methadone. It is said that it is easier to handle (the possibility of misuse is high) and enables the treatment team to control the intake of methadone. Only in exceptional cases (e.g. HIV-positive inmates) or in cases of medical incompatibility (which counts for 2-3 persons) is it inappropriate.

“Before you could get Substidol® regularly, we tried to introduce it – and then when it came on the market, we didn’t need to anymore. But ... it’s not a problem. Anyone coming in now gets put on methadone. ... Or what might happen is, we put them on methadone, and if they react badly to it, they get taken off again ... You always get 2 or 3 in here with a physical intolerance, or HIV, who can’t take it... Well with methadone in liquid form, that’s easy to supervise. I suppose you can always fiddle something, but not many people want to swallow something someone else has spit out.”

The nurses are supporting this view on the basis of their daily experience.

“... We can only do that as an exception to the rule, when there are really valid medical reasons. If a patient reacts badly to methadone, then we switch them over. And we’ve learned the hard way: everything that hasn’t been mixed with liquid gets collected up immediately. We had one person who hoarded it for a week and took it all at once. He only survived because he got first aid quickly. The risk of misuse is very high.” (Two nurses)

The retarded morphine is available in capsules containing pellets, which can not be dissolved in liquids, because they are embedded in a wax film. It is possible to hide pellets in the mouth and, although the patient has to drink afterwards, it is supposed to be less safe than methadone.

“Substidol® is a form of morphine, so it doesn’t have the same effect as methadone, and people prefer it and react better. Methadone tends to make

some people groggy or depressed, or they swell up ... It doesn't have those side effects. On the other hand, methadone helps people to stay off drugs better. It's a different substance and has slightly different effects from the heroin they're addicted to. So methadone has a more stabilizing effect than Substidol® ... perhaps because it lasts longer and works in a different way. Morphine is much more like heroin, so you run a greater risk of not just substituting, but getting back on the needle again." (A doctor)

The physician also reported that another reason is that the experience of morphine is supposed to be too close to the euphoric effects known from the use of the original substance (e.g. heroin). The drug user's internal distance to their previous use is supposed to be bigger with methadone than with morphine, which is closer in its effect to heroin. So, this is a therapeutic reason not to continue the prescription of morphine. It is reported that the change-over sometimes leads to conflicts with the inmates, who often insist on their preferred substitution drug.

Only very few patients receive retarded morphine:

"Maybe 1 or 2% Substidol®. It isn't really a big thing here – we have to be much more restrictive with it because of the risks. So we only use it when we can't avoid it."

The average dose of methadone is 60 mg. Urinalyses are taken occasionally on the basis suspicion but not as a tool for therapy.

"What can you do if you catch someone out? It's just not worth imposing restrictions, if you can't do anything about them ... You're only making life difficult for yourself." (A doctor)

According to the physicians, it is possible to see when an inmate is topping up the substitution drug with other drugs. The aim is that inmates feel able to report their use of other drugs and a degree of frankness is achieved in communication with the inmates.

The doctors don't work with treatment contracts, because they can't take away the substance someone needs as a possible consequence.

"Some people do [work with written agreements], but I've always found having a personal relationship is the best option, because you're always going to have to talk things over anyway, whether they've signed something or not. ... They all sign. It doesn't mean much; – as long as someone's be-

having themselves, they don't need the lecture, and if not, well you've got to talk to them anyway." (A doctor)

The intake of the prescription drugs is either done in the ambulance or on the wards within a specially locked carriage. On the wards, a member of the security staff accompanies the nurse. The intake is supervised through visual control: the inmates have to say a few words afterwards. Intoxicated inmates will be identified easily in the delivery of methadone.

Co-medication drugs which are prescribed are anti-depressants, neuroleptics. If an inmate is prescribed benzodiazepines this is reduced consequently. Physicians state that detoxification is a drawn-out process which is done in small steps of reduction and which can last several months. It is aimed to give inmates an awareness of the harmfulness of the benzodiazepines. The steps of reduction are taken following individual talks between physician and patient. The process of reduction of benzodiazepines is supposed to be a very painful treatment. According to the doctors, women need a longer period of reduction than men. A mono-dependency from the substitution drug is achieved.

"No, we cut it right back, but not all at once. We start with a big cut and then phase down slowly. If someone comes in who's on 10 tablets, then he gets 4, plus one of something else, like neuroleptics or anti-depressants, just to break the fall. Then we reduce gradually in really small steps, – from 50 mg to 30, then 15. Really slow, so they don't get the feeling they're missing something, or else they'd run straight out for a fill-up when they're released. That's the danger if you're too drastic. I like them to understand what I'm doing, and why. I want people to really understand that there's a valid medical reason for all this. That they understand what a mess they're really in. Of course, you always get the ones who say, – I was taking X on the outside, I need X now. I can't make do with 4. Its really our goal to get them off benzodiazepam. To get them off addiction full stop. Which is a very long, difficult process. I don't think there's anywhere you can come down off benzodiazepam as slowly as here. That's one of our big advantages." (A doctor)

It is also possible that inmates will be taken into prescription before release as a "starting point" and a form of relapse prevention (approx. 5 inmates).

"We do actually start people on methadone from scratch. It depends on the person's character, and how badly addicted they are – how bad the need is

and whether their first impulse when they get out is to fulfil that need. Other things we consider are the length of sentence and the momentary situation.”
(A doctor)

Once a year, all physicians working in penal institutions come together and discuss relevant topics.

If the drug users are on leave (e.g. week-end) they receive single doses prescriptions, which allow them to take the substitution drug under control in the pharmacy (the supervision of intake is noted on the prescription).

According to the nurses, information is lacking for wardens on the nature and character of substitution treatment and this could contribute to a better understanding of prisoners:

“These days, some of the staff, some of the workshops take people who are on methadone, and they’re quite satisfied with them. Only a few don’t want them. I don’t think there’s enough done about combatting prejudice, – that’s what I told the director, too. One officer even said he thought people ought to be better informed, so it wouldn’t scare them off so much. Well, some officers make the effort, and some just don’t want to know. I’ve already talked to the officers in charge of allocating jobs, and tried to get more allotted, because the ones who only take methadone are much more clear headed than the ones who take all this other stuff. Officers who’ve worked with them know that’s true. But people still call them names: the tox brigade, and stuff.”

Psychosocial care and support (self help/peer groups from inside and outside) is offered and inmates are able to access social workers when they are in need. Furthermore, the association “PASS” is caring for the transfer of inmates to therapeutic institutions (e.g. Schweizer Haus Hadersdorf, according to §39 SGG).

2.2.3 Views of prisoners

A focus group with inmates was held with four prisoners who all had long drug use histories and long prison careers (several stays in prison between 1.5 and 9 years and methadone doses between 45 mg and 120 mg methadone). They confirmed the fact that the prescription is continued once they get arrested:

“I’ve been in the substitution programme 8 years, outside and in. It has always gone fine. I didn’t have my prescription on me when I got arrested – but I was in the programme, so I am here too. When you’re in, you’re in.” (A prisoner)

Prisoners complained that they all got methadone instead of retarded morphine (as they got in the community).

“... I get Kapanol®. If possible, I think people should get what they were having on the outside. I was put on Kapanol® for a good reason.” (A prisoner)

The change-over is seen as an additional health burden. The reason for this change-over is that it has been shown that methadone is easier to handle. But the needs of the prisoners are not adequately addressed. In that respect, the substitution treatment reflects the needs of the system more than the patients. Substitution treatment modalities change considerable from prison to prison.

“Every prison’s different. Dr. Y., who we used to have here, he was all for soft drugs. He used to say: ‘We’re winning if we can get them off GBH and on to Breaking and Entering. ‘He was all for Kapanol®, he said it was much less harmful. And Dr. X., you’ll meet him, he’s carried things on much the same.” (A prisoner)

The dependency of the inmates on the doctors was emphasized by an inmate:

“You’re totally dependent on them, – and they’re holding the reins. You get the feeling they just give you whatever they’ve got in stock at the moment. They don’t care about the side effects, or whether or not it’s good for you.” (A prisoner)

Discrimination is present through the fact that the word “HEPTA” (for Heptanol, forerunner of methadone) is noted beside their cell door so that everyone knows that a drug user is living inside the cell. The prisoners think that this label as “Giftler” (drug user) is leading to prejudices against them.

As the methadone is given out at 7.30, everyone knows who gets methadone. Different forms of treatment are noticed between drug users receiving methadone and non-drug users. The prisoners feel that the staff are not very well informed about drug addiction and other related topics. The prescription of co-medication (like benzodiazepines) is felt to be dependent on the particular doctor. The prisoners complain that, apart from methadone, there is not an extended psycho-social care for them. Group meetings are notably ab-

sent and access to work and qualification is less, although this is also possible when in substitution treatment:

“I got my school-leaving exam (in Z.) and trained as a cook while I was in the methadone programme.” (A prisoner)

2.3 Prison of Stein

2.3.1 Description of the prison

The prison of Stein (“Justizanstalt Stein”) is a high security prison for sentenced prisoners located in the province of Lower Austria, not far from the Czech border. By June 2002, 677 inmates had been incarcerated, there is a total capacity of 730 places. The number of staff is about 315. 103 inmates receive substitution treatment (37 methadone and 63 retarded morphine e.g. Substitol®, 3 buprenorphine). 44 of the substitution patients are taken together on a special ward (V3) which has less restrictions. The Stein prison is the prison with the highest number of steady and long-term substitute programmes in Austria.

More and more the prison of Stein is designated to “problematic inmates”: a high proportion of lifers (75), a high prevalence of alcohol and drug users, a high percentage of migrants (28%), mentally ill persons, self harm and suicidal persons. A concept “Inmates against drugs” has been implemented here, intervening on two levels: Security measures to detect drug use and trafficking and demand reduction and care specific measures.

In the admission phase, inmates are allocated to one of the following categories:

- Drug free zone
- Abstinence-oriented therapy
- Drug users
- Substitutions treatment unit

The latter is focused on inmates already integrated into a methadone programme in the community as well as inmates who are eligible for this programme because they are long-term drug addicts. A treatment contract has to be signed, group therapy is offered and a transfer to the drug free areas, having finalized the substitution treatment is possible. There is a capacity for 45 inmates.

2.3.2 Goals and practical procedures of substitution treatment

In Stein, the number of patients in substitution treatment has increased considerably in the past decade.

“The number of people on substitution has escalated so much that we get a lot for substitution in here too.” (A nurse)

Furthermore, the people in charge are well aware of the fact that prison mirrors the external situation and that health care has to deal with the developments in the community:

“We mirror the situation in the outside world. There’s nothing in here that hasn’t come in from there! – Some of the staff think I’m experimenting, but I’m just keeping up with the drugs scene outside. I’d be the first to criticise benzodiazepam, but we’ve got people coming in here with a whole range of diseases, especially psychological ones, – people with massive panic disorders, who’ve been on prescription for it for years. You try taking them off it in a prison environment like we’ve got here! Clinically it would look better, but it would make for tougher living conditions.” (A doctor)

The doctor’s view of addiction (as a chronic relapsing disease) is essential for the treatment and the modalities of it:

“But if you work in methadone maintenance, you just have to accept that relapse is part of the illness. You need to work at a good doctor/client relationship. And that means you need to be in contact with the people. And some of them don’t like you keeping tabs on them, and some won’t accept treatment from a woman doctor ... But I’ve got my limits too and I refuse to work outside the legal boundaries. You’ve got to have supervision – even if its not very strict – you’ve got to stay inside the limits of the law. And you’ve got to remember that substitution isn’t obligator – its the state that’s under obligation to provide this option for the really serious cases. And don’t forget that people are always going to reach out more for things to ease pain and frustration in a prison atmosphere. And that means turning to drugs, because ’t’s just so much more brutal in here. And you can’t stop drugs getting into prisons, – no way. There was an experiment in America where everything was completely sealed off, and the staff and inmates all suffered from psychological decompensation. You just can’t do it.

I think you need to concentrate mostly on cooperation, – but keep tabs on them too. You’ve got to know what’s happening with the chronic cases and

the relapse risks. It doesn't mean rejecting the maintenance programme out of hand." (A doctor)

In most cases, the dosage from the remand prison is continued and the physician adjusts the dosage.

At 7 o'clock, the substitution drug is handed out to the prisoners. They have to swallow the dosage and to drink some water afterwards. Again, methadone is perceived to be safer than other drugs (see above).

"We dispense methadone and Substidol every day at 7 am. The prisoners are brought up, the nurse breaks open the capsules and tips them into a mug. A warder watches while the prisoner swallows it and checks their mouth afterwards to see its all gone. And then the next one, and so on. The same with methadone. After they drink it, they have to say something, so you can check if they've swallowed or not." (A nurse)

A special facility has been constructed for reasons of safety and supervision and to enable staff to talk to every prisoner individually:

"There's this room, and the cubicle is for the prisoner. Here's the table where we put the Substidol, and there's the opening in the cubicle so they can take it. The warder sits here on the left and checks the prisoners' mouths. The other prisoners wait in the corridor, only one comes in at a time. The cubicle door locks automatically when they shut it, and when they're finished they can just open it and leave." (A nurse)

"They really prefer Substidol, or Mundadol too. But they get more methadone now, – that's the way Dr. XY. prefers it – and we prefer methadone, because its easier to dispense. With Substidol you never know if they've still got it stuck behind their teeth ... they get it in a mug. The capsules are opened and the granules are tipped into a mug of liquid, then they drink that. But the granules don't actually dissolve first." (A nurse)

If inmates are on leave, they will be given the substitution drug for up to 3 days with the same allocation upon release, when the drug is given for 1-2 days whilst the patient looks for a doctor in the community.

The average dosage is 72 mg (for the 37 methadone patients at the time of visit). Here too, the number of inmates in substitution treatment has been risen sharply in the last years (from 25 patients in mid 2000 to more than 100 three years later). This is explained by the parallel increase substitution

treatment use in community and in remand prisons (especially Vienna Josefstadt, see above).

The nurses regard substitution treatment as a sort of privilege and there is more contact with the doctors and the other professional personnel.

Urinalyses are taken 1-2 times a month (under visual control with mirrors), the positive cannabis results do not lead to exclusion from the substitution programme but, if they test positive for urine controls on a regular basis, this then may lead to dosage reduction:

"If someone's urine tests positive for cannabis, then they have to go and see the specialist. He talks it over with them and they usually get a second chance. ... But if it keeps on happening, if their urine regularly tests positive, well, – they aren't taken off maintenance, but then the dosage gets reduced." (A nurse)

The doctor uses their discretion in the use of urine controls depending on the personal circumstances and abilities:

"I'm not for keeping tabs on people in the maintenance programme when they're outside, – except if its someone with a driving license who's working as a driver, for example. Someone who's stabilized and working in a responsible position should get regular urine checks.

Otherwise it's not so important, more a question of ethics. In here its a different story of course, – I'm not against checks – its not as though I'd stop someone's methadone treatment if they had a relapse, – its more about good communication. I get more and more people coming to me who say: I've relapsed, – my urine's going to test positive, so you'll find out anyway. Which brings us straight to the point: we don't only talk over the negative aspects, but about whether the dosage is high enough, whether they're getting the right drug. A lot of them wouldn't come to me, wouldn't say anything otherwise, so this way I can reassess the dosage, find out what they're using on the side, and so on." (A doctor)

If someone is topping up drugs and is detected, they will be sent to the specialist:

"If the specialist's on duty, then they have to go and see him straight away. And if the substitution specialist isn't there they have to see the GP at the prison hospital, or the psychiatrist. There's almost always a specialist on duty here. And there's always one on call." (A nurse)

Reduction steps are often requested before release. The reduction scheme is different according to individual needs and abilities.

If someone shows signs of drug abuse during his sentence, it is also possible to start a substitution treatment:

“Sometimes we start people on maintenance here too. If a prisoner approaches us with an ongoing drug problem, we can get the substitution treatment specialist to have a look at him to see if he needs to be on maintenance. It only needs a quick urine test and a check for symptoms. If there are needle marks or a positive urine test, then the prisoner can be put in the programme.” (A nurse)

For the doctor, it is not relevant whether or not somebody gets into the prison on a prescription but withdrawal symptoms and drug consumption signs are to be observed in the prison:

“When someone comes to see me, they’re already motivated enough to have made an appointment for their drug problems. Then I have to decide if this is just a tactic to get medication to ease withdrawal. So I do a urine test, I look for needle marks. Basically I have to make an on-the-spot diagnosis; ’ts obvious if someone’s having really extreme withdrawal problems. People used to get lost in the system – they’d be sitting there on their own with massive withdrawal symptoms. Our screening’s much better now – during admission for example ... or if someone’s already been in a maintenance programme and fits the criteria – positive urine test and so on. Then they can get into the programme. No problem.” (A doctor)

Reduction in the substitution drug dosage are possible at any time:

“... you can reduce anytime you want, it happens quite a lot. Usually just before release. One or two months before ... Of course, the long haul ones don’t do that so much. They get an appointment with the specialist and he reduces their dose week by week.” (A nurse)

The head physician leads a group for prisoners in substitution treatment and with drug problems in general. Benzodiazepines are seen as a big problem in this group because the strategy is to reduce the dosages (as 80% of those coming from remand prisons still have a prescription of those drugs). Furthermore, a psychologist is offers group and single sessions.

There are regular group discussions between doctor and inmates on the substitution ward:

“The group discussions aren’t only about therapeutic solutions for addiction problems. We talk about anything that comes up, – personal problems, – situation on the ward – anything that needs looking into. For example, we’ve got a washing machine in our department now. Or, that the outdoor yard stays open till lock-in. Just things that need discussing.” (A doctor)

2.3 *The views of prisoners*

The focus group consisted of four prisoners with different length of sentences (from 3 months to life), with various periods in prisons before. Partly, they were prescribed methadone, partly retarded morphine. All of them appreciated the continuation of substitution treatment. From their own experience of other regimes in which treatment was stopped, this had aggravated their situation and had not helped.. Substitution treatment is regarded as a form of security. According to those receiving retarded morphine, methadone does have the effect of making people depressive, feeble, and does not give any pleasure at all. Morphine is perceived to be good in physical respects and stimulating in terms of libido. But these effects vanish after some months and a feeling of functioning normally follows. The advantages and disadvantages of the substitution drugs have been discussed.

Q: How does Substitol work differently from methadone?

‘It varies. In my case, methadone made me groggy. I couldn’t think straight. I didn’t want to do anything. Not sex either.’

‘I went from 90 mg of methadone to 600 mg of substitol. I react better to Substitol. I’m back to normal now. I don’t want to be high anymore, just normal.’

Q: Can you confirm that it gives you a buzz during the first three weeks, then eases off?

Yeah, the first three weeks, then it gradually eases off. Now I can live quite normally’

Inmates reported both a change-over from retarded morphine to methadone and vice versa.

The inmates complained about the reduction of co-medication (e.g. benzodiazepines). Furthermore, they feel that there is not enough psycho-social care related staff to talk to. There is only one psychologist for the whole ward, who is overextended and a chaplain. They also feel resentment and discrimi-

nation from the staff regarding working facilities, and that there is a rough distinction between drug users and non-drug users (“Giftler” und “Nicht-Giftler”). So, consequently, more education is demanded for the staff about drug and addiction issues.

3 Summing up

Due to a decree from The Ministry of Justice, substitution treatment must be available in every prison and is supposed to be standard procedure. The number of prisoners receiving substitution treatment has steadily increased in recent years. The visit to the two prisons confirmed this trend. There was almost no discussion about the continuation of treatment. Additionally, a surprisingly high number of patients receive substitution treatment for the first time whilst in prison. In all three prisons, the atmosphere was basically positive towards substitution treatment. In discussions with prisoners, nurses and doctors it became clear that treatment modalities were relatively clear and that prisoners views were acknowledged and integrated in the treatment process. As an example, negotiation about dosage was possible and the decisions in favour of detoxification or maintenance were acknowledged as part of the doctor-patient relationship.

Nevertheless there were a few conflicts around the treatment process. Obviously, different policies and practices were applied regarding the substitution drugs of retarded morphine, which was judged differently by doctors in remand prison and in sentenced prison. If these drugs are prescribed in the community, they are replaced by methadone, which is seen as pharmacologically superior and easier to handle in terms of control and supervision of intake.

In addition, the prescription of benzodiazepines was a subject of debate. As these drugs are very widespread in the community, doctors in the remand prison prescribe and do not immediately reduce them but as part of a (longer) detoxification process whereas, in other prisons, these substances are only prescribed rarely. This leads to misunderstandings, as the prisoners themselves are usually unaware of the dangerousness of the drug. Prisoners mentioned the lack of adequate psycho-social care.

Belgium¹

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users (and type of drugs used)

There are an estimated 30,000 drug users in the country, a doctor reported.

Currently, there is an estimated number of 7,000 persons in substitution treatment in 2001/2002 (EMCDDA, 2003).

Approximately 50% of prisoners are drug users (Todts and Hariga, unpublished).

There are 224 drug-using prisoners on substitution treatment in prison, compared to 122 in 2002 (Todts, unpublished). 219 of them are on a methadone treatment. The mean dosage was 36.8 mg, varying from 1 to 205 mg. The mean age of patients was 32.8 years old. Substitution treatment is delivered in detoxification as well as maintenance programme.

Although the alcohol related problems are a much bigger problem than any other drug-related problem (a doctor reported), the most commonly used illicit psychoactive substances are in order of frequency of use cannabis, synthetic drugs, heroin and cocaine. (Reitox Belgium, 2002)

The treatment section (health care) in prisons is part of the responsibilities of the National Prison Administration, Ministry of Justice.

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Sven Todts, Ministry of Justice, who also provided national-general information and support with the finalisation of this country report. Special thanks again to Sven Todts for his availability, support and great expertise.

1.2 Substitution treatment

Data comes from an on-going review of research reports, websites and laws/regulations, as well as from interviews conducted during the field visit².

1.2.1 Historical and legal background

The law of 21/02/1921 known as the ‘drug law’ prohibited any doctor from maintaining dependence by prescribing medicine. The royal decree of 1930 lists the substances concerned by the drug law. Article 23 states that any physician who ‘starts, maintains or aggravates a pre-existing dependence’ will be prosecuted. From 1982 and on, most of the provincial medical commissions published guidelines on prescribing narcotics. The 1975 law was a revision of the 1921 drug law and was aimed at refining the list of substances and increasing the government’s control system to ‘fight drugs’. It stated that doctors ‘can be punished if they abuse their authority to prescribe, deliver or administer any product that can establish, maintain or aggravate dependence’ (no need to prove a pre-established dependence). (Todts, unpublished)

The first doctors to provide substitution treatment did so in the mid-nineteen seventies and in the form of methadone, bezitramide and dextromoramide. Deaths by overdose from topping up methadone with medication in the 1980s (Reisinger & Picard, 1996) resulted in the prosecution of doctors prescribing substitution treatment (not the treatment banning). Dr. Baudour and Dr. Nystrom were both sentenced for the prescription of methadone and bezitramide respectively.^{3 4}

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- 2 Interviews were conducted at the national level with:
- The Drug Co-ordinator, Ministry of Justice.
 - The Director General of the Directorate General Execution of Sentences and Measures, Ministry of Justice..
 - The medical doctor director of Penitentiary Health Service at the Ministry of Justice
 - The inspector of medical services for the prisons located in the French area of Belgium, Ministry of Justice.
 - The co-ordinator of Psychosocial Service for Prisons, Ministry of Justice.
 - The director of Modus Vivendi, NGO.
- 3 Corr. Brussel, 16 februari 1984, *J.Proc.*, 2 maart 1984, 25-33.
- 4 Brussel, 7 november 1985, *J.T.*, 1986, 371.

A legal battle started between the Belgian Medical Association (BMA)⁵ and doctors united in the 'Initiative Déontologique Médicale' (IDM) – Medical Deontological Initiative. Indeed, in 1986, the national council named the BMA and the judicial authorities responsible in judging what constitutes abuse (as the drug law does not define 'abuse'). Facing a growing epidemic of drug use and HIV, despite the legal conflict, doctors prescribed bezitramide, methadone and buprenorphine. The legal battle concluded in 1993 with the State Council (a Court with the authority to verify the legality of directives) reviewing the BMA's directives and supporting doctors' rights to prescribe substitution treatment. (Todts, unpublished)

A consensus conference on substitution treatment was held in Brussels in October 1994 (a follow-up of the Consensus conference was organised in 2000 and put forward a few additional recommendations) (Pelc, 2004). The consensus statement of 1994 acknowledged two substances for treatment: methadone and buprenorphine; and rejected bezitramide for a lack of scientific evidence. Although the statement underlines that substitution treatment should be provided to persons 18 years old or older who have used heroin for at least one year, specialised doctors are allowed to administer such treatment to anyone further to careful examination. The statement emphasises that methadone, if adequately provided, is safe and effective; effective to reduce heroin use, HIV-Hepatitis risk behaviours, and criminal behaviour, and to improve, social and professional skills. The statement claims that the daily dose of methadone – taken in an oral form - should start at 30 or 40 mg and eventually increase or decrease according to the individual's needs. Methadone treatment may be provided with or without a set duration. Short-term detoxification goes from 3 weeks to 3 months. Occasionally topping up the methadone treatment does not imply termination of the treatment. Finally, the statement underlines the importance of providing psychosocial care and support along with the substitution treatment.

On 1st October 2002 the drug law of 1921 was altered to include substitution treatment on a maintenance basis (Law of 22 August 2002). This law effectively states that substitution treatment is legal. (Todts, unpublished)

5 Each doctor practising medicine in Belgium must be a member of the Belgian Medical Association (BMA). The BMA has provincial councils and one national council and has disciplinary authority over its members.

The Royal Decree of 19 March 2004, published on 30 April 2004, defines the two substances to be used as a substitution treatment: methadone and buprenorphine. It also states that only medical doctors trained in substitution treatment can deliver this treatment; they must adopt a multi-disciplinary approach and must keep a medical record for every patient on the treatment. The decree differentiates between doctors who ‘habitually’ prescribe substitution treatment, who must be able to prove they have an expertise within substitution treatment, and other doctors, who are allowed to prescribe once registered with a specialised organisation or network. A registration of patients on substitution treatment is set through the insurance companies. This Royal Decree establishes a legal framework for the provision of substitution treatment. (Tods, unpublished)

Geographical differences

There is a tendency in Belgium for geographical differences in the provision of treatment to occur due to the country’s structure and the way health care to drug users is managed for. Prisons are managed at the federal level by the Ministry of Justice, but Belgium’s communities have autonomous competence.

At the moment, in the community, substitution treatment is offered at the level of MASS/MSOC in certain ambulatory centres and by a GP (private office). It was reported that the Flemish-speaking part of Belgium had been more reluctant and cautious in providing substitution treatment in the community and in prison, where the psychiatrist is generally in charge of the treatment. The French-speaking part of Belgium had been more in favour and ahead of the Flemish part, largely due to the influence of the ‘Initiative Déontologique Médicale’ (Medical Deontological Initiative). Generally, in the French community, the GP provides substitution treatment in the community and in prison.

1.2.2 Substitution treatment in prison

The two substances offered as part of a substitution treatment in prison are methadone and buprenorphine.

At first, substitution treatment was available in prisons on a limited basis. The BMA recommended providing the treatment mainly on a detoxification basis. Detoxification could also be conducted with the use of medications, such as benzodiazepines and neuroleptics. Substitution treatment on a main-

tenance basis was recommended for vulnerable groups, such as pregnant women, prisoners positive for HIV or hepatitis, and short-term incarceration (less than one year). Initiation of substitution treatment in prison was exceptional. A prisoner on substitution treatment was to continue his/her treatment if transferred to another prison. (Reitox National Report, 2002)⁶

Although BMA made recommendations, substitution treatment in prison was the sole responsibility of the prison's doctor.⁷ Nevertheless, in prisons, therapy choices are not only guided by doctors' personal insights, but often also by prison traditions and beliefs as expressed by the management and other stake holders, including drug free-oriented co-operators from specialised NGOs (Todts, unpublished).

The BMA no longer recommends detoxification. Although the guiding text is still the circular letter of December 2000, interpretations of what is allowed have been broadened, especially further to Todts's 'advice' on buprenorphine and methadone written in 2002. The methadone advice was signed by the Head of Health Service in prison and the Head of Psychosocial service in prison. In the near future, it is to be expected that possibilities of substitution treatment will broaden further and be available to a higher number of patients. (Todts, interviewed)

The Ministry of Justice provides health care in prison. All treatment and medication costs are paid by the Ministry of Justice.

Methadone has been the main substitution treatment provided in prisons, as buprenorphine has been reimbursed in the whole country only since August 2003. This change may impact on the type of substitution treatment provided in the country in and out of prison (although this still has not happened by May 2004).

There is no contract between the prisoner and the doctor regarding substitution treatment provision, although this was at the time of the visit under dis-

6 Ministerial circular number 1722 of 18 December 2000 relative to the integral approach of drug use in penitentiary establishments ('*Circulaire ministérielle n° 1722 du 18 décembre 2000 relative à l'approche intégrale de la problématique de la drogue dans les établissements pénitentiaires*').

7 Tijdschrift Nationale Raad Orde van Geneesheren, september 1996, vol. V nr. 73, 24, geciteerd in: Van Mol, F., *Gezondheid en detentie*, Brussel, Penitentiaire gezondheidsdienst, 80.

cussion as a plan to hold a contract was being drawn, further to some prisons, like Ypres Prison, asking for (or using 'unofficially') such a contract.

The provision of methadone in prison is provided by a local pharmacist (instead of a central one), meaning that one day per week (the same day every week, at the same time) the same person from the prison (either the psychiatrist or GP in charge of substitution treatment) goes to the pharmacist to get the doses for all prisoners for one week. All doses are prepared for daily use and are labelled with the name of the prisoner. Methadone is only provided in liquid form. (Todts, unpublished)

Upon arrival at the prison, a prisoner on substitution treatment in the community informs the prison of his/her doctor in the community. Once the trace is confirmed, substitution treatment is usually provided following the provision in the community. Usually, new entrants are not provided with methadone within the first 24 hours since their drug intake is unknown.

In case of transfer, although the computerised system allows information on prisoners to be transferred easily from one prison to the other, it was reported that a prisoner on maintenance transferred to a prison where substitution treatment is only provided on a detoxification basis, is very likely to receive substitution treatment on a detoxification basis (and not maintenance).

A liaison with a community centre or a doctor that provides substitution treatment must be organised prior to release for the prisoner to be able to continue his/ her treatment once released. (Todts, unpublished)

The Prison Health Service has the right to advise doctors to provide substitution treatment. Doctors have the right to 'therapeutic freedom', allowing them to choose or reject available therapies. This may lead to some prisoners not receiving substitution treatment because the doctor does not agree with such a treatment for ethical reasons.

Geographical differences

The geographical differences mentioned earlier have been illustrated in the field visit as – at the time of the visit – substitution treatment in the prison located in the Flemish part of the country was managed by psychiatrists; whereas substitution treatment in the prison located in the French part of the country was managed by a GP.

Generally speaking, in prison, doctors in charge of substitution treatment are either the GP or the psychiatrist. Each prison has a convention defining who is in charge of the treatment. GPs belong to the *Medical service for Prisons* at the Ministry of Justice, whereas psychiatrists belong to the *Psychosocial Service for Prisons* at the Ministry of Justice. Either the GP or the psychiatrist is to prescribe substitution treatment within the same prison. Although GPs do not draw ‘expertise reports’ on prisoners for the Ministry of Justice, some psychiatrists do. A psychiatrist is not allowed to provide clinical consultancy and conduct expertise within the same establishment. However, this may not be clear to all prisoners who may be somewhat reluctant to consult.

Psychosocial support and staff training

‘It is stated that psychosocial counselling and assistance to patients are factors improving the results of methadone treatment’ (Reitox National Report, 2002, pg. 87).

However, it was reported that in general no proper psychosocial treatment is offered to prisoners due to a lack of resources. Psychologists must also provide the Ministry of Justice with reports on the prisoner including referrals and links with the community regarding housing, jobs and health care.

There tends to be more external psychosocial services in the North part of Belgium, although the situation is problematic in the North and South part as financial means lack to fund such services.

Regarding training offered to medical staff in charge of the substitution treatment, it was reported that the Health Service has trained its staff extensively on substitution treatment.

1.3 Prison Population

Table 4 Data on the prison situation in Belgium (Source: King’s College London, International Centre for Prison Studies, Prison Brief for Belgium).

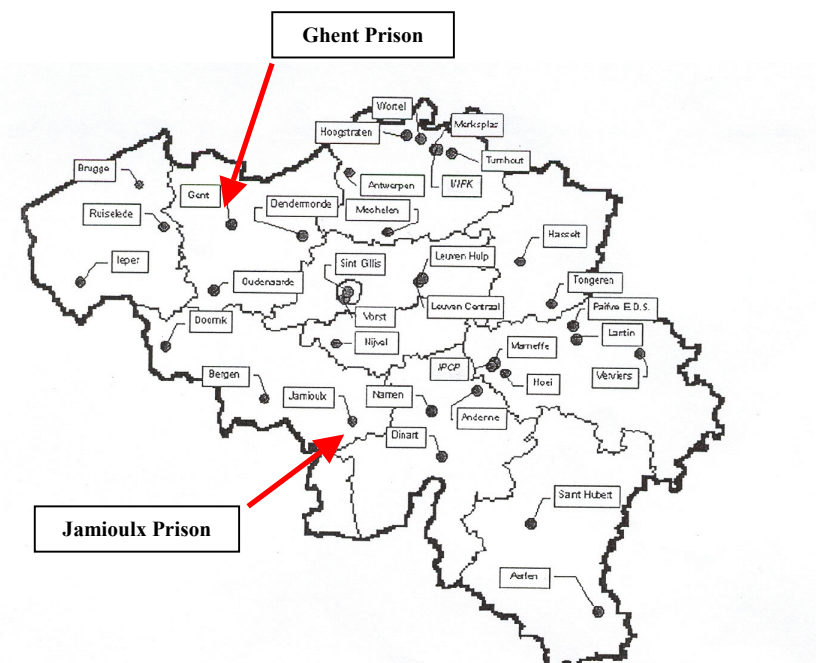
Country	BELGIUM
Ministry responsible of Prisons	Ministry of Justice
Prison administration	Directorate General of the Penitentiary Administration

Head of prison administration (and title)	Gisleen van Belle Director General
Prison population total (including pre-trial detainees / remand prisoners)	8,764 at 1.9.2001 (Council of Europe Annual Penal Statistics) 9,245 at 1/3/2004 (Ministry of Justice)
Prison population rate (per 100,000 of national population)	85 based on an estimated national po- pulation of 10.28 million at mid-2001 (from Council of Europe figures) 89.3 (based on a population of 10,355,844 on 1/1/2003, National In- stitute Statistics), Ministry of Justice
Pre-trial detainees / remand prisoners (percentage of prison population)	22.9% (1.9.2001 – plus 18.5% convicted but sen- tence unconfirmed) 39% (N=3,614 out of 9,245) (1/3/2004, Ministry of Justice)
Female prisoners (percentage of prison population)	4.1% (1.9.2000) 3.9% (N=362 out of 9,258) (30/12/2003), Ministry of Justice
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	1.1% (1.9.2000 – under 18) Special youth courts are competent for offences committed by youths.
Foreign prisoners (percentage of prison population)	40.4% (1.9.2000) 42.5 % (30/12/2000) – Ministry of Justice
Number of establishments / instituti- ons	32 (2002)
Official capacity of prison system	6,896 (1.9.2001) 8,092 (14/11/2003), Ministry of Justice
Occupancy level (based on official capacity)	127.1% (1.9.2001) 114.2% (9,245 out of 8,092) (1/3/2004, Ministry of Justice)
Recent prison population trend (year, prison population total, prison population rate)	1992 7,116 (71) 1995 7,561 (75) 1998 8,271 (81) 2004 9,245 (1/3/2004, Ministry of Justice)

2 The field visits⁸

Time frame. The field visit took place from 13 to 18 June 2003.

Location. Visits were conducted in two prisons: Jamioulx Prison and Ghent Prison.



Map of prisons in Belgium

Visits were conducted in two prisons: one in the French speaking area of Belgium, where the medical doctor is in charge of substitution treatment, and one in the Flemish speaking area of Belgium, where the psychiatrist is in

8 *Methodology.* Interviews were conducted with the hereunder mentioned individuals and focus groups (tape-recorded with consent) with the prisoners. The researcher conducted all interviews/ focus groups on her own, accompanied by a freelance and neutral interpreter in Ghent Prison, Flemish speaking area. All participants were briefed and told about ethical issues.

charge of substitution treatment, illustrating the differences between the North and the South of Belgium as reported above.

2.1 Jamioulx Prison⁹

2.1.1 Description of the prison

Jamioulx prison is located in the city of Charleroi, situated in Wallonia, the French speaking part of Belgium. Charleroi has a high level of criminality and unemployment.

Jamioulx prison is a male, remand prison, holding approximately 400 prisoners for a capacity of 269 (31/12/2003, Ministry of Justice), some of which are sentenced prisoners. The majority are in a closed detention with some prisoners in half-open detention. It was reported that the prison faces serious drug use (legal and illegal on the black market) inside the prison on a daily basis.

The prison was built in an L structure, the main surveillance point being located at the extremity (not the centre), posing practical issues and management difficulties to the penitentiary staff.

2.1.2 Goals and practical procedures

Substitution treatment was initiated in Jamioulx Prison by the doctor, a general practitioner (GP) who has been working for years on the drugs field in the community. It was reported that substitution treatment has been running for about 5 years in the prison. Resistance and obstacles from the prison staff were first felt at the implementation of substitution treatment in the prison, but substitution treatment is now a well-established programme managed by the medical team (GPs). Substitution treatment is offered as a continuation of what the patient received in the community (either detoxification or maintenance programme) or is initiated in the prison, further to the doctors' therapeutic freedom.

9 Interviews were conducted with:
– A medical doctor (GP) and doctor in charge.
– The physiotherapist.
– A security officer working in the medical centre.
– Security officers and a guard head of section.

The medical team said that out the 400 prisoners, 40 are on methadone treatment, receiving an average dose of 22 mg of methadone per day. It was reported that the maximum dose a prisoner has received in the prison is 110 mg of methadone. It was also reported that prisoners are given 10% less of the dose given in the community because the medical team feels that prisoners are better looked after in prison and can report their needs more easily than outside.

At the time of the visit, June 2003, methadone was the only substitution treatment provided. Buprenorphine has only been reimbursed in Belgium since August 2003, and was therefore not offered at the time of the visit. The GP reported that methadone is well managed and known by the medical doctors and the prisoners, contrarily to buprenorphine. The medical staff reported transferring a French prisoner who received buprenorphine treatment in France to a methadone programme when he was incarcerated at Jamioulx Prison successfully.

The medical team said they estimate that 10 out of the 40 prisoners on methadone treatment have no real motivation to stop drugs, 10 are going through a difficult time but do not use illegal drugs, 5 have a real motivation to become drug free, and the others are unstable. 20 out of the 40 prisoners on methadone were known from the community drug services before being incarcerated.

The medical team said that substitution treatment, provided on an individual basis, offers prisoners a chance to get off drugs if they are motivated to become drug free and to acquire stability. A security guard stated that substitution treatment is useful only for some prisoners, but is used as another drug (for consumption or for traffic) by others.

Difficulties linked to substitution treatment reported by the medical staff were: (i) thefts of methadone in the prison pharmacy (although the stolen items are often quickly found), (ii) medical doctors are not informed of prisoners' release; the file of the prisoner disappears from the prison screen, and (iii) overdoses due to alcohol and benzodiazepines from the black market topped up with methadone. However, the use of methadone has meant a decrease of the consumption of prescribed, legal drugs.

The medical team reported that drug-using prisoners with no treatment from the community or other prison are offered (i) analgesics (e.g. codeine), neuroleptics (e.g. triapridal), benzodiazepines (e.g. valium) towards detoxifica-

tion, given in the evening (although dependence on these legal drugs is common), or (ii) methadone treatment, known and requested by many prisoners.

Drug-using prisoners who are new entrants at the prison and who claim they received substitution treatment outside tend to ask to continue substitution treatment in prison. A trace with their situation in the community is established, and if needed, half of the dose of what they received outside is given if the individual is going through withdrawal and the trace could not be established right the way.

Substitution treatment is provided to prisoners every day, in the morning around 7.00 am or earlier if the prisoner is awoken earlier. When receiving his dose, the prisoner signs a receipt document. Methadone is prescribed once a week. The GP is in charge of receiving the substitution treatments, once a week from the local area pharmacist who always provides it to the same designated, person in charge every week on the same day of the week and at the same time.

It was reported that no urine analysis are conducted for prisoners on substitution treatment because this would imply a 'control' role from the medical team and control and treatment are seen as incompatible. Instead 'trust', better communication (asking prisoners about their drug use) and patients' competences and responsibilities in substitution treatment are encouraged.

The medical team and the psychosocial team¹⁰ do not work together. At Jamioulx Prison the psychosocial team plays no or very little role in substitution treatment. The medical team said they are not informed of the psychosocial aspect of prisoners by the psychosocial team. The psychiatrist (in charge of the psychosocial team) is in charge of the psychiatric wing and looks after abusers, mentally and physically ill prisoners (around 20 to 25 of them).

The GP doctor reported that he believes that the psychosocial team and the 'Directorate General Execution of Sentences and Measures' do not hold a negative perception of substitution treatment and of prisoners on substitution treatment. However, some prisoners believe that if they stop taking methadone, they will acquire conditional freedom earlier.

10 The psychosocial team focuses on providing the Ministry of Justice an expertise report and provides psycho-social support, when sufficient time and staff resources.

It was reported that although it is obvious to all prisoners and prison staff which prisoners take substitution treatment, not hiding who is on substitution treatment helps to de-stigmatise substitution treatment and drug users and encourages communication about the topic.

It was found that the medical team works closely with prison staff, especially security guards working in the medical centre, holding meetings, and trying to work closely together.

2.2 Ghent Prison¹¹

2.2.1 Description of the prison

Ghent Prison is located in the city of Ghent, situated in the Flemish speaking part of Belgium. The building is in a star-like shape, surveillance being located at the centre, enabling easy control and surveillance.

Ghent Prison is a remand prison, with some 40 sentenced prisoners and 60 ‘internés’ (i.e. individuals declared not responsible for their acts because of psychiatric problems)¹². The prison holds 315 prisoners (time of field visit) for a capacity of 283 (31/12/2003, Ministry of Justice). The majority are male prisoners located in 3 wings. 33 female prisoners (capacity for 42), on remand or sentenced for at least 5 years, are located in an attached but separated wing.

The prison counts 220 staff of which 180 are prison guards, 4 psychologists, 3 social workers, 3 psychiatrists, 5 nurses, and 4 GPs (who provide 2 types of consultations per day: to new entrants and to current prisoners).

2.2.2 Goals and practical procedures

The substitution treatment programme, as methadone, had only been running for a couple of months at the time of the visit. Methadone became available

11 Interviews were conducted with:

- The governor
- A psychiatrist
- A psychologist
- A nurse

12 ‘Internés’ should be sent to therapeutic settings, but one third remains in prison. Recently, a number of forensic psychiatric units have been set up in general psychiatric hospitals for medium security ‘internés’.

further to the initiative of a psychiatrist. Previously, it was reported, no substitution treatment was offered at all, mainly due to a doctor reluctance and opposition to the provision of methadone in prison. At the time of the visit, buprenorphine was not offered as it was not reimbursed and not a known treatment, increasing doctors' reluctance to provide it.

It was reported that the 3 psychiatrists at the Ghent Prison are in charge of prescribing substitution treatment, and decide together to provide substitution treatment or not, on a detoxification or maintenance basis. Two of them deliver methadone to prisoners. A psychiatrist stated that he tends to continue the treatment that the prisoner has received in the community and works on an individual approach. He also said that methadone treatment in prison can be initiated in prison but is rarely done. It was reported that substitution treatment is equally offered as maintenance and as detoxification to the current 3 prisoners on methadone; detoxification may go over a period of 5 to 6 weeks.

At the time of field visit the medical staff reported that 3 prisoners were on methadone treatment. The maximum dose that has been given at the prison is 80-90 mg.

It was reported that the governor of the prison is not asked for permission to implement and provide substitution treatment but he is debriefed on decisions and practises used in the prison.

The medical team stated that methadone is ordered from a local pharmacist and delivered every week on the same day, same time and to the same doctor in charge of collecting the treatment. They also said that prisoners receive their liquid dose of methadone daily at 5-6 pm at the medical centre, where no prison officers are present. All treatments (methadone and other) are distributed to all prisoners at the same time and place.

The psychologist reported that she is not automatically informed of which prisoners take substitution treatment, but she is told by prisoners. The psychiatrists may also inform her if perceived as relevant, and she might report specific issues linked to substitution treatment (individual topping up, or going through withdrawal, etc.) to the psychiatrist if needed.

It was reported that prisoners do not want to be identified as drug users as they fear the judicial authorities to be informed of their drug use, and as a result to obtain a more severe sentence.

2.3 Prisoners' experiences

Focus groups and interview were conducted with prisoners:

- A focus group with 3 prisoners – Jamioulx Prison
- A focus group with 6 male prisoners - Ghent Prison
- An interview with one female prisoner - Ghent Prison

Prisoners stated that methadone has helped them in many ways.

'Substitution treatment... it is a spare wheel.'

'Methadone, for us, it is good to reduce the dose.'

'I have been taking in prison methadone for 4 years, it has greatly helped me, in the sense that it has allows me to reduce the violence that is within me.'

'Why do they take methadone? Because we must live our days, find stability in prison.'

'I take methadone here in prison to calm me down, to do my sentence. But I am sure that once I am released, I will not want to hear about methadone anymore, because I do not want to be dependent. I have done 9 treatments and I think that now I am 30 years old and I am getting tired of it all.'

However, some prisoners reported viewing methadone as another drug or taking it on the black market.

'The pleasure I get from taking drugs is such that despite all that is offered to us to become drugs free, I do not want to stop (...) it is clear that I prefer methadone considering its purity and the kick it gives.'

'I know some people who take methadone (...) they put in a spoon and inject it. For them it is the same [as illegal drugs] and that is drugs that they do not pay. It is free.'

'Receiving methadone doesn't help us. I was drugs free for 7 years and realised that I felt better when I take nothing. (...) Taking methadone in prison is bad because it incites my desire [of drugs].'

'At first I couldn't have methadone because the prison where I was did not prescribe methadone at the time. So I smuggled some in from the black market.'

Prisoners reported side-effects of methadone.

'I don't like methadone anyway because when we need to detox from methadone, it is terrible.'

'I came in here [prison], and I said that I was on methadone. It was still in my urine, so they couldn't deny it. It [methadone] was just not to think; it wasn't because I was ill. It was just because it had the same effect or almost than heroin. It's even worse actually. The withdrawal from heroin, that lasts for 3-5 days. The withdrawal from methadone, that's 1 month (...). It's easier to stop heroin, you know you will suffer for 5 days. If you take medicine or methadone, you know you are going to suffer for longer. I asked to stop [methadone] within 20 days. I was on 40 mg and within 20 days, I stopped. So 2 per day. Here, in prison, it's better than outside. Outside, you suffer. Here, you don't feel it because you are busy, you don't think about it. But outside, you think about it and you know that you can have some [drugs] outside.'

'A heroin user will stop heroin, will be sick for 10 days. A methadone user, he will stop methadone and that might last for 25 days, 1 month. When we stop methadone directly or even progressively, the problem is to get a normal sleeping pattern, that is 4 to 6 hours of sleep, it will take us 2 to 4 months. Meaning that the bloke that stops methadone will sleep very, very poorly for 2 to 4 months and these 2 to 4 months can be critical and often people do not dare to stop because they apprehend that.'

'I was fed up with methadone (...) I felt even more down in fact.'

'For 2 months I was ok, I felt nothing. I felt ok in the morning, but afterwards, I felt it: my legs, my arms, my whole body was in pain. I drank methadone and 15 minutes later I was alive again. It's like a plant that needs water. You live like a plant, that's it, no other way, that's the reality.'

'When I took [methadone] I didn't think. Now my mind is working again. When you take methadone you have no feelings even towards your partner. It changes all. I have noticed. Even dreams, when I took methadone I stopped dreaming, I did not want sex, did not want this or that. Now that I no longer take methadone, all comes back, all feelings come back.'

It was reported that methadone is helpful and has various advantages but does not solve the problematic issue solely. Prisoners' needs were mainly about talking and wanting an individual approach allowing for more discussion (to be listened to and to talk to).

'The individual who decreases the dose needs to talk. The person in treatment, if s/he does not talk, then the therapy is wrong. So it is nice to get prescribed methadone, but it does not solve the problem.'

3 Summing up

Recently, in the community and in prison, a lot of changes concerning substitution treatment at the legislative level as well as the practical level have occurred. Old practises favouring detoxification with methadone are still in place, but means to increase the availability and offer of substitution treatment in and out of prison have been set.

Development within prisons may occur at different paces in different regions and prisons of the country, although it was reported that within one year (between the time of the visit and the publication of the report) progress occurred in the prisons visited.

Prisoners' perceptions of substitution treatment were often mixed, as some stated that methadone was a key progress in the treatment of drug users, but also was 'worse' than heroin to detox from. Prisoners also stated that psychosocial support was lacking: more of it and more dialogue between prisoners and prison and medical staff may help them all to understand substitution treatment (purpose and functioning) better.

The doctors' 'battle' to prescribe substitution treatment to drug users in and out of prison remains part of the history and may explain the reluctance of some doctors to prescribe the treatment or to still offer it on a maintenance basis, when a legal framework now exists supporting variety in the practise and response to individual needs.

The Czech Republic^{1 2}

1 General data: drug use, substitution treatment and prison population

1.1 Drug use

The number of drug users is estimated to be between 35 000 and 37 500³. In 9 Czech centres, 463 patients were registered on methadone and between 500 to 700 patients were on buprenorphine treatment (Reitox Czech Republic, 2002).

In 2001, prisons reported that 38.5 % of prisoners were registered as drug users. This trend has increased through the years (from a level of 22.5% in 1998). Prison specialists estimated that the number of drug users in prison today is approximately 46% (Sochurek and Slukova, 2003).

While the number of experimental and recreational drug users has been increasing in the Czech Republic (especially in relation to cannabis and ecstasy), the number of problem drug users (i.e. heroin and pervitin users) has stabilised (Reitox Czech Republic, 2002).

The most commonly used psychoactive substances are marijuana and pervitin or heroin⁴ (Reitox Czech Republic, 2002). Pervitin is a type of amphetamine, used intravenously. Pervitin causes faster thought, movement, a good mood, feelings of greater creativity and relaxation. But, in the long term, it

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Jan Sochurek, Prison Service Administration, and Jiri Richter, SANANIM NGO; both also provided national information and support with the finalisation of this country report.

2 Terminology: in the Czech Republic cells are often called rooms. Guards are also called 'uniform staff'. Type A prisoner is on the lowest security regime, whereas type D prisoner is on the highest security regime.

3 In 2002, among the 35-37 500 problem drug users, approximately 30 000 were injectors, 13 500 users of heroin and 21 800 users of pervitin (Reitox Czech Republic, 2003).

4 16% (1 150 000) of Czech citizens have used illicit drugs, mainly cannabis and hashish. 4% of Czech citizens aged 15-64 have used the party drug ecstasy at least once in their life. Less than 1% of the population have used other drugs such as heroin, pervitin, cocaine or LSD (Reitox Czech Republic, 2002).

may also cause psychological dependence and has side effects such as inducing a state of psychosis, hallucinations, or manic disorders.

The national prevalence of

- HIV/AIDS is 0.01% in the general population, 0.05% among intravenous drug users (IDUs)
- TB is 1.5/10 000 in the general population, unknown among IDUs
- Hepatitis is 5-7% in the general population, cca 10% in the IDUs, VHC cca 0,5% in the general population, 35% in IDUs, estimating that one in 3 intravenously drug user is infected with Hep C.

(Source: Reitox Czech Republic, 2002)

In all prisons in the Czech Republic, health care is covered by the Prison Service's own staff (medical doctors, nurses and specialists) and thus falls under the Ministry of Justice's umbrella. Services that are not available in prison are contracted out to specialised or general hospital units. Health insurance covers preventative care and medication. Therefore, according to the Czech law 169/1999 on the Execution of Penalty of Imprisonment, prisoners have the right to insurance.

1.2 Substitution treatment

Data comes from an on-going review of research reports, websites and laws/regulations of the Czech Republic, as well as from interviews conducted during the field visit⁵.

5 Interviews conducted at the national level with:

- Head of the department for special treatment with prisoners, Prison Administration Service, Ministry of Justice.
- An officer from the Prison Administration Service, the person in charge of social workers for juveniles and adults and the link with the Probation in all prisons in the Czech Republic.
- The Director and Head of the Probation and Mediation Services, Ministry of Justice.
- A psychiatrist, the prison hospital located in Prague.
- A psychiatrist M.D., Academia Medica Pragensis.
- A pedagogue and therapist, Pudane Ruce (NGO), Brno.
- A psychologist and psycho-therapeutic trainer, Pudane Ruce (NGO).
- A social worker, SANANIM (NGO).
- The Executive Director, SANANIM (NGO) and chairman of A.N.O. (umbrella association for NGOs).
- A social worker, LAXUS (NGO).

1.2.1 Historical and legal background

The Ministry of Health sets the rules for substitution treatment in the community.

Since the 1970s, Diolan® (containing ethylmorphine) and Temgesic® (that is low dosage of buprenorphine) were the two mostly used substitution substances. In 1992, methadone was introduced following the initiative of Dr. Jiri Presl (Head Physician of a drop-in centre) for the most problematic patients who had been unsuccessful with other types of treatment. Although Dr. Presl was authorised by the Ministry of Health of the Czech and Slovak Federal Republic to provide substitution treatment as a one-year pilot, the programme was not renewed. In 1997, following an increase in heroin use and public pressure, a second pilot programme – offering methadone to 20 patients – was carried out under the supervision of the Ministry of Health in the Department of Addiction Treatment of 1st Medical Faculty. On the back of a positive evaluation (results indicated better mental and physical health, as well as a reduction of recidivism), this programme was kept open and new treatment programmes were progressively opened all through the country. Indeed, the Criminal Code changed in April 1998. At the same time, the House of Representatives adopted a complimentary resolution – focusing on the treatment component of the drug policy – which resulted in an increase in treatment capacity. In 1999, the Ministry of Health set up a working group that presented ‘*Substitution Treatment Standards*’, an educational program for health professionals, and a ‘*Substitution Treatment Register*’. In May 2000, 7 new substitution programmes were opened in new areas of the country. Through substitution treatment, health professionals have managed to attract Romany opiate users. Waiting lists or geographical differences in the number of treatments offered are problematic for users who wish to engage into treatment (Reitox Czech Republic, 2002).

At the beginning of 2001, the National Institute of Drug Control (SÚKL) registered buprenorphine (Subutex®) as a medicine in the Czech legislation. Unlike methadone, doctors have no obligation to report buprenorphine use to the register. Buprenorphine is not paid by health insurance and must therefore be fully paid by the patient. (Reitox Czech Republic, 2002) Since 1 September 2003 buprenorphine was moved from “free” prescription to opiate prescription, meaning that ‘any doctor’, with or without specialisation, is allowed to prescribe it. However, the doctor must fulfil some ‘guidelines’ for the manipulation, such as keeping the medicine in a safe box,

making precise registration, etc. The idea behind these guidelines was to minimise the risks of substances on the black market and false prescriptions.

In 2002, 463 patients were treated in 9 substitution programmes: 105 of them were in treatment for the first time in their lives. Within the same year, 213 completed their treatment. In 2001, it was estimated that 40% of drug users (about 17 000 people) came in contact with treatment services (Reitox Czech Republic, 2002) with an increase to 59% in 2002 (Reitox Czech Republic, 2003). An NGO reported that the University Hospital has a capacity for 20 substitution patients but, maybe due to the low prevalence of heroin use, is not full at present. However, the low number of heroin users in treatment is partly due to the limited availability of substitution treatment in the Czech Republic. Indeed, in 2002 professional reported that the number of opiate users in a substitution treatment was, and remains, inadequate. With approximately 1 000 people on substitution treatment, only 7% of opiate users are being reached. Across the European Union, the average treatment level is 30% (Reitox Czech Republic, 2003).

It was reported that, since buprenorphine is available, there has been an increase in the prescription of buprenorphine in outpatient clinics of psychiatrists and general practitioners. (Executive Director, NGO). The government provides financial support to non-profit, NGO centres that provide the substitution treatment. 22 centres reported providing buprenorphine. However, GPs outside these centres also prescribe (Psychiatrist, Academia Medica Progensis).

In 2001, 167 drug-related deaths were identified, of which 39 were due to Rohypnol®, 30 with opiates, 27 with benzodiazepines other than Rohypnol® and 3 with methadone and other drugs (Reitox Czech Republic, 2002).

1.2.2 Substitution treatment in prison

Prisons have focused on abstinence-oriented programmes for drug users and do not offer substitution treatment. It was reported that the prison offers a different environment than in the community, where conditions for abstinence can be arranged (prison staff). Drug users and substitution treatment tend to be seen negatively by prison staff who are not in favour of such treatment (NGOs).

Nevertheless, the prison administration reported that the provision of substitution treatment in prison was currently being discussed. NGOs concurred

that it was being debated very carefully but added that, due to the prison management's reluctance, it was not part of broader discussions.

Further to the initiative of a psychiatrist working at the Prison Hospital in Prague, prisoners (Czech, foreigners, on remand or sentenced, female or male) may get substitution treatment on a short-term, detoxification basis with buprenorphine. The psychiatrist reported that prisoners often say that the only time they have abstained from drugs was whilst in prison. Therefore, the use of substitution as a maintenance treatment seems inappropriate at the moment (which does not mean that the situation may not change). Personally, she is not in favour of methadone.

Buprenorphine is provided in the medical centre by skilled medical staff. Prisoners must take the pill (sub-lingual) in front of the staff and remain there until the pill has melted. The dose decreases (every day or every other day), usually starting at 4mg and ending at 0.4mg. The detoxification usually covers a period of up to 10 days, although it may vary according to the doctor's decision. On weekends, the hospital staff go to the cells to deliver buprenorphine. It was reported that, from June to September 2003, 40 patients have received buprenorphine in the prison hospital.

The doctor stated she was satisfied with the treatment but was not in favour of methadone treatment as it was seen as more risky for overdoses. Staff are pleased with prisoners being quieter and more manageable. Prior to the provision of the treatment, meetings were organised to decide on the most suitable and secure way to provide buprenorphine.

Financial support for buprenorphine treatment has come from the Prison Service Headquarters. The medication is collected at a general pharmacy in the community.

The doctor stated that obstacles to implementing and developing the provision of this treatment are due to beliefs and prejudices from colleagues and prison administration.

1.2.3 Psychosocial support and staff training

Buprenorphine, widely available in the country, is prescribed by GPs but, as it is not linked to any specific programme, there is no follow-up. Many GPs do not follow the guidelines, e.g. double prescription, or provide no reports (Psychiatrist, Academia Medica Progensis).

Information on complimentary psycho-social support in prison is lacking due to the fact that substitution treatment is only offered on detoxification basis. All prison staff are trained (induction and on-going) by the Institute of Education of the Prison Service. No specific training on substitution treatment was mentioned.

1.3 Prison Population

Table 5 Data on the prison situation in the Czech Republic (Source: King's College London, International Centre for Prison Studies, Prison Brief for the Czech Republic)

Country	CZECH REPUBLIC
Ministry responsible	Ministry of Justice
Prison administration	Prison Service of the Czech Republic
Contact address	Soudni 1672/1a, P.O. Box 3, CZ-14067 PRAGUE 4, Czech Republic
Telephone / fax / website	tel: +42 02 6103 4405 fax: +42 02 4140 9072 url: www.vscr.cz
Head of prison administration	Kamila Meclova, Director General
Prison population total (including pre-trial detainees / remand prisoners)	17 429 at 16.1.2004 (national prison administration website)
Prison population rate (per 100,000 of national population)	171 (based on an estimated national population of 10.20 million at January 2004 from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	19.6% (16.1.2004)
Female prisoners (percentage of prison population)	4.2% (16.1.2004)
Juveniles / minors / young prisoners, incl. Definition (percentage of prison population)	1.2% (31.10.2003 – under 18)
Foreign prisoners (percentage of prison population)	9.9% (31.12.2003)
Number of establishments / institutions	35 (2003)

Official capacity of prison system	17 634 (1.9.2002 – Council of Europe Annual Penal Statistics)		
Occupancy level (based on official capacity)	95.6% (1.9.2002)		
Recent prison population trend (year, prison population total, prison population rate)	1992	12 730	(123)
	1995	18 753	(181)
	1998	21 560	(209)
	2001	21 538	(210)

2 The field visits⁶

Time frame. The field visit took place from 8 to 15 September 2003.

Location. Visits were conducted in two prisons: Opava prison and Pribram Prison.



6 Methodology: Interviews were conducted with the individuals and focus groups listed below (tape-recorded with consent) and with the prisoners. The researcher conducted all interviews and focus groups accompanied by a freelance and neutral interpreter in both prisons. All participants were briefed and told about ethical issues.

2.1 Opava Prison⁷

2.1.1 Description of the prison

Opava prison is located in Opava city (see map above). The prison consists of 2 buildings: one was formerly part of the Justice Palace and the other belonged to the army. The first building of the prison was founded in 1888 and the second part in the mid-1940s.

At the time of the visit, Opava prison held 365 prisoners with a capacity for 399, of all security types. The prison is intended for juveniles (capacity of 65), women (capacity of 91), and men (capacity of 190). 34 prisoners were on remand and the others sentenced.

The prison has approximately 307 members of staff of which 187 are prison guards. There is a shortage of doctors and lawyers.

Since 1999, the prison has had a *Specialised Drug Treatment Unit* (capacity of 26) for women with alcohol, drug and game dependence. These women have either volunteered to do the treatment or are on a Court Order. Prisoners on this unit reported that they wanted to abstain from using drugs and that they found the treatment unit very good and supportive. *'I'm quite happy with the quality of the therapy. I'm really happy that we have a separate therapist for ourselves we can talk to normally, who's easy to talk to and who tries really hard to help us in what we are doing'*

2.1.2 Goals and practical procedures

No substitution treatment is offered in this prison. It was reported that substitution treatment is not favoured as it is seen as a continuation of addiction. The staff reported that information from the press states that addiction lasts longer with substitution treatment and that it takes longer for prisoners to be sentenced. Substitution treatment is thus seen as unsuitable for prisoners. It

7 Data from interviews conducted with:

- The Governor.
- A pedagogue, psychologist and the head of the department in the juveniles area
- The doctor (GP).
- The psychotherapist in the Specialised Drug Treatment Unit.
- A psychologist and pedagogue in the Specialised Drug Treatment Unit.
- The Security Guard and the sub-chief.

was reported that it is rare to see women going through withdrawal in prison as they usually have already gone through detoxification.

However, it was reported that prison staff tend to lack expertise on drugs, their effects and withdrawals. Prisoners fear asking for further support on drug related issues and withdrawals as they are scared of being trapped in the care-security ‘battle’, becoming an item for security rather than for care. Some prisoners continue using drugs while in prison, managing withdrawals ‘thanks to’ illegal drugs. Prisoners are extremely reluctant to admit to any drug use or withdrawals due to the lack of standard procedures for legal support (Chief Executive, NGO).

It was stated that the prison management is thinking about setting up a substitution treatment centre for prisoners who were on substitution treatment in the community, prior to incarceration, but this is only an idea.

2.2 Pribram Prison⁸

2.2.1 *Description of the prison*

Pribram Prison is located about 30 minutes drive from Prague (see map above). The prison is surrounded by closed uranium mines. Formerly, the prison was a labour camp, built in 1953 for convicts who worked in the mines.

The prison employs approximately 300, staff of which 159 are prison guards. Pribram prison is a male prison, holding 596 prisoners with a capacity for 684 of all security types (A, B, C and D), with a majority of high security prisoners.

The *Specialised Drug Treatment Unit*, created in October 2002, has a team of 12 staff and a capacity for 32 men (there were 21 prisoners at the time of the study), who have volunteered to do the treatment. None are on a Court Order. Treatment focuses on psycho-social interventions. Prisoners tend to

8 Data coming from interviews were those conducted with:

- The Governor, the first deputy and an officer in charge.
- The team at the Specialised Unit, i.e. social worker, pedagogue, therapist, education-therapist, educator, psychologist and the head of the whole department (who is psychologist).
- The Head of nurses.
- The Head of guards.

stay in the unit for 6 to 12 months and are then transferred to the Drugs Free Unit, where the length of stay is unlimited and where the focus is on activities (education, workshops, work).

'It would be good to know the beginnings, what triggers the drug use, that's the basis, something to start with. Then the other thing that would be nice to talk about is, what is ahead of me, getting some feedback on the progress I'm making, because right now at the moment there's no feedback, and I would like to know what the progress is. Also I would like to know what I'm going to do after release, how to manage the situation once out of prison.' (Prisoner)

2.2.2 Goals and practical procedures

No substitution treatment is offered in this prison.

It was reported that the prison philosophy is abstinence, which is successful because of its isolation from the community. Moreover, prisoners come from a remand prison and have thus already gone through withdrawal.

An officer stated that providing substitution treatment is seen as an easy way to *'keep prisoners on drugs and make them calmer'*. However, he claimed that pressure is felt to introduce substitution treatment in prison. He said that whilst he is not in favour of substitution treatment for non-heavy drug users, he is for heavy drug users. He reported that methadone was portrayed as a good thing and should be introduced. He said that the information provided on drug use in prisons was false; as a result all arguments lost credibility.

2.3 Views of Prisoners

Three focus groups were conducted with:

- One group of 8 juveniles prisoners, aged 16 to 22
- One group of 6 women, aged 22 to 27, in the Specialised Drug Treatment Unit
- One group of 8 male prisoners, aged 22 to 26. 6 came from the Specialised Drug Treatment Unit and 2 from the Drugs Free Unit.

Prisoners who took part in the research started using drugs at ages between 14 to 16 and reported having used pervitin and heroin by injection, mari-

juana, LSD, and various legal pills. Juveniles have mainly used marijuana and glue, but sometimes LSD and mushrooms as well.

Prisoners confirmed the absence of substitution treatment in prison.

'Here in prison it's almost out of the question. You don't get any treatment for withdrawals, the doctors know that you can't die so they just let you crawl on the floor. Outside it's different, because you get treated in a different way, you get some substitution.'

However, some prisoners had experienced buprenorphine or methadone before incarceration, sometimes through a doctor, sometimes on the black market.

'I used to take methadone and while I was on methadone I was not doing heroine, at the beginning I was not doing any other drug, but then gradually I started taking pervitin and some other drugs that I was combining it with and I stopped the methadone because I got into jail.'

'Subutex® is basically a substitution for when there is no heroine available, so with heroine you take it and you have euphoria and with Subutex® you take it, but you don't have the pain and you don't feel sick.'

Prisoners reported going through withdrawal when arrested. Some received buprenorphine whilst at the hospital, guarded by the police.

'(Buprenorphine) lasted for 3 days. First, I started out with a dose of four, then gradually went down to one. It helped because alone I wouldn't have been able to go through it. The detox was bearable, the length was ok. I still had pains afterwards, but it was not as bad as if I was going through it without medication. They [the medical team] don't give methadone because that's a long-term treatment, so they substitute that with buprenorphine.'

Several prisoners reported going through withdrawal with no substitution treatment, especially with high levels of pervitin in their blood. Withdrawing from pervitin, they stated, was sometimes not painful.

'I was taken to a hospital in Prague, but I had too much pervitin in my system, and they [medical team] wouldn't accept me so I was then left alone ... then the next day I was taken to a doctor who gave me some pills, but I don't remember, I felt really sick, I was screaming, throwing up, I don't recollect all that much from that period. (...) I couldn't sleep for over a month.'

'I didn't go through detox [with medication] because I was on detox many times before and finally they [medical team] didn't accept me, so I was going through withdrawal on remand without any pills. Going through detox

without pills is not as long as going through detox with pills, it went much faster. Although I had reverse sleeping order for about a month, the detox itself was not that long. I was in great pain and it was very unpleasant but it didn't last long. I don't have the experience with heroin where you cannot sleep, but I had problems with pervitin, and withdrawal from pervitin is the opposite of heroin. You sleep a lot and you tend to eat a lot.' [Pervitin] is a mental, psychological addiction. So the withdrawal is different. There's a chance that you may have a psychosis and for that you need a doctor around. But that depends on the person. I have taken pervitin quite heavily for the past 7 years, being on it, every single day, taking a few doses a day, and for me all I needed was just to sleep it through and eat a lot. I was OK, but there are cases of people who take the drug only for 2 years and they just go crazy, when they go through withdrawal.'

Prisoners reported that buprenorphine is prescribed more than methadone and is perceived as more appropriate for fast detoxification:

'In Prague it is very common that doctors prescribe Subutex®. Methadone is really long term, I needed to get clean very quick because I was going to jail, so I wanted to take Subutex®. Doctors prescribe Subutex® because it's faster. Methadone is a long term treatment and it's basically going from one addiction to another. So if you want to become clean, there's no reason to take methadone.'

Prisoners who had received buprenorphine, stated they were satisfied with the treatment:

'(...) Subutex®, it's the best of all the medications because it's really quick, it takes you from the opium-based drugs to taking nothing very quickly and you feel a minimum of the withdrawal effect. It's a really good drug, very efficient.'

Prison administration and staff frequently stated that drugs do not circulate widely and are not problematic in prison. However, some prisoners disagreed:

'There is so much stuff today. You can buy it anywhere. You can buy drugs anywhere today. You just go out behind the gate here at the prison and somebody is offering you something. It's not so common in prison but you can smuggle an elephant into the prison. When you get something, double the price.'

Prisoners stated that substitution treatment should be offered to help them go through withdrawal for a period set according to individual needs. They also

claimed that substitution treatment should then be linked to support services such as therapy and psycho-social work.

3 Summing up

Throughout the Czech Republic, the provision of substitution treatment is inadequate and its provision ad hoc in terms of quantity, quality and geographical coverage. The demand from drug users tends to be low: this is partly due to the fact that the main illicit drug used is Pervitin (stimulant type), partly due to the lack of treatment on offer and partly due to the fear of being labelled as a drug user since makes prisoners' lives more difficult.

Only buprenorphine is offered, on a short-term detoxification basis at the Prison Hospital, to prisoners going through withdrawal due to opiate use. Although the doctor in charge of such 'treatment' is satisfied, the number of individuals benefiting from such care is extremely limited. Moreover, the lack of treatment options may neglect the needs of certain prisoners as individuals respond differently to methadone and to buprenorphine.

In the case of pervitin users, some prisoners have had no or little physical withdrawal effects whereas some heroin users experienced intense 'cold turkey'. Nevertheless, the health needs of opiate users should not be left in the shadow of pervitin users (who outnumber the opiate users) whose needs are different.

Drug treatment in prison focuses on psycho-social interventions. At best, prisoners are offered the chance to go through a Drugs Free Unit or Specialised Drug Treatment Unit. The intervention programmes tend to focus on activities (workshops, education, sports), resulting in the need for information and active personal work, on the effects of drugs on mental and physical health, as well as in-depth therapy (going back as far as the source of the use of drugs).

As drug use in prison (and the community) is heterogeneous and varies greatly from one place to the other. Quality monitoring of drug use in prison would be useful to acquire a better knowledge and understanding of the drug use in prison and prisoners' needs.

With further involvement from NGOs in prisons, greater expertise and support to prisoners and prison staff could be provided, enabling prisons to respond to their needs. Cooperation with experts and expert groups from the

community may play a key role in the prison setting, increasing satisfaction, well-being and motivation of both prisoners and professionals. In this way, improved understanding, management and treatment of drug issues could be acquired.

Denmark¹

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users

According to Christensen (2003), the number of heavy intravenous drug users in Denmark is estimated to be 14 000² (an average from the range of 12 752-15 248), corresponding to 0.26% of the population³. This estimate was confirmed by a capture/recapture analysis in Copenhagen where two registers, the National Board of Health register from 1996 onwards and the hospital based National Health Care Register, were combined with the Ministry of Justice register of drug related crime.⁴

According to Christensen (2003), the prevalence of drug users in all Danish prisons is calculated once a year. Drug users are defined as those who have taken any illegal drugs (including hashish) more than a few times within the half a year before admission. In 2000, 38% (1316 inmates; 37% among male prisoners, 52% of female prisoners) were drug users, a figure that has been rising from 22% in 1980 to 27% in 1990. The number of “hard drug users”, defined by the habitual use of drugs other than hashish, was 689 (20% of all prisoners, a figure that has risen from 10% in 1991). Retzmann (2003) reports figures, from a study on alcohol and drug use among clients of penal institutions and resocialisation services, that 56% of all the clients of those services were drug dependent (14% opioid dependence). 50% of all inmates were drug users prior to their incarceration (alcohol and illegal drugs).

1 The field visit in Denmark (16-19 June 2003), conducted by Heino Stöver, was facilitated by Alette Reventlow, Ministry of Justice of Denmark, who also provided national-general information and support with the finalisation of this country report.

2 Approximately half of them situated in the area of Copenhagen.

3 According to the National Board of Health, (Drug situation in Denmark 2003), the number of “heavy” drug users is estimated to 25 000, including 6 000 users of cannabis. The number of opioid addicts is thus estimated to about 19 000, corresponding to 0.35% of the population.

4 See also EMCDDA statistics “Estimated number of problem drug users in EU-Member States 1995-2001”, www.emcdda.int.org (20.6.03).

The mean age of drug users has risen slowly from 29 years in 1991 to 31 years in 1999. 25% of drug users were injecting drugs (IDUs) compared to 8,8% of all prisoners. According to the Department of Prisons and Probation, the figures of drug use should only be considered as estimates, due to the methodology used to collect the data.

1.2 Substitution treatment

1.2.1 Historical and legal background

The national focal point published information that in 1999, 4 398 drug users had been in substitution programmes (4 298 in methadone-based and 10 in buprenorphine-based programmes). This accounts for a coverage rate of 27-34% of all estimated drug users (12 752-15 248). The only indication for substitution treatment is dependency on opioids (Opiate Dependence-ICD-10, Kramp et al. 2003, P. 139). Methadone maintenance treatment is supposed to be a key strategy for risk reduction for Danish intravenous drug users. In a regulation released in 1995⁵, substitution treatment was been centralised at county level by local authorities (13 local communities exist in Denmark).

“Before this date, all general practitioners were allowed to prescribe methadone for drug-misuse treatments. But then there was a lot of political rumour about this area. It was recognized that quite a lot of drug misusers were found dead on streets. And it was believed – not really proved – that it was due to a fairly liberal prescription of methadone to too many people. And so the right wing party in parliament decided that should be regulated. And the doctors, all of us who were engaged in this problem, we were happy that it was put down in the law that, when you treat drug misusers by substitution, it should be part of a social treatment too. So it was taken away from the GPs and put into those local ‘amt-clinics’ (local communities). The doctors that are employed by the ‘amt’ are not practising doctors, they are employed in the local area just to do this job, to do the medical part of the social treatment for the drug misuser. It was a good law and we are happy that it’s put down.” (A doctor)

The treatment is carried out in special drug treatment clinics which provide a multi-sectoral treatment, with medical and psycho-social parts. Medical

5 Legislation on Methadone Treatment, ‘Lov om sygehøvsvesenet’.

doctors outside these facilities are not allowed to prescribe substitution drugs.

“Part of the philosophy is that the treatment of drug misusers is a multi-sectoral treatment.

The main part is social, the medical part is only a minor one and is only something to keep individuals in the position of having social treatments. And the social treatment is the job and responsibility of the social worker”
(A doctor)

According to Christensen (2003), the number of clients treated with methadone for more than five months a year increased from 3 376 in 1996 to 4 498 in 1999 and to 5 077 in 2003 (National Board of Health), corresponding to 25% of the estimated population of heavy drug users. This increase was due both to an increased treatment capacity and an increase in the number of drug users. Besides methadone treatment, pilot studies with buprenorphine were initiated in 1998 and have been positively evaluated.

1.2.2 Substitution treatment in prisons

Prisoners can apply for placement in drug free units and can receive detoxification treatment. The drug free units are segregated from the rest of the prison and, to enter, the prisoners have to sign a contract to remain drug free, to have regular urine tests and to cooperate with prison personnel. In exchange, the prisoners have better conditions for leave and other advantages.

Methadone maintenance treatment is generally available in all prisons and is continued when initiated before admission to prison. If a drug user has been integrated in a substitution programme in the community (the clinics) his dosage will be continued without problem. The principle of equivalence of health care standards and services is well known and guideline for policy and practice.

“So, when someone comes in we ask the prisoner: may we contact your clinic? And they are very happy that we contact because then they are sure that their methadone treatment is continued. We ask the clinic: ‘when did this person have its last dose, was it given under supervision, or was it a home arrangement and when was the man last in the clinic and what is your opinion of having this man back when he comes out of prison’. And I’d say that nearly all clinics in Denmark say: ‘when he comes back we take him again’. There are some areas in Denmark where there are some problems.

When they go into prison, get sentenced, they say: 'now he is in the legal system, it's not part of our business, so when he comes back they have to apply to have that man back'. And we do apply. But we tell them: 'according to the law of 1st of January 1996 you have to take him, there is nobody else who is allowed to take this man in methadone treatments. He should be in a local clinic in that amts (local community – the authors) area.'

If somebody is not known to the county clinics and shows symptoms of craving anyway, the patient will be treated and if he serves a short term sentence he will receive his/her substitution drug. According to the medical doctor interviewed, substitution prescriptions are done on an individual basis, the dosage received in the community treatment programme are taken as a basis. There is no time limit for the duration of the substitution programme.

In 1998, 232 persons (6.5% of all prisoners) were in methadone treatment in prisons. In 2003, at the time of the visit, there were approximately 300. Since then, the number has risen considerably. Since the beginning of 2004, the Department of Prison and Probation has reported once a month to the National Board of Health with the number of inmates who have been in substitution treatment during that particular month. As of May 2004, about 500 inmates were in substitution treatment. The figures are supposed to be reliable.

1.3 Prison Population

Table 6 Data on the prison situation in Denmark (Source: King's College London, International Centre for Prison Studies, Prison Brief for Denmark)

Country	DENMARK
Ministry responsible	Ministry of Justice
Prison administration	Department of Prisons and Probation
Contact address	Strandgade 100, DK-1401 COPENHAGEN K, Denmark
Telephone / fax / website	tel: +45 32 68 4000 fax: +45 32 68 4050 url: www.kriminalforsorgen.dk/info/krim_uk/index.html
Head of prison administration (and title)	William Rentzmann Director General
Prison population total (including pre-trial detainees / remand prisoners)	3,908 at 25.11.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	72 based on an estimated national population of 5.4 million at November 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	29.3% 1.9.2003 - including convicted but unsentenced)
Female prisoners (percentage of prison population)	4.7% (1.9.2002)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.3% (1.9.2002 - under 18)
Foreign prisoners (percentage of prison population)	16.3% (1.9.2002)
Number of establishments / institutions	56 (2000)
Official capacity of prison system	3,893 (25.11.2003)
Occupancy level (based on official capacity)	100.4% (25.11.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 3,406 (66) 1995 3,438 (66) 1998 3,413 (64) 2001 3,150 (59)

2 The field visits

The field visit in Denmark (16-19 June 2003), conducted by Heino Stöver, was facilitated by Alette Reventlow, Ministry of Justice of Denmark, senior advisor, who also provided national and general information and support with the finalisation of this country report. Two prisons were visited: the main one in Copenhagen (Vaestre Faengsel) and the state prison of Vridsløselille (out of the centre of Copenhagen).

In both prisons I talked to nurses, focus groups and social workers and probation officers. In addition, I held a meeting with Dr. Knud Christensen, chief medical doctor of the prisons of Copenhagen, and Peter Ege, medical doctor and head of the Drug Addiction Service in the city of Copenhagen. Finally, there was a meeting with Dr. Christian Hvidt (Specialinstitutionen Forchammersvej) from an institution of problematic drug users, mostly with methadone infectious diseases.

Prisons



2.1 Vaestre Faengsel

2.1.1 *Description of the prison*

Vaestre Faengsel is part of the Copenhagen prisons, and is the largest local prison of the Prison and Probation Service, with a total capacity of 530 inmates. The Copenhagen prisons function mainly as local prison for the metropolitan Copenhagen area and consist of two prisons located in the centre.

Vaestre Faengsel was erected in 1895 and considerably enlarged in 1918. The prison is a cross-shaped, panoptic cell prison of four storeys and has a capacity of 439 inmates. It contains a hospital with 36 beds, and a women's unit with space for 30 inmates (Ministry of Justice 1998).

2.1.2 *Goals and practical procedures of substitution treatment*

Substitution treatment has a long history in Danish prisons and has been seen as helpful to the reintegration process.. Consequently, from the very beginning, substitution treatment in prisons has been designed as through care and continuous prescription (see Schuller & Stöver, 1988).

In Vaestre Faengsel, methadone has already been prescribed since the 80s. Dr. Stuij, the chief medical doctor was already prescribing methadone in 1988 on three levels:

- Detoxification
- Bridging treatment (sentence not longer than 12 months)
- Methadone maintenance prescription (individual dosage)

The Council on Alcohol and Narcotics (Alkohol- og Narkotikarådet) recommended substitution treatment in its Methadone Guidelines, 1988, for persons imprisoned no longer than 12 months (see Metadonretningslinier, Alkohol- og Narkotikarådet, 1988)

The dosages given in the community treatment centres serve as a basis for the decision about dosages in prisons:

“When we (the doctors, the nurses, the social-workers) have good contact to the drug misuser then you speak to the man as a man, not as a convict. And when you give the man the impression: ‘I’d like to hear how you do feel about the dose of methadone or Subutex® is that ok to you?’ And when he says ‘No, I still feel I have some problems, then we increase a bit, then we go

from 80 to 90 or to 100 mg. Then we let a fortnight go and then we talk again.

Sometimes even they come to us: 'I have a bit too much.' Then there are some other drug misusers who only wish to have so much methadone that they are sleeping all the time, then we have to decide, he will not go further than 140, 150 mg.

Even if he still has some problems at that dose, we'll not exceed the dose. In some clinics they have gone up for 200 mg, for 300 mg. When they come into this business then I'm telling them that beyond 150/160 that's cosmetic. The prison doctors decide where to put the level. We have the patients and we decide where to end up. That's our responsibility. If the social worker is telling us: you better go a bit up because he is telling me that he is not doing well. We listen to him, we listen to the guards and we talk to the man 'should we go up? And he is happy.' So we try at least – some social workers will say that I am painting too nice a picture of our doings some guards will tell the same, – and some social workers will say: doctors are very tough, it's impossible to speak with them – but we try to have some kind of multi decisional treatment."

Although, in Denmark, a through prescription of substitution treatment is done in those cases where inmates are know to a community-based treatment clinic, the goal of drug treatment in general is for patients to become drug free. As a chief probation officer said:

"And when we agree and the social workers and the doctors agree then the person gets methadone. But of course it is the goal that people are drug-free. Some of the prisoners are not very motivated, maybe they are drug-addicts for many years and maybe it's not up for them right now to start to be drug-free, but its our goal. And it is the social worker's goal though. Try to get treatment."

If an inmate has to be referred to another prison, they are given an accompanying letter:

"So if he is here we continue with methadone; and if he gets a sentence about 4 months then he will leave this remand house and go for a state prison outside. Then, the doctors from there will have the papers from this place, the prisoners has to accept that we send it to the doctor. And if he does accept us sending the papers to the other doctor then we won't give it to

the other doctor. But normally they agree. Sometimes they think: with the next doctor we can have a higher dose – so they do not allow us.” (A doctor)

Generally, an oral or written permission (which has to be signed by the inmate), is necessary when information is handed from one doctor or clinic to another:

“An allowance given by an inmate – patient to doctor – is good enough. Of course, the doctor has to write a paper: ‘the patient has given permission to me to contact the clinic.’ This should be written before he phones to the clinic. We haven’t been accused yet that we do not use written permission. But in some cases the clinics are asking for written permission and then we fax one to the clinic. We have formula where the man is putting his name underneath and we send it to the clinic.” (A doctor)

In Vaestre Faengsel, approximately one fourth of the prison population are supposed to be opiate users (approximately 120 out of 530). 70-80% of the inmates are drug users. The number of inmates in substitution treatment has risen considerably, from 10-15 patients in 1991, to 103 inmates in June 2003.

At the time of the visit, urinalyses had not been carried out on a large scale. Cannabis is not seen as a reason to stop substitution treatment. The policy is to talk to inmates and to observe them. Since 1st July 2004, mandatory urine testing has been introduced by law⁶. This is part of the Government’s general policy to intensify the fight against drugs in and outside prison.

The chief medical doctor applies a restricted prescribing policy with regard to benzodiazepines. He refused to prescribe substances of that category; now a common practice among physicians outside prison.

The probation service and the social worker involved have to organize the continuation of the treatment at time of admission to the prison and at time of release after his or her sentence: *“Because we can’t give methadone here if people don’t get it when they get out.”*

Apart from the continuation of substitution treatments, inmates can also start such a treatment whilst in prison:

“We have the possibility to start a substitution treatment. If someone comes in and takes heroin, they get normally 16 days, then they can talk to the social worker and then they can come with a plan to start a treatment of sub-

6 lov om ændring af lov om euforiserende stoffer og straffuldbyrdsloven.

stitution. And we have many prisoners who can start this here. Then we write to the centre outside. Having left, they go to the centre and can continue. The nurses talk to the people who come in and I tell them about the possibility of treatment in the jail. It depends how long they have to stay here, and maybe, if they are interested, they can start after one or two days.” (A doctor)

For the staff, substitution treatment is seen as a normal treatment and the benefit, in terms of better conditions for the prison management, is seen widely.

“I don’t think it’s very controversial because, here in Vaestre Faengsel, they were used to people getting methadone because a lot of prisoners get methadone. So, I think it’s very common to the staff. In some respects, it’s a good thing because it is less problematic with the prisoners, less violence, less problems.” (A probation officer)

The medical and the social part of the substitution treatment take confidentiality as an important point in the treatment process; it is not clear to the staff who is getting substitution drugs or not:

“... actually it’s a little bit strange. They make a secret of who is on methadone. The social workers don’t know if the person in trouble is on methadone ... They are very strict about confidentiality ... Sometimes it gives problems because the social workers don’t know what’s going on – but that’s the way it is and we have to respect that.” (A probation officer)

Prisoners on home leave are given a dosage for two days and, after release, the prescription is continued by the community clinic. A positive urine test, either before or after the leave, will lead to a ban on home leave for up to ten weeks.

In selected cases, there are financial reasons to prescribe buprenorphine only:

“The reason why Subutex® is not used is that it costs ten times as much as methadone. ... If someone wants to get out of drugs, out of methadone, out of substitution then we can give Subutex® in selected cases. And if inmates come from outside and tell us: we had Subutex® in this clinic then we say ok, we continue with Subutex®. We have a fund for medicine of about 1 million

DK's; out of this we pay about 4-500 000 DK on methadone⁷. And if al that l should be converted to Subutex® ... so we try to be in between.” (A nurse)

The central role of the nurse within substitution treatment is pointed out by the staff. They see the inmates on a day-to-day-basis:

“The nurses know the patients, they go around with the doctors. Those the nurses who have been here for several years, not the new nurses. The doctors have to prescribe the drugs, the doctors go to the nurses and ask for information on the patient.” (A doctor)

Substitution treatment in the community is seen as an appropriate and necessary treatment for drug users, and its success has been proven in the past:

“... they get very restless in the jail and people cut themselves and eat some glass and things from the radio and from the bed to get out of the cells. That we do not have any more. That is what is better now and that there is some opportunity for treatment in the jail.” (A nurse)

In Vaestre Faengsel, and in other Danish prisons, “KRIS Denmark” is an NGO offering active support for inmates. This organization is paid by the government and works in most of the prisons in the area of Copenhagen. The association consists of ex-prisoners and ex-addicts and their basic approach is peer support. For them, it is important to look at who is bringing the message across. And it’s different and more convincing when it comes from one of the peer group:

“We try to focus on the individual. Usually we can look to the addicts, talk, whatever, get some connection, and we can say some pretty clear things to them, because we are former criminals they will accept it, they won’t accept it from others.” (An NGO staff member)

The chief probation officer, responsible for the whole drug treatment facilities, agreed:

“It’s important to work with former criminals and drug-addicts because they may get the best connections with some of our prisoners, because it earns a lot of respect among the prisoners to meet someone who actually got out of the drug-addiction and out of criminal behaviour ... It’s something quite new

7 This seems to be a bit exaggerated; Vestre Fængsel is paid 823.314 kr for medicine. As methadone is cheap, it seems unlikely that 50% of their budget is used for this kind of medicine.

to work with former criminals ... They come here and have motivation groups and talk to the prisoners three times a week and a lot of the prisoners who did not have motivation group go ... So we are very happy about this cooperation, we hope to have the people from ... five times a week.” (A probation officer)

The representative of Kris Denmark explained the benefit of employing former addicts and criminals in prison work. The policy approach of KRIS Denmark is drug free oriented:

“They are all drug free orientated. We have connection with different treatment centres in Denmark ... we can always get them a place if they want, but it’s our experience that those who want to be drug-free – that it’s not that big a deal getting out of drugs ... The problem is that you eventually start again.” (NGO staff member)

Substitution treatment is only regarded as useful in the form of detoxification:

“... There is a lot of methadone in the prisons, that’s the problem. It’s harder to get out of methadone than to get out of heroin...[Methadone is given out] much too easily. Anything more than 14 ml is pure nonsense. Lots of people get 18 ml, ... 14 ml is more than enough to keep the ... pattern ... making it much worse than it is ... It’s given out much too lightly, it’s a hard drug ... it seems they should take more care about methadone and do more about keeping drugs out of the prisons.” (NGO staff member)

On the other hand, the representative of KRIS saw the problem of reducing methadone and at, the same time, not being able to successfully reduce the supply:

“When I speak with anyone they always say: ‘I’m taking methadone so that I don’t get in trouble. On the other side: if the prison takes away the methadone that will bring the people big trouble. They’ll have to buy heroin and that will give big trouble. So you can’t just remove methadone without making sure that Heroin doesn’t come in. That’s difficult.” (NGO staff member)

2.1.3 Views of prisoners

Four prisoners were invited to attend the focus group. Prisoners talked frankly about the substitution treatment they are in. One prisoner complained about the time at which methadone is dispensed:

“... normally, outside, they give liquid and in here they give tablets. I don’t know if it’s the same but normally I have some problems when I go from tablets to liquid. They give it with juice. And if you have a stomach pain or something then it’s cleaner with a tablet. They come in and give you the methadone before you are getting your breakfast.” (Prisoner)

In addition, the lack of confidentiality is criticized, though it is recognised that the identity of substitution treatment patients is hard to hide within the prison setting:

“... when they come with the nurse, they carry all the tablets in a small box. Of course, some other people- who don’t like people who take drug – can see, you cannot hide, so sometimes you get problems, people call you junkies or something like that. For my case I don’t care ... normally you don’t care if there are some other people who take drugs.” (Prisoner)

Prisoners expressed their doubts about whether there was confidentiality in relation to methadone provision:

“I think it’s in all our papers and there is a medicine card in the office of the guards and so the guard can see what one gets. You also have this card inside the rooms in the closet, the doctors is only coming once a week so the guards are giving the medicine in place of the doctor.” (Prisoner)

The prisoners state that there is an important psychological component in relation to the optimal dosage and form of substitution drug:

“They say that tablets stay longer in the body, but sometimes it depends on your mind, if you focus in the morning already: it stays in the body for 24 to 36 hours ... it’s in the mind, you don’t get stoned. It’s only the first week or 14 days when you start getting it ...” (Prisoner)

The prisoners also confirm that they are able to negotiate the dosage with the doctors and, during the continuation of their prescription, the results are communicated with the treatment centres outside:

“... but then they contact your centre, they have to give the same when you come out. Normally it’s no problem for the centre, it’s more a problem here.” (Prisoner)

According to the inmates interviewed, the cooperation with the treatment centres outside is seen as very efficient. But, in the case of benzodiazepine

prescription – prescribed in drug clinics but not by the prison doctor, differences are marked:

“I went in and out four times – it worked. It’s only with methadone like outside. If you got benzos, you don’t get it here. In the clinic they prescribe, but not here. It’s pretty bad. If you are used to a lot of benzos and you come in you can get cold turkey. [Q: Would you like to have access to Benzos?] Yes, of course, if you get it outside every day and don’t get it in here you get a lot of problems. Q: Do you understand the reason why doctors do not prescribe Benzos in here?] They do in the community, in the clinic, but not here ... I think they could do that. I don’t know what the problem is.” (Prisoner)

The prisoners negotiate with nurses about new substitution drugs (e.g. buprenorphine) and, in doing so, discover new treatment options for themselves:

“I talked to the nurses, they can also give us Subutex® in here. Then we have to make a withdrawal ... I go down with methadone, I get sick on it, I get about 8 mg Subutex®, that’s not enough, but 12 mg was enough and they took one away each day and the dose has gone down. I think it was much better because I tried to go down to zero methadone ... I had never heard before that you could get Subutex® when you are on methadone. I wanted to get rid of the methadone and they said to me: ‘yes we can do that.’ That’s new to me. I didn’t think that before, I didn’t think it would work. When you go from methadone to Subutex® you have to go down to four, and I waited for two hours, check my body and then you can take Subutex®. They start with 8 mg. Then they go to 12 and then they take one away every day to zero again. If I had done it the other way I would not sleep for one month.” (Prisoner)

The prisoners in a substitution treatment also face negative views from other inmates:

“... not all of them but, if you take drugs they call us junkies, people like us are nothing. They can try to make it more serious for people who want to be clean from drugs.” (Prisoner)

2.2 Vridsløselille State Prison

2.2.1 *Description of the prison*

The Vridsløselille State Prison was built in 1859 as a cellular confinement prison. The prison is star-shaped with four three-storied wings. Since July 2004, it has become one of 6 closed prisons in Denmark with a capacity of 222 places. The prison admits men over 23 years old from metropolitan Copenhagen, Zealand and Bornholm, who have to be committed to a closed prison (convicted of robbery, drug offences, homicide and other serious assault offences; see Ministry of Justice 1998, p. 70).

2.2.2 *Goals and practical procedures of substitution treatment*

Out of a total population of 240, there are 22 inmates in the substitution programme – 10 receive methadone, twelve receive buprenorphine, the first choice is buprenorphine which, according to the nurses, is supposed to have milder effects. The inmates are given enough of the substitution drug for a few days when they are on home leave.

According to the inmates and nurses, there are some drug addicted inmates who, for various reasons, don't want to get into the substitution programme. One reason is that they want to hide their status as drug users to avoid the negative picture that staff and maybe other inmates might have of them. Another reason is that the community service brought in a drug free oriented treatment programme, 'Kongens 0', which is now used by 30 inmates. *The target group* for the treatment are inmates who are drug addicts and who want to become drug-free and who, after becoming acquainted with the contents of the treatment, sincerely wish to participate in the programme. The inmates come from both the Vridsløselille State Prison and from the other state and local prisons of the Prison and Probation Service. In connection with referral of inmates to the unit, there are, in principle, no restrictions concerning the length of the inmate's residual sentence. It is assumed, though, that the primary target group are inmates who can be released for continued treatment outside the prison after completion of their treatment in the unit. The stay in a treatment unit is on average about 4 months. In some cases, the stay may be longer (Stöver, 2002). The substitution programme has to be seen in the context of enlarged treatment facilities in the prison. It is possible for the inmates in the substitution treatment to move over to the drug free oriented treatment of Kongens 0.

According to the nurse and some inmates, the staff now regard the substitution treatment as very normal. This is due to the long history of that form of treatment and the enhanced education and training of the staff members:

“It has changed in the last 10-15 years. To be a guard in prison needs a long education. 20 years ago, the guards were very exciting about substitution treatment and so on. It changed, now you have paedagogical education ... we also have a lot of women guards ... that also means, you are using more talk, not power, talk, talk, talk ... Addiction is called a disease now. We think in another way when we see drug users now.” (A nurse)

Regarding dosage, nurses recognize a change in that the inmates themselves now try to reduce the dosage.

“... earlier it was as much as possible, today it’s more normal that people come to us and say ‘Can we get down from 100 mg to 80 mg’, its quite common that people come and say I’m trying to get rid of methadone, that’s a change.” (A nurse)

Regarding the correct dosage, the nurses point out that a prison setting with high control measures does not allow a high level of consumption of other drugs and this influences the dosage of methadone. Moreover, the nurse pointed to the importance of integration of the inmate’s wishes:

“Our experience is that it is not necessary to give more than 100 mg; some people say they don’t take anything else ... But they normally admit a maximum of about 60 mg and then they can stop thinking about drugs. But I think you get the best result if you let the patient decide which level is best for them.” (A nurse)

The nurses state that, in the substitution programme, there aren’t that many urine controls. The consumption of cannabis does not have negative effects on the methadone treatment. The nurses claim to see the inmates every day and say they would recognize additional drug use if it were present:

“We had control but we stopped it 3 years ago. We found that the consensus between us and the inmates was very important. If some of the inmates have some problems with side-abuse they will come to us. We don’t need control. From the results of all these urine-tests, very few are positive. So I think they have a very low side-use in prison. ... Earlier, when we took urine-tests, then they didn’t take drugs for the last 4 days or so and you didn’t know how much they use. They take some kind of stuff and they know how to handle it.” (A nurse)

Psycho-social care, connected to the substitution treatment, is not requested by the inmates; they state that it is more for inmates who are in substitution programme for shorter periods but not for inmates in the programme for more than ten years.

2.2.3 Views of prisoners

Two prisoners were able to attend the focus group.

Again, the prisoners stressed the importance of confidentiality in methadone provision. In Vridsløselille, the inmates receive their methadone at 7.30 in the morning. This can be noticed by other prisoners who might envy their allowance:

“We get methadone to become normal and to be able to go to work. But some other inmates don’t believe that.” (A prisoner)

But for prisoners, it is also possible to go to the medical unit at 8.00 o’clock and then receive their methadone when other inmates, who are ill, attend the unit as well. In this context, it becomes less obvious.

Some prisoners report from experiences in other prisons receiving methadone and see that it was sometimes not that easy to get it when entering prison: “To lose the prescription was easy, but not to get it.”

3 Summing up

In Denmark, substitution treatment is seen as a valuable treatment of opiate addiction. The treatment is organised by special drug clinics on a local level. The cooperation and communication with the prisons seem to work smoothly, so that the interface of community/prisons/community works without any problems. The continuation of substitution treatment for drug users is guaranteed when entering prison and on release. For the drug users, negotiations about dosage, appropriate substitution drug or the start of a substitution drug is possible. A perception of the value of acknowledging patient’s needs was expressed by several interviewees. In particular, two topics were discussed intensively:

- the use and/or prescription of Benzodiazepines
- the more general problem of how to guarantee confidentiality in the provision of substitution treatment, on an every day basis.

Finland¹

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users

In 1999, according to EMCDDA figures, Finland reported the number of problem drug users to be 12,550 (EMCDDA, 2003). Most are poly-drug users, including benzodiazepines and alcohol (Arpo, 2001). Finland ranks among the countries with the lowest rate – 0.2-0.4% – of problem opiate users per 100 000 population. Koski-Jänes, Mäki & Jungner (2004) point out that substance misuse is common in most offender populations. It has been estimated that about 80% of prisoners have serious problems with alcohol and other drugs. Compared to 1988, when about 2% of prisoners had been convicted for drug offences, the figure rose to 16% and to 19% in 2002. In 1995, in a study of four prisons, about one third of the inmates admitted drug use whilst in prison.

1.2 Substitution treatment

1.2.1 *Historical and legal background*

Finland has a long history of a treatment oriented response, to crime in general and particularly to problematic alcohol and drug use, both in the community and in prison. Drug services have increased in the last decade due to the recent increase in drug use: Almost all prisons have drug free wards and most open institutions are essentially drug free (Koski-Jänes, Mäki & Jungner, 2004), even relapse treatment programmes have been implemented in all prisons for those prisoners who have relapsed during the institution's drug treatment programmes (see Silvennoinen).

1 The field visit, conducted by Jutta Engelhardt (Mainline Amsterdam, The Netherlands), was facilitated by Leena Arpo, Chief Medical Officer of the Prison Administration, who also provided national-general information and support with the finalisation of this country report. The study visit took place from June 2-5, 2003.

After the consumption of illicit drugs increased in the 1990s, substitution treatment was initiated in Finland in 1997, in both the community and in prison. Before this period of political unrest and reformation in the neighbouring countries of the former Soviet Union, the primary addiction in Finland was alcohol addiction. 'Illicit' drug use of e.g. cannabis, amphetamines, or opiates was not considered a major health risk in Finnish society.

In 1997, the Ministry of Social Affairs and Health reacted to the new developments and the increase of illicit drug use in the country with a new regulation on treatment. The discussion of substitution treatment was controversial but implemented even against public and political opposition. It was decided that a limitation to a few urban sites was sensible, as research was necessary in order to collect enough national data on substitution treatment. Treatment was thus only started in a few, large hospitals in the urban area of Helsinki. Shortly after the first implementation, many advocates for substitution treatment requested numerical enlargement of the programme and geographical extension to other parts of the country. Since 1999, the number of care units providing substitution treatment has been enlarged greatly. In June 2003, 110 units such as hospitals, health centres, addiction clinics and prisons provide substitution treatment with both methadone and buprenorphine.

As Finland's authorities fully embrace the WHO guidelines on equal treatment, in and outside of penitentiaries, substitution treatment was provided in prison right from its introduction to the Finnish health system in 1997. The first decree of the Ministry of Social Affairs and Health limited treatment to the need of new inmates to be granted the continuation of treatment when facing incarceration. In April 2002, the legal situation changed when the Ministry of Social Affairs and Health issued a new decree², after which, the Chief Medical Officer of the Prison Administration released a communiqué³ in which authorised medical staff in prisons could start substitution treatment for certain prisoners under specific circumstances. However, the practice is little known and only tentatively embraced by medical staff in prison. Consequently, neither medical staff in detention facilities nor prisoners entering prison, without being on treatment before, seriously consider the possibilities of starting ST behind bars.

2 No. 289/2002 of April 15, 2002.

3 Communiqué No.5/442/2002 of September 2002.

The political debate about the usefulness and necessity of substitution treatment in Finland has lost its force. Research data, collected during the last 6 years of implementation, proves that substitution treatment can have the following positive effects on public health policy as well as the health status of the individual in treatment:

- Reducing risk-behaviour, leading to public health problems such as an HIV-/HCV-epidemic
- Linking the addicted person to existing treatment services
- Reducing criminal activity procuring illicit drugs
- Breaking the cycle of addictive behaviour when used as a detoxification treatment

However, these positive research results do not hinder the controversial political debate covering the general aims and the regulations underlying the day-to-day implementation of substitution treatment. As in many other European countries, treatment issues such as access criteria, links to other treatment regimes and national uniformity of the treatment are still the subject of controversy.

Practical procedures

When introduced in 1997, the general aim of substitution treatment was withdrawal from opium addiction in all cases. All treatments required a treatment plan. This plan was developed by professionals, specifying medical and psychosocial care received by the patient along with the medicinal treatment of the substitution drug. Treatment plans are still required today. However, in the June 2000 Decree on the treatment of opium addicts (607/2000), the aim of the treatment has been specified and broadened by the Ministry of Social Affairs and Health. Now substitution treatment does not only aim at withdrawal in all cases, its aims are threefold:

- detoxification
- substitution
- maintenance

Detoxification treatment is defined as care in which the care period does not exceed one month and which aims at a drug-free lifestyle using buprenorphine or methadone for the transitional period only.

Substitution treatment is defined as medicinal care in which the care period exceeds one month and which aims at a drug-free lifestyle after a maximum

of five years. The treatment plan for substitution treatment can be divided into the following phases:

1. Attachment phase: 6 months
2. Rehabilitation phase: 6 months - 1 year
3. Stabilisation phase: 1-4 years
4. Detachment phase: 4-5 years

Substitution treatment can only be started after previous treatment attempts, with approved care practices and procedures for curing the patient's opium addiction, have not been successful.

Maintenance treatment is defined as rehabilitative care of opium users, where the care period exceeds one month and where stress is put on harm reduction and the improvement of the patient's quality of life. Maintenance treatment can only be started with patients with a special need for the reduction of harm caused by opium use. Maintenance treatment is chosen if it is not probable that the individual's drug use pattern can be ended through substitution treatment. Maintenance treatment aims at preventing the spread of communicable diseases and other public health hazards, at binding the client to existing health services and at improving the patient's quality of life. It also aims at preparing the patient for a more ambitious rehabilitative substitution treatment (Yrjö and Tourunen 2002).

The Finnish government is still working on unified national guidelines with regard to access criteria. Due to the fact that, in the past, only a few university hospital wards were allowed to grant access to therapy, the need to develop and publish national access guidelines arose at a comparatively late stage. The following general rules are handled as guidelines for the start of treatment for patients outside prison. Patients need to meet the following profile in order to be granted access to treatment:

- To be officially diagnosed with an active opium addiction after having received a referral to an assessment from a social welfare, health care or substance abuse service unit
- To be able to prove a previous attempt to cure the addiction with approved practices and procedures.

Once accepted into treatment – which can, due to the limited amount of treatment places and too much demand, take more than a year – the patient needs to pass the commencement phase which includes an in-patient period of up to one week. Prior to this period, the patient has the chance to discuss

with his/her doctor whether substitution is provided in the form of methadone or buprenorphine treatment (both authorised). On the other hand, the decision of whether detoxification, substitution or maintenance treatment will be implemented remains fully in the hands of the medical professional.

With regard to the qualification of those medical staff that can start substitution treatment, today's criteria are defined as follows. The treatment can be started

“if the doctor responsible for the activity has special qualifications in addiction medicine

OR

if the unit has been involved in continuing treatment before

OR

if the staff has acquired the theoretical and practical knowledge needed to carry out treatment.”⁴

This means that a large number of physicians outside prison qualify for evaluating patients or for having the responsibility to continue the patients' substitution treatment. For health care units in prison, an exception was stated in the Communiqué of September 6th, 2002:

“Exceptionally, it may come up that the evaluation and possibility of starting opium treatment during a patient's stay in prison should be considered. In these cases, the prisoner may be sent to an ambulatory or hospital unit outside prison. The person may also have already been accepted for treatment, with the support of opium, but be waiting for it to start upon arrival in prison. In such cases, care should be taken that getting into prison is not an obstacle, unless there are medical reasons for abstaining from starting the treatment. Evaluation and starting treatment can also be done in a hospital unit of the prison service, after the Chief Medical Officer has agreed and the provincial government has been informed 30 days in advance of starting the treatment.”⁵

4 Communiqué 5/442/3002 on Treatment of patients dependent on opioids with certain medicines, September 6, 2002. p. 1.

5 *ibid.* p. 2.

However, as most doctors and medical staff in prison are not aware of the changes in the legislation, namely that treatment can be started in prison, little information is passed on to prisoners who might qualify for starting substitution treatment in prison. This development is quietly welcomed by those aware of the legal changes, as medical staff in prison fear a wave of substitution treatment requests once prisoners become widely aware of their new opportunities.

The treatment plan, to be developed prior to the start of the substitution treatment, officially needs to include alternative treatment methods next to the medicinal substitution with methadone or buprenorphine. Psychosocial care and relapse prevention seminars are two additional pillars on which addiction treatment should rely. Officially, once a patient participates in substitution treatment, the participation in psychosocial care activities is obligatory. For example, the treatment contract for Subutex substitution treatment in Hämeenlinna Prison Hospital is quoted as stating: “1. Most important in treatment is psychosocial treatment, which is supported by opioid treatment”.⁶

However, in most locations where substitution treatment is provided – in and outside of prison – there is no or very little psychosocial care activity in which patients can enrol. None of those prisoners interviewed during the study visit reported being actively enrolled and obliged to participate in a psychosocial support program, such as a conversational support group or motivational training to break their addictive behaviour. Some of the inpatient clinics make use of the Narcotics Anonymous (NA) meetings, utilising their principles of recognition and relapse prevention as a support group for their patients. Some prison facilities, such as Mikkeli remand Prison, have developed their own, elaborate system of relapse treatment programmes and motivational seminars which are, however the exception rather than the rule in Finnish penitentiaries (Riittinen). A nation-wide program is to be developed according to new legislation and in combination with the new national access criteria.

Infection with a chronic incurable disease such as HCV, HIV, or TB does not necessarily ease the way into substitution treatment for injection drug users. Access criteria are more often determined by the assessment procedure mentioned above; in which medical professionals determine the motivation and

6 See Annex 3.

the medical necessity needed to reach the aim of detoxification, substitution or maintenance treatment. However, most intravenous drugs users infected with HIV qualify for an amelioration of their quality of life and therefore, if their medical record is made know to the substitution treatment specialist evaluating their application, they are granted access to substitution or maintenance treatment.

1.2.2 Substitution treatment in prisons

The scope of substitution treatment in the Finnish prison system is numerically very small. In the 14 Finnish prisons in which substitution treatment is provided, a total number of 116 prisoners have been treated from 1998 to the end of May 2003 (e.g. in 2001: 45 prisoners, 10 received methadone, 12 Subutex®). The rate of prisoners receiving substitution treatment has increased since its introduction in 1997. All of them were enrolled in the treatment programme before entering the penitentiary and might have been released again after having served relatively short sentences, from 3-6 months, for defaulting on fines. In most cases, treatment lasted until release and was continued outside by the local health centre, the regional hospital or other institutions authorised to distribute substitution medication. The continuation of substitution treatment is in line with the basic principle for substitution treatment, issued by the Prison Administration (Health Care)⁷ which states:

“... opioid treatment which has been started in accordance with the decree and based on a treatment plan must not be interrupted suddenly due to the fact that the patient gets into prison or is transferred to another institution. Thus, it must be possible to continue the treatment in all prisons and prison hospitals, as well as during transfers between institutions and short leaves from prison.” (p. 1)

Substitution treatment can be started in prison but, usually, it is not due to difficulties in the connection to outside programmes for the continuation of treatment.

The daily practice of distributing substitution drugs in prison takes the privacy rights of the patient into account. There are no specific substitution treatment units in Finnish penitentiaries nor is the diagnosis of drug addiction made public to wardens or other inmates. During the week, the dosage is

7 Communiqué 5/442/3002 on Treatment of patients dependent on opioids with certain medicines, September 6, 2002.

given to the patient in the prison health care unit under direct observation whereas prison officers distribute the medication on the weekends when hospital units are closed. Although a maximum degree of confidentiality is attempted by the prison administration, most imprisoned interviewees reported difficulties with fellow prisoners who knew about their substitution treatment demanding to receive a share of the desired opiates. To counteract this development, prison administrations have developed an intricate system of direct observed therapy in which inmates receive their medication under supervision. Methadone is distributed in liquid form whereas buprenorphine is slipped on the patient's tongue in pill form, the mouth being checked carefully by staff after the dissolving period. Urine tests are taken regularly to make sure that inmates in treatment do not top up their daily dose with illicit drugs and there are regular checks for injection marks. If a patient has shown cooperation and no incidents have occurred, he or she might qualify for the maximum of 8 daily doses at a time in order to spend a leave period uninterrupted and independently.

In case of a referral to another penitentiary, medical dossiers and information about the dosage are communicated between medical staff of the different institutions. So far, only one incident has been reported in which the patient was denied the continuation of treatment after being transferred by a prison doctor strongly opposed to substitution treatment in general. The patient was immediately resent to the prison of departure where her treatment was continued. The medical employee refusing to distribute substitution treatment received an official reprimand by the Ministry of Justice stating that the discontinuation of treatment did not fall within his authority. This centralised approach, and the awareness that substitution treatment is generally perceived as medical treatment, seems to prevent discontinuation in prison or a major change in dosage for the individual prisoner.

Relying on the treatment plan, set up by the medical officials who started substitution treatment after the intricate phase of assessment, medical staff in prison fill in an official protocol recording the day-to-day implementation of the treatment during the patient's stay in prison.⁸ In this chart, the daily developments towards the (ultimate) aims set in the treatment plan are monitored and the individual's progress is recorded. These documents are

8 See annex 4.

passed on to medical staff taking over the supervision of the individual after transferral to another institution or release from prison.

If the weekly random urine test is positive, according to the Prison Administration's issued communiqué (5/442/3002) "*the continuation, intensification or tapering down of the medication is considered individually in each case in co-operation with the unit which has started or continued the treatment before the imprisonment. When necessary, the treatment decision is discussed with the doctor responsible for treatment in prison. Essential changes in the treatment shall be reported to the Chief Medical Officer. Refusal to give a urine sample or other non-compliance to the treatment plan agreed upon is to be considered as a breach of the treatment agreement.*" (p. 1)

In order to guarantee continuity of care and eased communication between prison and ongoing treatment centre in the community, the patient's written consent is required.

Controversial issues among staff are (i) suspicion of misuse of methadone or buprenorphine, (ii) the double bind of giving out drugs when, at the same time, prisoners are told not to use drugs, (iii) prisoners' inability to work under substitution treatment. Regarding the latter, it was mentioned that some staff members assumed that patients will fall asleep during work. However, this is a matter of providing the right dose. The employers should not know who is in what type of health treatment.

According to the interviewees there is no involvement of outside agencies (like NGOs) in substitution treatment, but there is close cooperation with doctors in the community.

1.3 Prison Population

Table 7 *Data on the prison situation in Finland (Source: King's College London, International Centre for Prison Studies, Prison Brief for Finland)*

Country	FINLAND
Ministry responsible	Ministry of Justice
Prison administration	Department of Prison Administration
Contact address	P O Box 319, Albertinkatu 25, FIN-00181 Helsinki, Finland

Telephone / fax / website	tel: +358 9 1601 fax: +358 9 1608 8556 or 8410 url: www.vn.fi/om/suomi/vaho/summay.htm
Head of prison administration (and title)	Markku Salminen Director General
Prison population total (including pre-trial detainees / remand prisoners)	3 719 (15.4.2004, national prison administration)
Prison population rate (per 100,000 of national population)	71 based on an estimated national population of 5.22 million in April 2004 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	12.7% (15.4.2004, not including 104 remand prisoners in police establishments)
Female prisoners (percentage of prison population)	5.6% (15.4.2004)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.2% (15.4.2004 – under 18)
Foreign prisoners (percentage of prison population)	7.9% (15.4.2004)
Number of establishments / institutions	37 (2004 – 16 closed prisons, 5 open prisons, 14 open prison units (including 4 labour colonies), 2 prison hospitals of which one is a psychiatric hospital)
Official capacity of prison system	3 473 (15.4.2004)
Occupancy level (based on official capacity)	107.1% (5.4.2004)
Recent prison population trend (year, prison population total, prison population rate)	1992 3 295 (65) 1995 3 018 (59) 1998 2 569 (50) 2001 3 040 (59)

2 The field visits

In addition to the interviews held in the two penitentiaries, further information was collected through interviews in the Ministry of Justice (interviews with Leena Arpo, Chief Medical Officer of the prison administration), in Järvenpää Addiction Hospital and in Munkkisaari substitution therapy clinic (Pekka Tuomola, head of drug and mental health work of the Helsinki Deaconess Institute, Dr. Outi Kuikanmäki, head of substitution therapy clinic) and service centre for HIV infected drug addicts. In the Ministry, Senior Medical Officer Terhi Hermanson was willing to provide information on the historical and legal development underlying the introduction of substitution treatment and harm reduction methods in Finland, as well as the current political debate on financing and implementation of substitution treatment.

In Järvenpää Addiction Hospital, a part of the non-profit private A-clinic foundation, information was provided by Jouni Tourunen and a staff member of the day-care clinic. The former is mostly involved in researching the development of substitution treatment in the face of the typical addiction patterns encountered in Finland, whereas, the latter was able to provide information on the day-to-day practice of treating in-patients for both acute withdrawal symptoms as well as long-term addictive problems.

In Munkkisaari substitution therapy clinic, the urban Helsinki institute, three employees took the time to relate the scope and daily practice of treating opiate using patients with methadone and Subutex, in operation since 2000. 42 of the approximately 200 patients who were on substitution treatment are HIV-infected drug users relying on the services offered by the institution – such as a day-care ward, a dormitory, individual and group therapy, as well as medical and social services.

2.1 Vantaa prison

2.1.1 *Description of the prison*

Vantaa prison is a closed prison, mainly for male remand prisoners, with a few places for women and some sentenced prisoners. In 2002, the average population was 155 men and 12 women. It has a drug free unit for 60 men. It is situated just outside of Helsinki's city boundaries. In this facility, the psychiatrist, Aulikki Ahlgrén, and a nurse responsible for distribution of the substitution medication were interviewed as well as two male prisoners on treatment.

2.2 Hämeenlinna Prison

2.2.1 Description of the prison

This is the main institution for women prisoners. Hämeenlinna is a closed prison, in which both remand (female) prisoners and sentenced prisoners are held. It is close to the city of Hämeenlinna, some 100 km from Helsinki. In November 2003, it held 172 men and 131 women with a staffing capacity of 223.

In Hämeenlinna Prison, the chief physician, Päivi Viitanen, and the nurse responsible for the pharmacy were able to provide information on the daily distribution practices and experiences in the institution. This information was supplemented by information given by one male prisoner, interviewed individually, and three female prisoners, interviewed as a focus group.

2.3 The views of prisoners in both prisons

No problems have been reported concerning discontinuation or change of dosage; communication channels between the outside agencies and the medical staff inside of prison facilities seem to be well established and function satisfactory for all parties involved.

Prisoners interviewed during the study visit did not report any complications or arbitrary dose change by medical staff in the penitentiaries or the police cells, where they were kept before being placed in remand prisons. They also reported being encouraged to keep in contact with the medical staff outside whilst being imprisoned in order to avoid treatment gaps after release. This is also advantageous as a means to avoid mental isolation and to communicate a prepared release procedure rather than a return into the well-known drug scene that might endanger the continuation of substitution treatment through additional illicit drug use. Though confidentiality is attempted by the prison administration, most imprisoned interviewees reported difficulties with those fellow prisoners who knew about their substitution treatment demanding to receive a share of the desired opiates. In addition, there is the difficulty of dispensing the substitution drug on weekends by staff members, which informs them of who is in substitution treatment.

3 Summing up

So far, Finnish substitution treatment in prisons runs on a rather small scale. This is due to the nature of the introduction of substitution treatment into the Finnish health system and the fact that the treatment could only be started by a few renowned university clinics in the urban area of Helsinki. Medical staff in prison began implementing treatment plans that were decided by staff outside the prison system. In September 2002, the legal situation changed when the Ministry of Justice gave permission to medical staff in prisons to start substitution treatment under specific circumstances. However, prison doctors who were qualified for starting treatment were anxious to take on this responsibility, as they feared a wave of requests from the prison population that would be larger than they could handle. Consequently, no treatment has been started inside prison yet and the number of prisoners enrolled in substitution treatment can easily be monitored.

Of the three forms of substitution treatment determined in federal regulations, most inmates are enrolled as ‘substitution’ or ‘maintenance’ patients. For patients that only qualify for detoxification treatment, imprisonment is usually postponed until the detoxification process has been completed successfully. ‘Substitution’ treatment patients – supposed to overcome their addictive behaviour by medicinal aid within a maximum of 5 years – differ from ‘maintenance’ patients for whom the reduction of harm and the improvement of their quality of life stand in the foreground of the treatment. In practice, however, substitution treatment received is in most cases closer to permanent maintenance than to substitution treatment aiming at opiate withdrawal, as defined in the official Decree.

Substitution is provided in the form of liquid methadone or buprenorphine whilst Subutex® pills are the preferred drug by most patients in treatment. Many of the Finnish drug users seem to have an undefined fear of a surplus addiction to methadone without having experienced the effects of the substitute.

Imprisonment and transfers to other prisons, as well as the release procedures, seem well organised in the Finnish prison system. Active cooperation and good communication between the external health services handing out substitution medication and the internal medical units in prison prevent patients from experiencing long periods without medication or an unexpected change in their dosage. Keeping in touch with the external health unit, responsible for the substitution treatment during incarceration, guarantees the

continuation of treatment after release. If patients ask for a raise in their dosage, prison staff are more likely to be conservative than outside health units, this can lead to complaints by prisoners to their external supervisors during their incarceration.

Every patient that enters substitution treatment receives a treatment plan by the medical unit, assessing the patient's record and granting access. This treatment plan includes an alternative treatment scheme in addition to the medicinal substitution. Psychosocial care, motivational seminars and relapse prevention programmes, as well as re-integration programmes into society, are part of this treatment scheme. However, most prisoners interviewed during the visit to Finland stated that extra medicinal treatment offers were scarce, inside as well as outside of prison.

There are no special substitution units in Finnish prisons. On weekdays, prisoners on substitution take their daily dose under supervision at the medical unit whereas, on weekends, they receive their medication from wardens when pharmacies and medical units are closed. A maximum degree of confidentiality is granted to the individuals but usually fellow inmates are well aware of the special daily medical treatment. Urine tests and checks for injection marks are a regular routine for participants in the substitution treatment. Topping up with illegal drugs usually leads to intensified care and supervision but, so far, has not yet led to the expulsion of any patient from the substitution treatment.

The Finnish substitution treatment in prison is still young and small in scope. Its quality can be regarded as high due to the fact that patients and doctors alike are satisfied with the legal framework and the organisational set-up. Drug users pledge for more access possibilities and warmly welcome the opportunity to start substitution treatment in prison once the necessary changes legislation are communicated openly and implemented in all Finnish penitentiaries. Medical staff will have to get used to the responsibility of evaluating addiction files and to granting access to substitution therapy. This could mean that many of the prison doctors will have to follow vocational training in order to obtain more expertise in the field and that more staff will be needed to implement the therapy for a greater number of patients.

Two further developments can be welcomed: the fact that the Finnish government is attempting to unify the access criteria to treatment as well as the attempt to stress the importance of extra medicinal treatment and the development of a national curriculum of these activities for all institutions pro-

viding substitution treatment. Both, the guidelines for access criteria and the curriculum of extra medicinal treatment, need to be regulated for the whole country if randomisation of access and discrepancy in quality of treatment is to be avoided when the program is enlarged in the near future.

France¹

1 General data: drug use, substitution treatment and prison population

1.1 Drug use

The two most frequently used psychoactive substances in France are alcohol and cannabis, followed by cocaine, LSD, ecstasy, heroine and to a lesser extent amphetamines. Most of the drug users are poly-drugs users. (Reitox France, 2001).

The number of drug users is estimated to be 120-180,000. About 100,000 are on a substitution treatment: 82,000 on Subutex® (that is approximately 80% of the total) and the rest on methadone. These figures are given by the laboratory.² (Interview with the Ministry of Health)

In the community, 70,000 people were on a substitution treatment (Subutex® or methadone) in 1999, increasing to 92,000 in 2001 (80,000 on Subutex® and 12,000 on methadone). (Figures from the Ministry of Health)

In prison, in 1999, there was a total of 1 653 prisoners on substitution treatment for a population of 50,041 prisoners (3,3%). Out of these 1 653, 272 were on methadone and 1 381 on subutex®. These figures increased in 2001 to 2 548 prisoners in substitution treatment for a population of 47,311 prisoners (5,4%), with 366 on methadone and 2 182 on subutex®. (Figures delivered to the Ministry of Health from each prison of the country on a given date, Ministry of Health)

There was a total of approximately 60,000 prisoners for the whole of France prior to July 2004 (at the time of the field visit) for a total of 168 prisons in France (France Metropolitan and French overseas departments (DOM), excluding half open prisons). (The Ministry of Health)

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Saadia Yakoub, psychologist, who gave great support in the preparation phase and actual field visit. Special thanks to Laurent Michel, Pierre Lamothe, and Frédéric Meunier for their support.

2 It must be taken into account that some (a minority) of these prescriptions/ treatments are misused, sold on the black market, or prescribed twice for the same patient.

1.2 Substitution treatment

Data comes from an on-going review of research reports, websites and laws/regulations, as well as from interviews conducted during the field visit³.

1.2.1 Historical and legal background

Health care in prison is under the management of the Ministry of Health further to the 1994 reform, as stated by the law of 18 January 1994 (law number 94-43). From that date prisoners' health care depends on the Ministry of Health and the public hospital service, and no longer to the penitentiary administration. Clinicians are employed by the Ministry of Health and attached to a public hospital, but practise in a prison. This law also sets that drug-using prisoners are to be cared for by the UCSA and the SMPR. The circular of 8 December 1994 (inter-ministerial circular of application of the law of 18 January 1994) sets an objective 'to ensure equivalence of care to prisoners as it is provided in the community'.

A UCSA is a '*Unité de Consultations et de Soins Ambulatoires*' or Ambulatory Health Care Consultation Units. A SMPR is a '*Service médico-psychologique régional*' or Regional Medical-psychological services that were created through the decree of 14 March 1986. SMPRs are in charge of psychiatric care in prison and are attached to a public health hospital but implemented in a prison. The staff team usually comprises psychiatrists, psychologists, nurses, educators and social workers. Some SMPRs benefit from a CSST. A CSST is a '*Centre Spécialisé de Soins aux Toxicomanes*' or a Specialised Health Care Centres for Drug Users in prisons. CSST are managed by the doctor in charge of the SMPR. The circular of 3 November 1987 specifies the CSST modalities.

There are around 168 prisons in France (Metropolitan France and French overseas departments (DOM), excluding half open prisons). Each prison has a UCSA but only 26 prisons have a SMPR, of which 16 have a CSST. Substitution treatments are normally offered through a UCSA or SMPR. Prescription rarely occurs in a CSST. Treatments and health care frameworks

3 Interviews were conducted at the national level with:

- The department (Ministry) of Health,
- an administrator at the DR, Regional Prison Administration,
- the ex-president of the MILDT, and
- a clinical psychologist and president of ANIT.

vary tremendously all through the country. (Fatome, 2001; Michel & Maquet, 2003)

French sanitary authorities remained reluctant towards substitution treatments for a long time (Fatome et al, 2001). However, since the end of the 1990s they have been involved in the promotion of these treatments, as abstinence is no longer seen as the only possible response to opiate dependency.

In the community, substitution treatments with methadone were first offered in 1973 on an experimental basis and limited for over twenty years to approximately 50 patients at a time. Treatment to drug dependents focused on psychological support and detoxification.

The spread of HIV/Aids and Hepatitis infections, brought forward a harm reduction policy. In 1984 some GPs in the community already prescribed Temgesic® (low dosage of buprenorphine) (Courty, 2001). This resulted in a number of doctors being prosecuted in 1992 for prescribing Temgesic®.

The circular n°72 of 9 November 1993 of the Secretary of State of Health, permitted the enlargement of the number of places which provide methadone treatment in health care centres to 250. This was further developed with the circular of the Ministry of Health n° 14 of 7 March 1994 on harm reduction and increase of methadone treatment offers to 1000. However, the conditions for the centres and for the patients were very restrictive.

1995 was an important year regarding substitution treatment. The circular n° 4 of 11 January 1995 relative to the Ministry of Health generalises methadone programmes to all aggregated CSST. The circular n° 29 of 31 March 1995 (Circular DGS/SP3/95 relative to substitution treatment for opiate dependents) authorises the introduction of Subutex® into the market for '*major opiate pharmacodependences within the frame of a medical, social and psychological structure and support*'. This circular clarifies the structure within which substitution treatments must be offered and sets that 'health care of drug users now includes substitution treatment and is part of public health policy'. It also underlines that buprenorphine and methadone are to be used for major opiate pharmacodependency. Methadone no longer has an experimental status.

The circular DGS/DH n°96-239 of 3 April 1996 focuses on the 'improvement of access to substitution treatment'. It sets a limit for the conditions of financing of aggregated centres, restricts budgets for urine tests, and limits

evaluation means of the clinical efficacy of treatment. This circular also sets the prescription modalities for buprenorphine, which are almost the opposite of methadone. Any doctor is allowed to prescribe buprenorphine, without preliminary urine tests, controls or check-ups. Even though doctors are advised to prescribe for 7 days, it is possible to prescribe for 28 days at once.

The circular health-justice of 5 December 1996 states the health care organisations through the ‘fight’ against HIV infection in prison (circular DGS/DH/DAP n° 739) and that initiation or continuation of substitution treatment are allowed in prison with buprenorphine or methadone. *‘A health care integrating the whole of the problems of dependence must be proposed in prison. In particular, for drug dependent, a substitution treatment with methadone or Subutex® can be continued or initiated’.*

In the community and in prison, methadone is offered in a heavily controlled structure. Methadone is offered in a more restricted and controlled environment because of the risk of overdose. Patients must undergo a certain number of major constraints at the beginning of the programme, such as urine tests, daily visits to the aggregated centre, prescription for 7 days maximum. The treatment could only be initiated by a specialised doctor, contrary to buprenorphine that is available at pharmacists since the beginning of 1996 and can be initiated by any doctor. This meant that there was a significant difference of access to buprenorphine and methadone treatment. The circular DGS/DHOS n° 57/2002 of 30 January 2002 concerns the modalities of methadone prescription and aims at re-balancing its accessibility. The circular allows any doctor practising in a health care centre or hospital to initialise methadone treatment. This brings progress in regard to methadone and allows UCSA doctors and psychiatrists in prison to initialise this treatment.

The law n°2002-1487 of 20 December 2002 transfers the funding of CSST to the Social Security (Assurance Maladie) renovating the social and medico-social actions. The decree n° 2003-160 of 26 February 2003 redefines the CSST missions setting the minimal conditions of the organisation and functioning of the CSST.

1.2.2 Substitution treatment in prison

Substitution treatment has been a useful tool for the health care and treatment of opiate dependents. A 5 year delay existed between the provision of substitution treatment in the community and in prison. The attitudes were:

(i) we are no dealers, (ii) a drug that replaces another one, (iii) abstinence is possible in prison (interview with the ex-president of the MILDT).

Although misuse exists, different studies have shown that substitution treatments allow access to medical and social structures, contribute to improving the health state of drug users and are part of harm (infections) reduction in prison. (Stankoff & Dhérot, 2000; Fatome et al, 2001) It was reported that buprenorphine progressed rapidly because the prescription framework was easy, however, around 10-15% of all patients in a substitution treatment traffic Subutex®. Although only a minority misuse buprenorphine, traffic is a problem (interview with the ex-president of the MILDT).

However, it was reported that access to treatments (continuation or initiation) is not guaranteed in prison due to the disparity of practise and care from one prison and region to the other. Furthermore, the psychosocial support is often lacking, protocols are not always respected due to a lack of staff (such as having staff to monitor the provision and distribution of substitution treatment). Detoxification seems to be the most common response to treatment of drug users. Diversity of health care offer is not guaranteed in all prisons. (Stankoff & Dhérot, 2000) The Ministry of Health when interviewed reported that all regions of France do not benefit from a similar medical team. Some areas are 'deserted' and lack psychiatrists.

Michel & Maguet (2003) also reported a great heterogeneity between prisons. They also underlined the importance of training and information and put forward 13 recommendations for substitution treatment in prison. Michel & Maguet's study was authorised and supported by both the Ministry of Justice and the Ministry of Health. The report of the study was distributed in every single prison of the country as a guide and support to the provision of substitution treatment.

Stankoff & Dhérot (2000) further reported that a number of doctors refuse to prescribe substitution treatment in prison (as it occurs in the community). Contrary to the community, the prisoner cannot visit another doctor or health care centre. This refusal has further negative consequences when a treatment was initiated in the community and could be continued in prison. Staff's reluctance to provide substitution treatments are linked to the difficulty in assimilating these treatments to medical treatments. Furthermore, the lack of information on the release date is sometimes used as a justification for refusing to provide the treatment. Some doctors question the end-goal and possible risks of a long-term substitution treatment.

1.3 Prison Population

Table 8: *Data on the prison situation in France (Source: King's College London, International Centre for Prison Studies, Prison Brief for France)*

Country	FRANCE
Ministry responsible	Ministere de la Justice
Prison administration	French Prison Service
Contact address	DAP/SCERI 13 Place Vendome, 75042 Paris, France
Telephone / fax / website	tel: +33 1 49 96 28 15 fax: +33 1 49 96 28 80 url: www.justice.gouv.fr/minister/sceri
Head of prison administration (and title)	Didier Lallement , Director of the Prison Administration
Prison population total (including pre-trial detainees / remand prisoners)	55,382 at 1.4.2003 in metropolitan France (Ministry of Justice)
Prison population rate (per 100,000 of national population)	93 based on an estimated national population of 59.70 million at April 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	38.3% (1.4.2003)
Female prisoners (percentage of prison population)	3.9% (1.4.2003)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	1.4% (1.4.2003 – under 18)
Foreign prisoners (percentage of prison population)	21.4% (1.4.2003)
Number of establishments / institutions	185 (2002)
Official capacity of prison system	45,881 (1.4.2003)
Occupancy level (based on official capacity)	120.7% (1.4.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 48,113 in metropolitan France (84) 1995 51,623 in metropolitan France (89) 1998 50,744 in metropolitan France (86) 2001 46,376 in metropolitan France (78)

There was a total of approximately 60,000 prisoners for the whole of France at the time of the field visit for a total of 168 prisons in France (France Metropolitan and French overseas departments (DOM), excluding half open prisons) (The Ministry of Health).

2 The field visits⁴

Time frame: The field visit took place from 28 to 30 April 2004 in the Paris area and 25 to 26 May 2004 in the Lyon area.

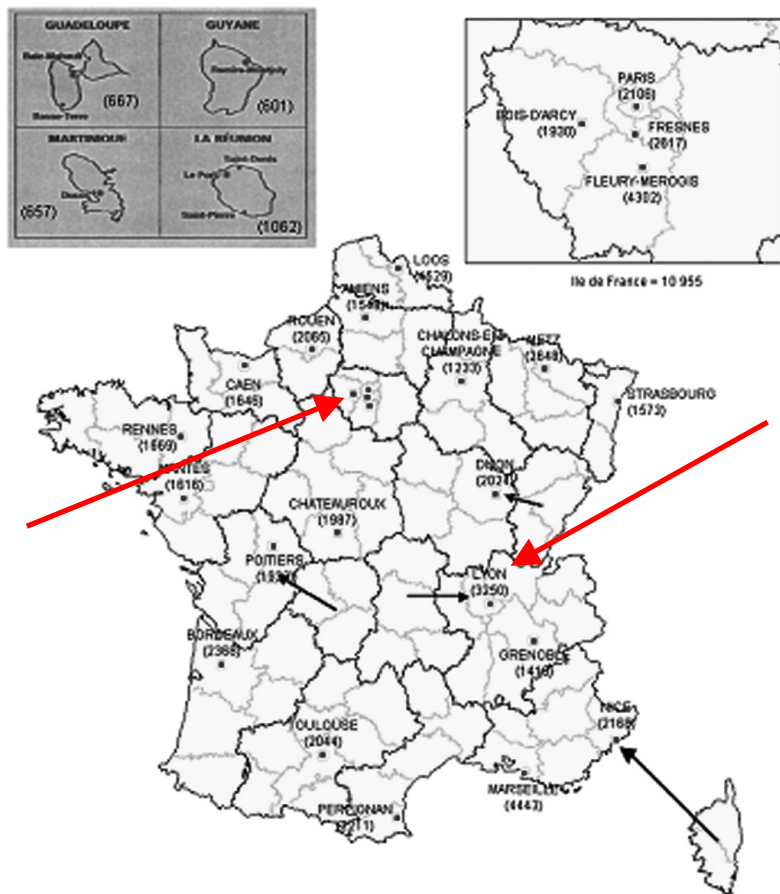
Location: Visits were conducted in two prisons: The Yvelines Prison (Bois d'Arcy) and Lyon Prison.



Map of France

4 *Methodology:* Interviews were conducted with the individuals listed below as well as focus groups and interviews with the prisoners. No tape-recorder was used. The researcher conducted all interviews/ focus groups on her own. All participants were briefed and told about ethical issues.

Population pénale desservie par les SMPR



OHOS-0-02
(Données 1^{er} Mars 83)

2.1 The Yvelines Prison (Bois d'Arcy)⁵

2.1.1 Description of the prison

The Yvelines prison (Bois d'Arcy) is located in the suburb of Paris, just south of Versailles. The area is known for having level of delinquencies, partly linked to social housing complexes in the area, and to bordering a large city.

The prison, built in 1980, in the shape of a star, is a remand male prison. However, 40% of the prisoners are sentenced, waiting to be transferred to sentenced prisons, which is resulting in a late or no transfer.

The prison has a capacity of 512, at the visit, approximately 850 prisoners (of which approximately 30 were juveniles). From 1980 to 1990, the prison was overcrowded and over-used holding approximately 1 000 prisoners on a given day, at one time reaching a maximum of 1 500 prisoners. This prison has thus aged very rapidly and faces maintenance issues.

The prison has approximately 265 guards per week, of which, the governor reported, half are in their training scheme and thus there is a high turnover and guards have little experience.

The prison has a UCSA, as well as a SMPR and CSST (managed by the Ministry of Health), attached to the hospital Mignot and to the hospital Charcot à Plaisir respectively. The SMPR-CSST counts 5 psychiatrists full-time, 5 psychologists (4 full-time), 10 nurses (4 full-time), 2 head of nurses, 2 medical secretaries, and 1 social worker.

5 Data from interviews were those conducted with:

- The governor of the prison,
- a magistrate (juge d'application des peines),
- a psychiatrist (SMPR/ CSST) and head of CSST and SMPR,
- the head of nurse/ health care (SMPR),
- a nurse (SMPR),
- a clinical psychologist (SMPR),
- a social worker (SMPR),
- a social worker, SPIP (Probation Services), Ministry of Justice, Prison Administration,
- the head of guards,
- a guard (SMPR unit),
- a social worker, CAAT, NGO.

2.1.2 *Goals and practical procedures*

Upon entry to the prison, the prisoner is seen by the UCSA as soon as possible (usually within 24 to 48 hours of arrival, except when arriving over the week-end) and then by the SMPR/CSST. The UCSA informs the SMPR-CSST in case anything 'specific' needs to be 'treated'. The SMPR-CSST may be informed by the UCSA, guards or SPIP (Probation and Insertion Services) if the prisoner says or reports something peculiar or alarming requiring further SMPR-CSST care. There is no auto-description or identification to SMPR-CSST in order to avoid abuse, except through written request asking to see a specialist. Usually, after such a written request, the prisoner is attended by a psychologist, psychiatrist or nurse depending on the request. Patients on a specific treatment (psychiatric or drugs, like substitution treatment) are followed on individual cases by the SMPR-CSST.

At the time of the visit 35 prisoners were receiving a substitution treatment: 11 were on methadone (syrup) and 24 on buprenorphine (tablet or pill).

The Ministry of Health reported the following figures:

- no individual on methadone or buprenorphine in 1999
- 17 on buprenorphine and 3 on methadone in 2001
- 21 on buprenorphine and 15 on methadone in 2004

(figures provided by the prison on a given day in November 1999, December 2001 and February 2004).

Substitution treatment is entirely managed by the SMPR-CSST. UCSA focuses on somatic issues. The two departments liaise when needed. Collaboration between the medical services and with the prison and prison administration was reported as working well (direction of the prison, prison and medical staff).

Substitution treatment in the prison was offered further to the initiative of one of the psychiatrists and head of SMPR in post since November 2000, and after discussion with the staff for initiation of substitution treatment. Previously, the post was occupied by a psychiatrist who was not in favour of substitution treatment: she considered substitution treatment as a 'one drug replacing another one'. Prior to 2001 no substitution treatment was offered in prison. At the end of 2000, beginning of 2001, continuation of a treatment started outside was put into practise. At the end of 2002, beginning of 2003, initiation of treatment was put into practise.

The prison staff viewed substitution treatment negatively and would say 'Rave party at the SMPR' when talking about the availability of substitution treatment. The SMPR organised information group sessions on substitution treatment that were provided to every single guard working at the prison. This contributed to a change of attitude and to substitution treatment being considered as a medical treatment.

The methadone is delivered to the prison by a laboratory located outside the prison in small bottles of dosage 60, 40, 20, 10 and 5 mg and are kept in a safe box (as set by the law) in the medical centre. The taste is bitter but sugar is added for the taste, and also to make injection impossible. Buprenorphine is delivered in tablets of 0.4, 2 and 8 mg.

Methadone has the reputation of being a safer treatment, but it was reported that this is a false idea. This idea comes from the fact that it is provided within a supervised team and centre (CSST).

When prescribing either treatment, the psychiatrist attempts to put the prisoner in a health care perspective and starting a clinical approach by talking about the treatment, liaising with the psychosocial team, and discussing follow-up at release. The goal of substitution treatment is also to offer a harm reduction measure, better reinsertion after release and possibly abstinence.

Deliveries for buprenorphine and methadone are different. Prisoners on a buprenorphine treatment must visit the SMPR during the first one to two weeks of treatment. They are taught about the sub-lingual intake, which is supervised, as well as the benefits and risks of buprenorphine. Doses of buprenorphine can be easily and quickly increased, but the average dose is 8 to 10 mg. After these first weeks, the prisoner receives the buprenorphine treatment by hand twice a week (for daily intake) along with other medicine. Some prisoners choose to get their treatment delivered to their cell by a nurse (as it can be done for any medical treatment) or get it at the SMPR twice a week. Others visit the SMPR continue visiting the SMPR every day to receive their treatment. They may do so if they are unstable, if they need a daily contact with the medical centre, if they wish to increase discretion about their treatment and decrease the chances of being bullied or victim of racket. They may also do so in order to stay in close contact with the SMPR. However, it was underlined that substitution treatment must allow patients to gain certain autonomy.

For the delivery of methadone, any individual on methadone must visit the SMPR every single day to receive his treatment. The intake is supervised as according to the law. The delivery is between 8.30 am and 12.00 am. The SMPR guard notifies the respective guards to send to the SMPR the concerned prisoners by groups (or all at once) in the morning at 8.30 am, 9.45 am, or 11.45 am. Although the treatment is not divulged to any prison staff, it was reported that it is relatively easy to 'guess' that a prisoner sent to the SMPR on every single day is on a methadone treatment (prisoners, and guards). However, this did not raise any particular questions of confidentiality. It was reported that although respecting confidentiality and ethical conduct is done at its best, like it is done outside, it cannot be done at 100% in a prison setting. A guard stated that when enquiring about a particular prisoner, they are told it is confidential information ('medical secret'). As a result they cannot be warned about or understand better certain prisoners with particular behaviours.

Guards are not involved in health care. Their job is security and because of medical secret are not informed about health care of prisoners. A guard reported that there was a lack of doctors and punctuality from the medical team. Some difficulties have occurred when a prisoner has not been called for treatment (omission or error). The guards said that substitution treatment is perceived as a medical treatment in which the most obvious effect was to soothe and calm the prison environment for drug users. A guard said that some prisoners told them that they had been on a substitution treatment from the beginning; others talked about it when they discussed things with the guards.

A social worker reported that sex offenders are highly stigmatised in prison; drug users are much less so. Moreover, there are a lot of conflicts related to drugs, mostly related to issues at the pre-incarceration stage. This may explain the fear of some prisoners of being identified or stigmatised as a drug user.

When a methadone treatment is initiated, the starting dose for methadone is usually 15 to 30 mg. Initiation and maintenance are both offered at the prison according to individual needs. When delivering a methadone treatment, the psychiatrist makes sure the treatment can be continued after released, in order to avoid the brutal interruption of treatment.

The psychiatrist reported that prison is not the best place to end a substitution treatment (methadone or buprenorphine), because of the high level of stress and anxiety, and high risk of overdoses after release.

Some prisoners are usually offered to transfer to a methadone treatment:

- when they have been misusing buprenorphine, sniffing or injecting it
- they have a ‘drug-use’-relation to the substance
- they could still benefit from a substitution treatment

When transferring from buprenorphine to methadone, the prisoner must wait for 48 hours after the last intake of buprenorphine before receiving the new treatment. After 48 hours 20 to 30 mg of methadone is given; no withdrawals can occur with such a dose. The average dose of methadone is 60 to 80 mg, although there is great variability from one patient to the other. Patients with a fast absorption may need to take methadone two times per day.

Over weekends, buprenorphine is delivered prior to the weekend, whereas the prisoner must go to the SMPR for methadone, which is delivered by a nurse. A doctor is always on duty on Saturdays. For Sundays, the nurse manages alone. In case of emergencies in the absence of medical staff (Sundays and every day after 6.00 pm), the prison is linked to ‘ERIC’ (i.e. rapid crisis intervention team), a medical psychiatric team that intervenes only in case of emergencies. They intervene for any prisoner and are linked to the Charcot hospital in Plaisir. ERIC may also be warned in case there is a likely probability for an emergency.

There is no contract or consent form for substitution treatment but some written information and warning about misuse.

The SMPR is entitled to conduct urine tests on prisoners who are on a substitution treatment. This is not conducted towards punitive measures. Urine tests are conducted:

- before starting a new treatment.
- When continuing a treatment. Confirmation of methadone treatment tends to be easily obtained since methadone is offered within a very supervised frame, which is not the case for buprenorphine.
- as an assessment or check up when needed for medical reasons.
- on prisoners who deny to the psychiatrist that they are using various drugs in prison; this use is obvious to the psychiatrist. The test allows the doctor to make the prisoner face his intake and remove any chance of denial.

In case of topping up the substitution treatment is not necessarily removed, but may be if it is supported medically. Otherwise, the treatment may be changed (transfer to buprenorphine or methadone, dose) and the relation prisoner with the psychosocial support is likely to be increased further.

Nurses provide do the follow-up of the psychiatrist's tasks, conduct assessment such as for pre-release. Relaxation is also offered at the prison by a nurse. SMPR nurses work on the four different axis: 'addictology', general psychiatry, juveniles and sex offenders.

Advantages and disadvantages

The different interviewees reported that substitution treatment has various advantages and disadvantages.

In general, thanks to substitution treatment,

- Self-harm and overdoses in prison have largely decreased since the introduction of substitution treatment.
- there is a better '*prise en charge*' (follow up) of drug users
- doctors feel less or no longer helpless with drug users and more accept to treat them
- the prisoner can 'enter' a therapeutic and care approach.
- Abstinence and detoxification have been reached by some prisoners
- Drug users have been identified
- a health care system was set up and offered to drug users
- prisoners take care of some personal issues themselves, such as making sure their social security is in order

In general, because of substitution treatment, there is a new traffic, although other licit medicines largely generate the black market. Substitution treatment is viewed by some as a substance (a drug) rather than a treatment, which relates to the idea that substitution treatment is just replacing one drug with another one. Prisoners still hold the idea that to consult a psychiatrist is especially for deep psychiatric disorders. As a result they are not keen to consult. Finally, substitution treatment brings no solution to the withdrawal and craving effect, which is partly psychological: users must still grieve their drug use.

A magistrate reported that she considered a prisoner on substitution treatment as someone who is better, taking care of himself and who has entered a health care approach. Other judges may see a prisoner on substitution treat-

ment negatively, as someone who is still using. She further stated that substitution treatment needs to be provided with psycho-medico-social support, often lacking among doctors who simply prescribe. She also said that one must take advantage of prison as a moment when a health care team has access to the drug users in order to offer them support through specialists, and also to link up with health care and treatment. However, a full follow-up (*prise en charge*), although better than it was previously, is still often lacking.

Medically, buprenorphine offers clear advantages that methadone does not have:

- the use is flexible,
- there is less risk of overdose, and no risk of overdose with high doses of buprenorphine taken on its own,
- stocking is easy (tablets) and easier than bottles,
- delivery is easy (twice a week) and does not require a high number of staff,
- weekly (but twice a week if unstable) doctor consultation is acceptable to a still-using prisoner, who would not consult every day,
- the treatment is good even for heavy-users.

Medically, the disadvantages of buprenorphine are:

- sub-lingual intake is difficult and time consuming. The supervision of the intake is difficult,
- The taste is unpleasant,
- The context and frame of the provision is not the best fit and is too lax,
- The effect is not euphoric – when taken properly – and may not appeal to some drug users in search of some euphoria. This results in topping up or misusing.

Medically, the advantages of methadone are:

- Easy intake (drinkable solution), that is time effective,
- Does not generate a traffic and is not misused,
- Any individual on methadone ends up in a health care environment, which offers support, supervision, guidance,
- It is appropriate for those who have misused buprenorphine,
- Produces a certain euphoric effect (similar to morphine) and some pleasure related to the intake.

Medically, the disadvantages of methadone are:

- because of this euphoric effect, the withdrawal and craving effects are stronger with methadone,
- it is very bad for the teeth,
- and a single dose of 1 mg per kg may be lethal for any “naïve” patient,

Guards reported that prisoners on a substitution treatment are stabilised much faster than when receiving any other type of treatment. There would be a lot more incidents in prison without the treatment. The movement of prisoners to the SMPR does not have a great impact on the rest of the prison and does not impede other activities.

Substitution treatment plays a trigger role and brings the individual within a treatment and health care environment. To be really efficient, substitution treatment must be provided along with support and supervision.

There are still some negative attitudes or perceptions of substitution treatment although it only applies to buprenorphine which is seen as toxic. Because of the highly supervised environment for methadone, this latter is seen as a medical treatment. Going from buprenorphine to methadone is seen as a therapeutic progress by some staff.

The biggest disadvantage of substitution treatment is the new traffic it has generated. The governor reported that the negative aspect of substitution treatment is the traffic of buprenorphine; nevertheless it is worth providing such treatment. *‘With a global ‘prise en charge’ (follow up), it is a success-ful.’*

Misuse of buprenorphine sniffed or injected is common, as it is out of prison. 10 to 20% of drug users on a buprenorphine treatment inject Subutex®. There are some corrupt doctors outside (and in prison) who give more than one prescription per medical consultation. Some individuals get Subutex® only to do traffic and deal and have no intention of engaging in a health treatment. These people make up the minority of those prescribing or receiving a buprenorphine prescription, but *‘they have messed up the whole French system’* (a doctor).

The starches present in the substance – when injected – are toxic and are likely to cause abscess, which may result in the need for amputation. Suboxone treatment (i.e. buprenorphine with Naloxone) is offered in the United States and Australia. This treatment presents no advantages to injec-

tors and is thus not (or much less) misused. The unavailability of this treatment in Europe remains unexplained by all interviewees.

Drug users tend to remain dependent, if not on the substance, then on the gesture. It is therefore not surprising that they continue their use in whatever way possible. Moreover, when sniffing or injecting buprenorphine, users report getting a kick and euphoric state. This misuse results in an increased number of prisoners being transferred to methadone treatment.

Guards reported that there is drug traffic inside the prison and 'it is not a taboo topic'. They said that some prisoners get prescribed medicine to sell it. Guards feel they cannot control everything in prison and cannot fight back endlessly.

The need of support, supervision, frame and '*prise en charge*' (follow up) was underlined by all participants in the study as being a key part of the success of the treatment.

Psychosocial support and training

Psychosocial support is delivered through the psychosocial team at the SMPR and the social workers from SPIP or NGOs collaborating with the prison. The SMPR psychosocial team tries to offer support to drug users via group sessions that focus on the body image, expression of emotions, sensations of the body (like pains), natural relaxation (offered by a nurse), self-esteem. The majority of prisoners do not follow a therapy. Prisoners who have started a substitution treatment outside usually have gone through a proper '*prise en charge*' (follow up). Drug users on substitution treatment are not accessible on an individual basis immediately after incarceration, unless they have had a therapeutic care previously or while outside. They tend to be closed and it is easier to first talk about administrative issues to 'break the ice'. They eventually open up to talk about more personal issues. Each individual is different and requires a different type of psychological support.

Social workers focus on social, employment and family aspects but do not neglect medico-psycho issues and, if needed, liaise with appropriate individuals. They also work on the preparation for release and throughcare with outside centres.

The SPIP social worker must make sure that sentences are applied, and that reinsertion is possible.

It was reported that there is a need for a better structure and access to health care, with a real '*prise en charge*' (follow up) (quantitative and qualitative). For prisoners who must wait 2 months before the '*prise en charge*', this is not adequate and is likely to result in relapses (in and/or out of prison).

All staff (especially under the justice umbrella) stated their training was too short and did not cover important issues about drugs. It was reported that training for staff is insufficient regarding to substitution treatment. Training for medical staff, such as doctors, was reported as being very important. Specialisation is equally important, but it was reported that ideally there must be a rotation among the nurses as 'the specialisation enriches the polyvalence': a nurse can be specialised but must also know general health care.

2.2 Prison of Lyon

2.2.1 *Description of the prison*⁶

The prison of Lyon is located in the centre of Lyon. The prison comprises two buildings linked by a tunnel. St Joseph was built in 1830, and St Paul was built in 1860. The SMPR with a CSST is located in the St Paul building, where most of the interviews were conducted.

The prison is a remand male prison, with a separate section for female prisoners in the St Joseph building. Approximately 40% of the prisoners are sentenced. This is due to their waiting to be transferred to sentenced prisons.

The governor reported that the prison has a capacity of 361. The number of prisoners has been approximately:

- in 1999: 500 prisoners
- in 2000: 600 prisoners

6 Data from interviews were those conducted with:

- The governor of the prison
- The psychiatrist and head of CSST and SMPR
- Psychiatrists (CSST)
- A psychologist (CSST)
- The Head of nurses (SMPR/CSST) with a specialisation in mental health
- A nurse (SMPR/CSST)
- An educator (CSST)
- A GP (UCSA)
- A social worker
- The pharmacist
- Guards (SMPR)

- in 2001: 700 prisoners
- in 2002: 800 prisoners
- in 2004: 1000 prisoners

The prison has been overcrowded for several years. It was reported that the prison is in a poor 'physical' state due to its old structure and overcrowding.

The number of staff is approximately 380 (guards and administrative staff) since 1999. There are approximately 1 guard per 60 prisoners.

The prison has a UCSA (with 12 nurses, 2 GPs, 2 physiotherapists, a dentist, a specialised doctor, administrative staff), as well as a SMPR and CSST (managed by the Ministry of Health), attached to the hospital Le Vinatier, that manages substitution treatment. The SMPR-CSST counts 1 psychologist, 1 GP (Public Health), 1 specialised GP, 2 educators, 1 administrative staff (CSST), and nurses and psychiatrists (SMPR).

The UCSA and SMPR/CSST are located in two different parts/ buildings of the prison, resulting in less contact and communication between the two centres.

2.2.2 Goals and practical procedures

Upon entry to the prison, the prisoner is seen by the UCSA as soon as possible and then by the SMPR/CSST, SPIP (Probation and Insertion Services), etc.

The two substances provided as substitution treatment are buprenorphine and methadone.

The Ministry of Health reported the following figures:

- 45 on buprenorphine and 3 on methadone in 1999
- 53 on buprenorphine and 3 on methadone in 2001
- 62 on buprenorphine and 12 on methadone in 2004

(figures provided by the prison of Lyon on a given day in November 1999, December 2001 and February 2004).

The pharmacist, located in the prison (which is actually not statutory), prepares prisoners' medical treatment which are placed in individual boxes with the prisoner's name and cell number. The procedure is: the doctor prescribes, the pharmacist prepares and the nurse fetches the treatment from the pharmacist and delivers it. Each prescription form is duplicated so that both the pharmacist and the prisoner have a copy. A copy is kept in the prisoner's

medical file (for the doctor's use). The prescription form cannot be falsified. Pharmacists verify the association of prescribed medicine, the doses and mode of use. If they perceive a problem, they directly contact the prescribing doctor. Once a month, they present a report taking bearings of the treatments prescribed. The prescription is valid for 28 days for buprenorphine and 7 days for methadone.

The maximal dose of buprenorphine allowed by the pharmacist is 16 mg (2 times 8 mg), although 16 mg should be exceptional as doses in prison should be less. The pharmacist recommends buprenorphine doses of 8 mg. The pharmacist said that detoxification with buprenorphine or methadone is not frequent in prison.

At first, buprenorphine is distributed at the SMPR/CSST by nurses who control the intake. After the first 2 weeks of treatment (or sometimes earlier), the same two guards accompany one nurse to prisoners' cells for the distribution of buprenorphine. Buprenorphine is delivered either every day, once a week or twice a week (it varies on individual basis). It is delivered on Mondays and/or Fridays at noon. No pressure or conflicts from prisoners during the distribution of buprenorphine were reported as rules are clearly established. However, conflicts arise from a lack of follow-up; for instance, the prescription is not renewed on time, which results in the prisoner being unsatisfied as, it was stated, they often take their treatment for granted.

During the weekend and bank holiday, two nurses work from 8.30 am to 5.30 pm. There is no medical staff at night. Medical services may be called for emergency cases. The medical staff stated that the offer (i.e. having medical staff overnight or a doctor during the weekend) would create the demand.

A nurse reported that substitution treatment is 'health care' and, therefore, should be delivered within the SMPR setting. He further stated that he felt he had a lot of pressure from prisoners who want buprenorphine. He stated that the follow-up and therapeutic approach as part of the treatment is often lacking. *'I don't feel I am a health care worker, I don't feel I am helping people.'* He also said that the diversity of practise, ethics and perception of substitution treatment within the medical team is problematic as a coherent, structured framework of practise should be in place. For instance, it was reported that if a nurse refuses to give a buprenorphine pill that the prisoner says he has lost, the doctor might accept to replace this 'lost' pill underlying

the trust relationship. The nurse said that the prisoner took advantage of the situation.

It was reported that within the same prison some doctors are in favour of a reduction of the dose towards abstinence, whereas others are in favour of maintenance treatment. A psychiatrist said that each doctor should be free to choose and offer the health care approach he supports. Diversity of medical practise among doctors within the same penitentiary establishment increases the prisoner's range of choice of doctor and treatment. No precise protocol exists for the prison, permitting a certain freedom of practise.

Doctors reported that some prisoners were often keen on reducing the dose too rapidly. The end-goal of substitution treatment does not have to be absolute abstinence, unlike an antibiotic.

Guards reported that buprenorphine facilitates withdrawal, which is difficult to go through for the prisoner but also for the guard. The prison environment has become calmer thanks to substitution treatment. However, buprenorphine is valuable and is often swapped for other products on the black market. A guard stated that she felt substitution treatment (especially, buprenorphine) is prescribed too easily and doses are frequently maintained. The governor stated that the disadvantage with substitution treatment (especially Subutex®) is the risk of being used on the black market and thus being part of traffic or the racket associated with it.

The situation is very different with methadone, where few problems and conflicts arise. Indeed, methadone is provided at the SMPR under close supervision, due to the possible fatal risks linked to the substance intake. The prisoner must take methadone in front of the nurse. There is a general willingness to decrease the dose of methadone. It was said that methadone is especially recommended for those who misuse buprenorphine, cannot manage the intake on their own or need close supervision.

The main problem with methadone is the continuation of the treatment once the prisoner is released as not many doctors prescribe methadone outside, due to the compulsory urine tests, daily intake and close supervision. Furthermore, many doctors are reluctant to prescribe methadone due to the possible fatal risks. Moreover, although 3 medical centres based in Lyon outside of prison accept to continue methadone for released prisoners, many prisoners refuse to visit the centre on a daily basis, a doctor reported. '*Daily visits*

work well in prison, but not outside'. One outside, released prisoners are also more reluctant to adhere to urine tests.

In prison, the starting dose of methadone is on average 20 mg. The maximal dose is normally 110 mg. The pharmacist stated that it is easier to adapt the dose with methadone than buprenorphine because of its liquid form. One bottle contains a dose of 5 mg to 60 mg. Prisoners' doses of methadone at the time of the visit were 10, 20, 50, 60, 65, 85 g. The pharmacists do not intervene with methadone doses as they perceive methadone as less problematic due to its distribution in a more supervised and individualised approach.

Substitution treatment is rarely initiated in prison for the very first time. Usually, most prisoners have had, at some point, a substitution treatment (buprenorphine and/or methadone) prior to incarceration. The 'appropriate' dose is set according to past history and discussion between the doctor and patient.

Urine tests are conducted regularly with prisoners on methadone. Nurses may also recommend conducting a urine test on prisoners they suspect have topped up their treatment. The purpose is medical, not security. If any illicit drugs are found in the urine, the doctor will engage in a discussion with the prisoner and will not expulse him from the treatment.

Overall, medical staff's feelings about substitution treatment were mixed. Many criticised it, especially buprenorphine, due to the lack of supervision and global therapeutic approach. The traffic is also problematic and questions their role as doctor and 'curer'. Nevertheless, they acknowledged that it is a tool to get a contact with a drug-using prisoner, even though a minority of prisoners on substitution treatment are truly willing to engage in a therapeutic work. They further said that substitution treatment has reduced self-harm in prison, prevents HIV and hepatitis infections, and helps drug-using prisoners' through withdrawal and possibly towards reaching abstinence.

Psychosocial support and staff training

There was no particular mention of psychosocial support or staff training.

The psychologist stated that psychosocial support is provided to prisoners on substitution treatment. They often need a surrounding to 'reconstruct' themselves and their identity (other than that of a 'drug user'), manage 'psycholo-

gical' withdrawal symptoms; psychosocial support tries to help them in that sense.

Many doctors stated that a global therapeutic approach should be offered to prisoners on substitution treatment. They also said that they often had learned about drugs and substitution treatment while working, which is not always appropriate.

2.3 Views of prisoners

A total of 6 male prisoners were interviewed. At the Prison des Yvelines, two together and two on an individual basis. At the Prison of Lyon, two on an individual basis.

Most of the prisoners disagreed to be interviewed in a group. Although a focus group was planned with 5 to 6 prisoners, only 2 showed up. They agreed to be interviewed together. They said they did not care about being seen and identified as a drug user.

Prisoners explained they did not take the treatment as advised to.

'I have asked to stop Subutex® because I ended up having a stock of subutex® because I was taking only half of one pill. I asked to stop subutex® until I no longer had any stock. Then I asked to continue the treatment and decrease until complete detox. But the doctor refused because he said that I had asked to stop the treatment. I should have asked to stop temporarily.'

Prisoners reported misusing buprenorphine in prison. When buprenorphine is associated to the substance and misused, it loses its treatment value. It becomes another drug and falls into the 'love-hate' relationship other prisoners reported in other countries when talking about methadone treatment. Receiving substitution treatment in a supervised and appropriate health care scheme increases prisoners' satisfaction.

'Subutex® did not work for me because it tempts me and reminds me of heroin. Subutex® replaces heroin for a moment, and then becomes similar to heroin. I took a lot of Subutex® but never sub-lingual, always sniffed.'

'I injected Subutex® a few times, which is a problem because we then do not get out of the drugs field and drugs pattern.'

'I took Subutex® for 2 to 3 years but it's awful, disgusting. It has no effect. I used to take a lot of it. I had high doses. I took it on the black market,

through 'magouille' [dirty tricks]. It was the same as injecting other drugs, the same perspective and environment. Now I'm on methadone (since 2-3 weeks) on 80 mg. I tried methadone once before on the black market. Now I get a syrup that I must drink in front of the nurse. It is efficient; it works. There are no risks of 'magouille'. I must wait a few days with methadone to feel the effect. You don't get a kick with methadone 'ça ne défonce pas. (...) I only see the psychiatrist, no psychologist. I have been here for 1 month. The system is efficient. The medical centre is very good. There are a lot of doctors who do not know about drugs and do not want to do anything (or do not want to tackle) drug issues. (...) I do not need anything like psycho-medico-social support. It goes well physically and psychologically. I have no special needs. Psychologically, I get support from the psychiatrist, who knows about drugs and addictions (even better than doctors outside).'

Needs for psychological support was important and lacking to some prisoners

'I only see the psychiatrist in prison. I also have a contact with an external centre 'CEDAT'. The 'prise en charge' (follow up) in prison is good. However, there is a need for more social workers, psychologists, people to talk to. I have not seen one yet.'

The need to attend the SMPR daily for methadone provision may not be clear to all patients, although prisoners were satisfied with the SMPR service.

'My mind being woken up every morning to go to the SMPR. I want to attend the mass on Sundays but I must go to the SMPR at the same time. I want to be allowed to receive methadone on the Saturday for the Sunday.'

'The SMPR is good and provide good support and health care. The people there are professionals and know what they do.'

When taken properly, prisoners reported being satisfied with the treatment.

'I feel good with methadone. I no longer am dependent on drugs psychologically and I am a lot calmer. When I am released, I don't want to be dependent on drugs. But it's harder and more stressful outside with the family, and all.'

Prisoners reported getting no discrimination from the guards.

'Guards must know or have suspicions about why the prisoner goes to the medical centre every day, but I get no discrimination.'

Confidentiality was not reported as being problematic either.

'Confidentiality is not a problem. It all depends on who you share your cell with.'

3 Summing up

Substitution treatment is delivered in prison under the management of the Ministry of Health. Although the treatment has been allowed in and out of prison for approximately 10 years, in practice, the treatment has been offered in prison more recently. Sometimes, the treatment is not offered due to a doctor's own convictions, or due to a lack of resources (especially for methadone) or lack of SMPR-CSST.

Any prisoner is considered and talked about as a patient (not prisoner) by the UCSA and SMPR-CSST. Substitution treatment is considered to be a medical treatment, successful in the stabilisation and treatment of drug users, and especially successful if provided within a thorough psychosocial-medico support and health care.

Buprenorphine is misused by users and some doctors who prescribe it too lightly in the community. Buprenorphine is misused through injection or sniffing in prison as prisoners receive their treatment for one week. This results in buprenorphine being considered as 'just another drug' or a toxic substance. On the contrary, methadone is provided in a closed, supervised environment on a daily basis. Prisoners, who were motivated to tackle their drug use, preferred a supervised health care environment and a medicine that they did not remind them of drugs.

It must be underlined that out of the 168 prisons in France, only 26 have a SMPR, of which 16 have a CSST. Although the structure SMPR-CSST in prison seems to bring a lot of support for drug treatment to the prison staff, medical staff and prisoners, there is a clear disparity of the availability of such structure in the French prisons. Substitution treatment is provided differently across the country: there is great disparity among the different prisons and from one doctor to the other.

Moreover, although France seems to be exemplary in terms of the health care management and structure in prison, as well as the way substitution treat-

ment is considered (as a medical treatment), it was emphasised that substitution treatment should be offered with more psychosocial and therapeutic support, which is often lacking in prison. Some doctors questioned the end-goal and meaning of substitution treatment without such global therapeutic structure.

Germany¹

1 General data:

Drug use, substitution treatment and prison population

1.1 Number of drug users

According to EMCCDA (2003), the number of problematic drug users is 171 242. The use of opiates (lifetime prevalence) is considerably low, 1.4% of the age group 18-59, though this does mark a slight increase in comparison with 0.9% in 2000. Lifetime prevalence of cocaine is much higher: 3.0%. The prevalence of cocaine use in the age group 18-24, 3.9%, has increased fivefold when compared to a level of 0.8% in 1980 (Die Drogenbeauftragte der Bundesregierung, 2004, 60f). According to the Robert-Koch Institute in Berlin, approximately 9% of all HIV cases are accounted for by intravenous drug users. Hepatitis C is most widespread in the population of drug users, according to the different populations studied, 60-90% of drug users are infected with HCV.

1.2 Substitution treatment

1.2.1 *Historical and legal background*²

Although the first, experimental methadone programme was carried out in Germany (in Hanover/Lower-Saxony) from 1973 to 1975 (with levomethadone, L-Polamidon®), substitution treatment was introduced on a larger scale relatively late. The first methadone maintenance treatment (MMT) was started at the end of the 1980s (initially in North-Rhine Westphalia) as a response to the threat of HIV/AIDS. Since then, a number of other substitute substances have been authorised such as methadone (1994), buprenorphine (2000), dihydrocodeine, and codeine. The German Narcotics Act was revised in 1992, finally clarifying that drug substitution treatment is legal. A randomized, controlled heroin trial started in 2002. According to the drug commis-

1 The field visit, conducted by Heino Stöver. Thanks to Inge Schulten and Klaus Tieding, Prison of Lingen, who also provided information and support.

2 Parts of this section are based on Gerlach 2002.

sioner, the number of participants in drug-substitution treatment has risen over the past 15 years, from 1 000 to an official figure of 56 000 by the end of 2003 (Die Drogenbeauftragte der Bundesregierung, 2004, p. 82).

Until the early 1990s, methadone could only be administered to drug users when tight indication criteria were met (e.g. emergency cases, such as life-threatening conditions of withdrawal or conditions of severe pain). In general medical practice, however, German doctors were prevented from using methadone to treat heroin addicts, since MMT was considered to be medical malpractice. Nevertheless, there were a few general practitioners (GPs) who ignored the legal regulations and prescribed methadone to opiate addicts, most of these doctors were persecuted and prosecuted as a result of ‘evidence’ presented by medical ‘experts’.

The final goal of the substitution treatment is abstinence. But, as essential steps to reach this goal, other goals are pursued: to secure survival, health and social stabilisation, social and professional rehabilitation. Moreover, substitution treatment is supposed to help prevent infectious diseases (Die Drogenbeauftragte der Bundesregierung, 2003, p. 76).

Legislation on drug-substitution treatment

The German Narcotics Act was passed in 1971 and modified in 1982. With regard to substitution treatment, it was only in 1992 that the amendment of the Regulation on the Prescription of Narcotics (BtMVV – Betäubungsmittelverschreibungs-Verordnung) was introduced which clarified the legal position of methadone prescribers. Doctors prescribing substitute substances have to keep to the “generally accepted state of the art of medical science”, as defined by the Federal Medical Board. In March 2002, this board released “Regulations for the Substitution Treatment of opiate addicts”, according to which substitution treatment is indicated as permissible:

- When there is long-term opiate addiction and attempts to achieve abstinence have not been successful,
- When a drug free therapy cannot be carried out
- When substitution treatment offers the biggest chance for healing and recovery

The main regulations, as documented in Section 5 of the Regulation on the Prescription of Narcotics (BtMVV), are summarised below:

In accordance with section 13 (1) of the Narcotics Act, substitute drugs may be prescribed for the following regulation purposes (treatment goals):

1. Treatment of opiate addiction with the goal of step-by-step recovery to abstinence including the improvement and stabilisation in general health status;
2. Treatment of patients addicted to opiates who have undergone medical treatment for severe medical illnesses;
3. To reduce the risks of opiate addiction during pregnancy and after birth.

Doctors are authorized to prescribe substitute substances if and as long as:

1. The patient is eligible for substitution treatment;
2. Substitution treatment is embedded in a comprehensive treatment incorporating psychiatric, psychotherapeutic or psychosocial care;
3. Patients are registered at the Federal Narcotics Control Board (Bundesopiumstelle) (effective of 1 July, 2002);
4. There is no evidence that the patient:
 - a. receives substitution substances on prescription from another doctor,
 - b. does not participate in accompanying treatment and care,
 - c. uses substances that endanger the purpose of substitution treatment,
 - d. does not use the substitute as directed by law;
5. The patient sees his/her doctor regularly (usually once a week);
6. They have qualified for addiction treatment according to the guidelines of the relevant state or regional medical boards (effective 1 July, 2002).

Doctors are obliged to document all relevant patient and treatment data. Substitute substances must not be prescribed for intravenous use. The substitute may be dispensed and/or taken under supervision in GP's offices, hospitals, pharmacies or other facilities approved by the relevant state authorities. For substitution treatment funded by the Social Health Insurance (SHI) additional guidelines have been drawn up by the Federal Association of Physicians and Social Health Insurance Organisations (Kassenärztliche Bundesvereinigung) which regulate the conditions for reimbursement of treatment costs (BUB-Richtlinien). These guidelines may be ignored with patients who have no public health insurance.

Doctors are required to test patients' urine and to monitor poly-drug use. There are no rules regulating the frequency of taking urine samples. In practice, during the first weeks of treatment, doctors usually test their patients'

urine at least once a week. According to the BUB guidelines, continued collateral use of addictive substances must result in the termination of treatment.

All doctors seeking to provide drug-substitution treatment must provide evidence of having sufficient qualification in pharmacology and drug addiction by participating in special medical qualification programs. Training covers topics such as opioid dependence, the role of substitute substances, understanding and caring for the substitution patient, assessment and management and clinical practice dosing procedures (Poehlke et al., 2000). By December 2003, approximately 8 000 doctors had completed this vocational training (but only 2 600 actually provided substitution treatment; see Die Drogenbeauftragte der Bundesregierung 2004, p. 82).

Depending on the number of substitution treatment providers in a given area, doctors can be authorised to treat up to 20 patients funded by Social Health Insurance (SHI). There is no such limitation given in the Regulations on the Prescription of Narcotics (BtMVV). Thus, doctors approved to treat 20 SHI patients may care, for example, for another 20 patients funded by social welfare or paying for their treatment themselves. Despite the fact that the BUB guidelines are effective nationwide, there are considerable variations between the federal states on the organisation and delivery of substitution treatment and accompanying psychosocial care.

As documented above, legislation on drug substitution treatment remains oriented towards abstinence rather than maintenance, although research findings and experience gathered from medical practice indicate that limiting the duration of participation in treatment does not prove successful for the majority of the patients (Gerlach 2001).

Treatment modalities and costs

In Germany, treatment and prescription (medication) costs are generally covered by social health insurance schemes (SHI) which are mandatory for almost 90 percent of the population (in special cases, e.g. homelessness, doctors' fees are met by social welfare services). There is also the freedom to choose one's own general practitioner (GP) or hospital (Whitney 1993; Weil & Brenner, 1997). However, this praised German health care system has failed in respect of opiate addiction treatment since public health insurers are not under a legal obligation to meet drug-substitution treatment and pre-

scription costs. Up to the present, they do not accept opiate addiction as a sufficient indication for treatment with substitute substances.

Psycho-social care

The legal guidelines (of both the BtMVV and the BUB) demand mandatory participation of patients in psychosocial care, although there is no empirical evidence of an obligation for *all* patients to attend psychosocial support (Ullmann, 1996). However, these regulations do not provide any instructions on the frequency, mode and scope of psychosocial care provisions and, to date, there are no nationwide standards of how to organise and structure accompanying support. Psychosocial care is a collective name for a number of different areas. These may include, for example, legal advice, managing financial problems (e.g. debts, rents), recreational activities, crisis intervention, (psychotherapeutic) group sessions, assistance with finding accommodation and jobs, and qualifying for school and vocational training. Psychosocial care is not funded by the SHI. There are great variations in psychosocial provision between different states and communities, and variations in quality and funding.

1.2.2 Substitution treatment in prison

1.3 Prison population

Table 9 Data on the prison situation in Germany (Source: King's College London, International Centre for Prison Studies, Prison Brief for Germany)

Country	GERMANY
Ministry responsible	Ministry of Justice (Bundesministerium der Justiz)
Prison administration	Prison and Probation Service (Das Referat Strafvollzug und Bewährungshilfe)
Contact address	Mohrenstrasse 37, 10117 Berlin, Germany
Telephone / fax / website	tel: +49 30 20 25 92 22 fax: +49 1888 10 580 92 22
Head of prison administration (and title)	Christian Lehmann Ministerial dirigent

Prison population total (including pre-trial detainees / remand prisoners)	79 153 at 30.11.2003 (Federal Ministry of Justice)
Prison population rate (per 100,000 of national population)	96 based on an estimated national population of 82.62 million at November 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	21.2% (30.11.2003)
Female prisoners (percentage of prison population)	5.0% (30.11.2003)
Juveniles / minors / young prisoners (incl. definition percentage of prison population)	4.4% (of pre-trial prisoners only – under 18, 30.11.2003)
Foreign prisoners (percentage of prison population)	29.9% (31.3.2002 – Council of Europe Annual Penal Statistics)
Number of establishments / institutions	222 (2002)
Official capacity of prison system	78 753 (30.11.2003)
Occupancy level (based on official capacity)	100.5% (30.11.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 57 448 (71) 1995 66 146 (81) 1998 78 584 (96) 2000 78 707 (96)

Legal responsibility (Prison Act) for medical care of prisoners

Whilst the German Prison Act (Strafvollzugsgesetz) is a federal law, its implementation is in the hands of the 16 individual states. The Prison Act is supplemented by many administrative regulations at state level as well with those of particular prisons (cf. Feest/Bammann, 2003). According to the Prison Act (§§56-66), the state (i.e. 16 Ministries of Justice) is responsible for providing adequate medical care to prisoners. Medical care must follow the guidelines of the National Health Insurance system and comply with the medical standards outside the prison. Therefore, substitution treatment within the prison system should follow the same regulations and standards

that apply to substitution treatment under the National Health Insurance system outside of prison.

This principle of equality is basically reflected in two paragraphs of the Prison Act (Art. 3, cf Feest/Bammann, 2004). It is based on:

- The principle of normalisation: meaning life in corrections shall resemble general living conditions outside prison as much as possible, and
- The principle of damage reduction: correctional authorities shall mitigate against the damaging consequences of imprisonment.

However, with regard to substitution treatment, there are several important distinctions (see Keppler/Stöver, 1998):

- 1 In German prisons, patients may not choose their doctors, i.e., the relationship between patient and physician is somewhat coerced. In general, inmates have tendency to mistrust doctors and meet them with reservation and prejudice.
2. Outside prison, methadone patients are often required to disassociate physically, socially, and mentally from the drug scene, which was the focal point of their lives and personal experience. Behind bars, this disassociation is only possible to a limited extent.
3. Effectiveness and attraction of substitution treatment depends on the positive attitude of the treatment staff as well as on the entry threshold level. The prison system often has problems with both of these conditions.
4. Where politicians and the public are concerned, methadone maintenance was linked to expectations which were partly unrealistic and which exceeded medical outcomes. These expectations were not fulfilled. The large-scale distribution of substitute drugs was supposed to have a wide-spread effect which – in addition to medical and social stabilisation – should eliminate drug subcultures and drug scenes in and outside prison. The outcome, however, fell short of expectations.
5. Maintenance is considered very time and labour intensive, particularly in the starting phase of treatment and medical staff have to acquire the necessary ‘maintenance know-how’. This can sometimes be an arduous process. However, methadone maintenance remains costly throughout the programme, i.e., when the number of methadone patients increases.

6. Methadone maintenance is still approached in entirely different ways across the nation. It varies from state to state and even from prison to prison.
7. Drug testing for the additional use of psychotropic substances is mandatory for all methadone patients. This also applies within the prisons. Due to a variety of manipulation techniques in urine testing, usual testing procedures should be interpreted with great care.

There is a consensus both outside and inside the prisons that, besides providing the substitute drug, supportive psychosocial measures are sensible and can contribute to achieving therapeutic objectives.

The number of drug addicts in prison

There are approximately 80 000 prisoners in Germany (including remand prisons). 25% of these are estimated to be intravenous drug users (IVDUs) (Stöver, 2002a). Detailed studies show that up to 50% of the prisoners have experienced illicit drugs (with even higher numbers in juvenile and women's prisons). Despite rigid controls, about 50% of all imprisoned IVDUs continue to use drugs. It is estimated that the drug using population in prisons exceeds 10 000. These are only rough estimates since no specific data is available. Neither is any information available on the number of substitution patients in penal institutions. Only 6 out of 16 federal states in Germany provide substitution treatment in prisons (Hamburg, Bremen, Berlin, Hesse, Lower Saxony and North Rhine-Westphalia). Admission criteria varies between states and substitution treatment is not available in each of the single state's prisons (Kepler, 2000; Stöver, 2001).

Goals of Substitution Treatment in prisons

In German prisons, substitution treatment is often an integral component of a broader drug service concept (c.f. Ministry of Justice/North Rhine-Westphalia/Germany 1998) and includes psycho-social support, provided by prison staff, alongside health or social workers. The goals of the treatment are diverse and can be grouped into the categories of medical, socio-rehabilitative and prison-code requirements:

Medical goals:

- Reduced use of drugs through injection needle and medical drug sharing
- Reduction in the spread of infectious diseases and drug-related health deterioration (HIV, Hepatitis B+C, abscesses, overdoses)

- Stabilisation of drug users who had been in substitution treatment before imprisonment
- Preparation of inmates for a transfer to an open prison

Socio-rehabilitative goals:

- To improve the success of relapse prevention (with stabilisation through methadone as the basis for preparation for release)
- To reduce recidivism
- To promote personal potential and development

Prison-code specific goals

- Reduction in drug use and smuggling within in prison
- Reduction in the development of prison specific and sub-cultural dependencies, meaning that prisoners no longer need to buy and sell drugs on the prison black market
- To draw inmates out of the prison subculture, by giving them medical and psycho-social support in order to distance them from the drug scene

Consistency of substitution treatment in prisons

The practice of methadone use in prison is consistent with external practise in the community. Thus, in places where methadone is freely prescribed in the community, it is also prescribed in the prisons. Conversely, in those locations where it is offered rarely, it is seldom found within the prisons.

Up until now, maintenance treatment has not been implemented on a regular basis or in all prisons. There is a distinct difference between Northern and Southern, Eastern and Western Germany. Only a few states continue methadone treatment in prison if it was initiated before detention. These opportunities are usually restricted to short-term detainees in order to help them “bridge” the time spent in prison. Long-term methadone treatment has been rejected by most prison doctors in Germany (Stöver, 2002c). Some penal institutions offer a “gradual withdrawal” program for addicts. A few drug addicted inmates who are likely to relapse after imprisonment, and for whom post-incarceration treatment has been planned, are permitted to begin methadone shortly before their prison sentence ends in order to prepare them for release.

States that have adopted methadone maintenance are the city-states of Hamburg, Bremen and Berlin, as well as the states of Lower Saxony, Hesse and North Rhine-Westphalia. All of the other ‘old’ federal states have a rather

negative attitude towards maintenance treatment. According to the low spread of opiate use in Eastern Germany, the provision of substitution treatment in East German prisons is low as well.

In August 1994, at a hearing of the Ministries of Health and Justice, methadone maintenance in prison was still proving controversial with positions on social indication differing markedly. Some of the participants favoured an expansion of maintenance programmes in order to achieve a reduction in the demand of drugs, reduce crime in prison, achieve psychological, physical and social stabilisation as well as reinforce the motivation for abstinence. The representatives of Bavaria and Baden-Württemberg agreed that in individual cases the maintenance treatment could be continued if it existed prior to the person's imprisonment. Both states laid emphasis on prison doctors being able to act at their own discretion, but immediately limited this medical licence by issuing guidelines. For Bavaria, consideration of large scale methadone programmes is out of the question and the so-called 'cold-turkey' method of detoxification is used instead of methadone-based withdrawal. In principle, Saarland and Schleswig-Holstein are inclined to implement maintenance treatment in order to prepare inmates for their release from prison, while Rheinland-Pfalz argues that drug dependents in prison are usually detoxified already rendering maintenance pointless. In Schleswig-Holstein, a decree providing for maintenance treatment was issued by the Ministry of Justice, giving methadone maintenance political backing. However, the representative from Schleswig-Holstein indicates that maintenance treatment in prison is not implemented regularly enough.

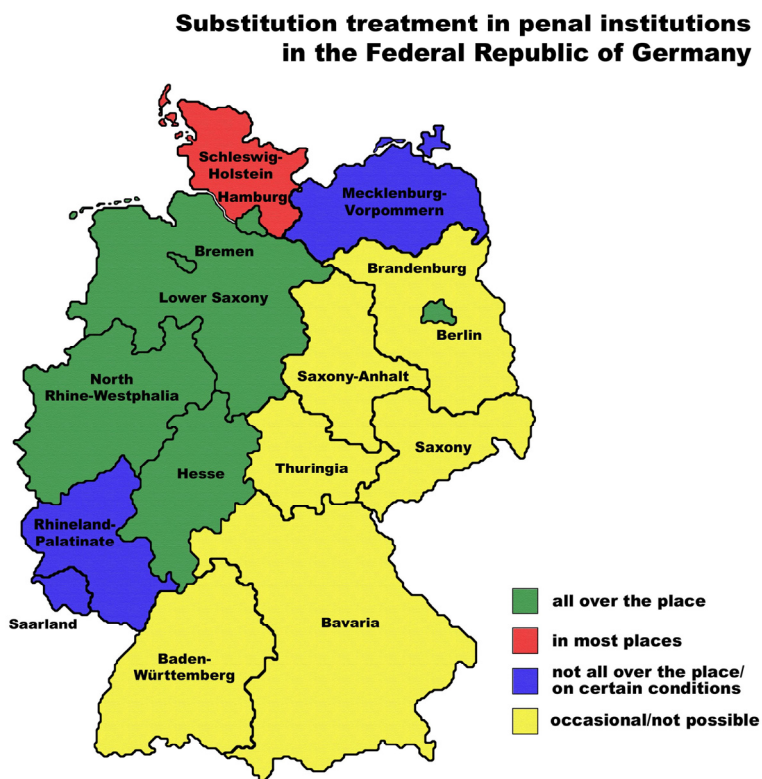
In terms numbers, the drug problem in Germany's five new states is only small. Hence, the use of illegal drugs in prison is low and maintenance treatment is not administered often.

Table 10 Possibilities for substitution treatment in penal institutions in the Federal Republic of Germany

Possibilities for substitution in penal institutions in the Federal Republic of Germany



Table 11 Substitution treatment in penal institutions in the Federal Republic of Germany



Number of prisoners in substitution treatment

No precise figure is available for prisoners in substitution treatment in German prisons. The current situation can be described as follows: it is estimated that methadone patients number approximately 700 among the 20 000 incarcerated inmates who use hard drugs (25% of the total number of inmates, 80 000). Given that half quit their drug use (Weilandt et al.) and only a third of the remaining group, 10 000 drug users, are eligible for substitution treatment, there should be more than 3 333 prisoners in substitution treatment in German prisons. In reality, the prevalence of treatment is much less common.

Reasons for the discontinuation of substitution therapy in prisons

Keppler et al. (2004) found that the reasons for the discontinuation of treatment and other basic problems in prisons are nearly identical to those found in similar programmes in the outside community. Other difficulties are prison specific. The latter issues include the following:

- Basic abstinence orientation: Doctors view the period of imprisonment as the most appropriate time to overcome drug addiction and to attain a drug-free state. This philosophy rejects methadone treatment as counterproductive in that it prolongs the addiction.
- According to a French survey, the criteria for receiving substitution treatment are unclear: “In prison some people are regarded as patients and others as drug abusers” (Trabut, 2000, p. 30). This distinction arises because some patients have been in a number of programmes. Given the variation in prison practices, prisoners perceive the prescription of substitutes to be allocated on an arbitrary basis.
- The provision of methadone treatment is determined by the medical team located within each institution
- Methadone is often seen by staff as a drug that provides pleasure, rather than as a medical treatment (Keppler/Stöver, 1997) Staff members are often critical of substitution treatment because many recipients supplement that drug with others (often illegal and often through injection).
- It is impossible to ensure that users distance themselves from the drug scene and the prison subculture fully. In some prisons in Germany and Austria, inmates who receive methadone treatment are housed in special units and provided other forms of support.
- Anonymity and confidentiality are difficult to secure because inmates in methadone programmes are generally housed with other offenders and easily identified by them.
- Some studies suggest that methadone treatment is non-disruptive and has a positive effect on prisoners’ drug using behaviour (for Scotland see Shewan et al., 1996), constitutes a basis for further medical contact and treatment, has a significant impact on the reduction of the transmission of communicable diseases (Hall/Ward/Mattick, 1993), prevents opioid-related overdoses, along with other advantages. Despite these advantages, methadone is seen by many officials as undesirable because it undermines the prisons’ efforts and strategies aiming at abstinence:

- Detoxification doses and procedures are discussed often. In some countries, criticisms have suggested that there are no standard procedures and that doses are reduced too quickly (Italy, Germany).
- Some countries lack personnel and financial support and are inconsistent in their use of methadone treatment.

Finally, problems exist in relation to the continuation of substitution treatment during home leave/holidays, following release or after transfer to another prison.

Problem Areas of Substitution Treatment – Case studies

As indicated above, the limits and extent of medical care for prisoners are defined by the Prison Act in the chapter on medical aid (§§ 56-66). The Prison Act refers repeatedly, and sometimes adheres literally, to the restrictions laid down by the German Social Health Insurance system (SHI: comparable NHS in England). The gist of the law is quite clearly to make prison medical care conform to the treatment prescribed for SHI insures. Nevertheless, the guidelines for reimbursement of treatment costs (BUB-Richtlinien) on drug substitution laid down by the CHI are only valid in prisons via a sub-ruling. In some federal states, for example, drug substitution treatment is so closely circumscribed that in all cases the BUB guidelines are explicitly referred to.

The transfer of patients on drug substitution treatment from the CHI system into the prison system, and vice versa after release, invariably meets with difficulties.

This is demonstrated by the following case studies³:

No continuation of treatment due to prison doctor's negative attitude

Anton B. is currently receiving methadone maintenance under the CHI system due to an existing HCV infection complicated by HCV-RNA. Even under the old, restrictive guidelines laid down by the BUB (see above), this treatment is clearly indicated, and permits unlimited methadone maintenance chargeable to the CHI. To date, treatment has gone off without a hitch. However, Anton B. is in Prison X in Baden-Württemberg (one of the 16 'Länder' in the South of Germany) on account of a crime committed three years previously; the gap between offence and imprisonment being so long on account

3 All names and personal characteristics changed.

of various appeal procedures. Methadone maintenance is not available here because the doctor in charge considers it “capitulation in the face of addiction”. Substitution is discontinued and Anton B. is switched to withdrawal on codeine compounds. Anton B.’s only option is a laborious appeal procedure. Court rulings have already been passed in such cases, – the District Court in Dortmund (LG Dortmund 1995) stated in a case summary that although the court could not force a doctor to provide drug substitution, it could rule that the prison system must enable a detainee to receive treatment. In practice, this might mean transfer to a different institution. Similar rulings have been handed down by District Courts in other cities (Frankfurt and Bochum).

Substitution discontinued on account of failure to approve treatment by the Union of CHI approved Doctors (UCD)

Christian D. is undergoing “private” drug substitution which means that, although his doctor works under the CHI system, the allotted number of places in his UCD substitution scheme has been used up. Christian D. starts his sentence in Prison Y in North Rhine Westphalia where drug substitution is standard procedure. Although the substitution scheme is already full up here too, a legal ruling allows the prison doctor to use his judgement to continue treatment if the patient had been granted UCD treatment under his previous doctor. A call to his GP reveals that Christian D. is not registered for substitution treatment with the UCD and his methadone is withdrawn. In many cases a prison doctor’s decision to discontinue drug substitution might be simplified if the patient is a recognisable “subsidiary user” on entry, or if he has been neglecting his substitution treatment on the outside.

Substitution discontinued on grounds of limited capacity in drug substitution schemes

Emil F. is a drug user and has received notice that his prison sentence will begin soon. He has heard that the prison in which he will be serving his sentence provides a substitution programme and that he will have a much better chance of being accepted if he begins treatment beforehand. Therefore, he registers with Dr. Z. (a local doctor who administers drug substitutes in cooperation with a local drug advice centre), but Dr. Z. has no places free on his programme at that moment. Emil F. explains that he is due to start a prison sentence in a few days time, and is hardly going to be a burden on Dr. Z.’s limited resources. In view of this, Dr. Z. agrees to start treatment, and after a few days Emil F. reports at Prison Y to start his sentence. This

institution is known for its committed attitude and wide range of substitution programmes, but the burden of this is carried solely by the existing medical staff. Although they have been providing substitution for over 10 years and are currently treating more than 100 patients they have never officially received any additional financial resources or extra staff. Their aim, therefore, is to keep the substitution programme down to roughly 100 patients, with 15 on the waiting list (some of whom have been waiting several months). From experience, the doctor in charge knows that far more patients on drug substitution arrive than can continue treatment during imprisonment. For this reason, criteria have been drawn up among the staff to decide which new patients should receive uninterrupted treatment, and which should go on a waiting list. Emil F's is a typical case that the doctor has seen before; the patient starts drug substitution shortly before starting sentence to ensure continued treatment in prison. The doctor and his staff have decided to ignore patients with less than 4 weeks treatment prior to arrival. Emil F. is given withdrawal on methadone and an option to go on the waiting list.

Substitution refused on grounds of insufficient experience with the new substitution drug Buprenorphin (Subutex®)

Grete H. is a pregnant drug addict. Before starting sentence, she begins treatment under her home GP with the new substitution drug buprenorphine (Subutex®). Buprenorphine causes fewer neonatal withdrawal symptoms than conventional methadone treatment and, in some cases, none at all. Haven been taken into custody in a Women's Prison in Bavaria, it turns out that the new drug has never been administered there. She receives no answer when she enquires whether she can switch from buprenorphine to methadone. The buprenorphine is discontinued and she is simply treated for withdrawal symptoms.

Continuation of substitution to prevent subsequent relapse meets with difficulties on release from prison

In preparation for his release from prison, Ingo J. commences Methadone treatment. Ingo J. and the members of the prison drug counselling staff hope to reduce the danger of a relapse during the difficult adjustment phase after release. The counselling staff attempt to find a doctor in a large town in Thuringia who would be prepared to continue treatment after Ingo J. is released. But not one doctor in the whole city is prepared to take him on as a substitution patient. In view of this, Ingo J. decides to move to a large town in Hesse

after his release. The counsellors contact the drugs advice centre there and ask for a list of doctors providing substitution treatment. But after ringing through the entire list, it turns out that all of them are full up and no one has a free space for him in a substitution scheme. After this set back, the counselling staff ring the local drugs advice centre again. Strictly in confidence, they are advised to let Ingo J. wait until the end of his sentence and then simply go to a doctor and explain that he is a newly released prisoner on drug substitutes. At this point, he will be treated as an emergency and his substitution treatment continued.

This unsatisfactory situation among the medical profession arises from their dislike of administering substitution treatment. They are afraid that having drug addicts as patients will frighten their regular clientele away (“I wouldn’t go to a drug doctor”). In addition, the rates paid by the UCD for substitution treatment are so low that they provide absolutely no incentive to work in this sector.

No substitution possible in home town, resulting in rejection of transfer in spite of detainee being an AIDS sufferer

Karl L. is getting substitution treatment in a prison in north Germany. He is HIV positive and suffers from several AIDS related diseases. He is on methadone maintenance following high level addiction. Five years ago, he robbed a north German petrol station to meet his addiction expenses. Originally, he comes from south Germany and still has contact with his family there. As he doesn’t know how long he has to live and he wants to be closer to them, he applies to be transferred to a prison nearer home. His drugs counsellor enquires about methadone maintenance in the south German prison before the transfer and is told it won’t be possible there. Staying on methadone is so important to Karl L. that he takes the decision to turn down the transfer and stay in the north German prison, managing without family contacts for the length of his extended sentence. If family members want to visit, they have to cope with a journey of 700 km each way. If Karl L. ever gets out on parole and wants to visit his family, he will have to travel the same distance.

Substitution in a Mother and Child detention centre

Maria N. lives in Bavaria. She is a drug addict with two children. Her oldest child died at the age of six as a result of physical abuse by the father. The

court ruled that the young, overburdened mother, herself a victim of her husband's abuse, should have realised the danger of potentially fatal injuries to her child. Therefore, she received a 4 year sentence for abetting and failure to assist an injured person. Now, Maria's youngest child is 1 year old and she has come to terms with the fact that her addiction may have been part of the reason for her choice of husband, the state of their partnership, and the events leading up to her older child's death. To avoid all potential harm to her youngest child, she takes the decision to keep her addiction under control by getting into a drug substitution scheme. She doesn't want to be parted from her child and tries to gain admittance to a prison with a Mothers and Children ward. But none of the prisons in her home state of Bavaria allow either drug substitution treatment or the admittance of addicted mothers with children to their Mother and Child centres. Enquiries to Mother and Child centres in other federal states reveal a similar picture. Only one state has recently started admitting addicted mothers, and then, only if they demonstrate willingness to end their addiction, for example, by entering a substitution scheme.

Substitution refused despite assurance of continued treatment to a "voluntary surrendered" ⁴

Klaus S. lives in freedom, has been on drug substitution treatment for some time, but still has an 8 week sentence to serve. A drugs advice counsellor is able to get a judge's postponement of the sentence until provision has been made to continue administering substitutes in the prison in question. Klaus S. is sceptical, having had first hand experience of interrupted substitution treatment in prison. But the guarantee of continued treatment allays his fears sufficiently for him to report on time to finish his sentence.

However, a routine admission urine test (conducted for administrative reasons at a different prison) shows up traces of subsidiary drug use. The doctor responsible decides to ignore the existing agreement and transfers Klaus S. to yet another prison, one in which methadone maintenance is never permitted, regardless of Ministry of Justice rulings, even for non-subsidiary users. Viable alternatives for a transfer still exist at this point but, at the doctor's discretion, Klaus S's dosage is immediately reduced from 140 mg to 0 mg.

4 Case study description has been delivered by Inge Hönekopp, Mannheim, Baden-Württemberg.

Protests and attempts by other doctors to maintain substitution during the relatively short period that Klaus S has left meet with no success. The reason given being that the prisoner must have known that subsidiary drug use would cancel any entitlement to continued treatment. The community-based doctor is left to prescribe the substitution drug.

Conclusion

To summarise how substitution works in the various federal states and, with the help of case studies, to highlight the difficulties surrounding substitution on admission to prison, during sentence, transfer and release. In spite of the formal parameters of federal law, and specific administrative regulations laid down by the federal states, the practice of drug substitution in individual German prisons is inconsistent in relation to the following questions:

- Whether to administer substitutes at all
- Whether to administer substitutes as a withdrawal treatment only (tailored to meet individual patients' needs)
- Whether to use substitution as a long term treatment with controlled transition upon release
- Whether to instigate treatment during imprisonment (directly after arrival or as a health stabiliser prior to release)

There is similar variation in the choice of substitution drug and its average dosage within each prison, as well as the type and organisation of psychosocial support. Coherent practice on a federal level is imperative, if only to avoid the pitfalls shown in the cases above, and certainly if any degree of consistency in conditions in and outside of prison walls is to be achieved.

2 The field visits

2.1 Women's prison Vechta, Lower-Saxony⁵

2.1.1 Short description

The Women's Prison in Vechta, 40 km south of Oldenburg in the North West of Germany holds approximately 170 inmates and is the only women's prison in Lower-Saxony. Prisoners are on remand as well as sentenced.

5 The visits took place in May and August 2003.

2.1.2 Goals and practical procedures of the provision of substitution programmes

The medical doctor explained that he started substitution treatment in 1992 with five drug addicted inmates. The programme started without any official recognition from the chief medical supervising doctor in Hanover (Ministry of Justice), a formal ruling was only laid out in 1995/1996. At the time substitution treatment started, no support was forthcoming from the Ministry of Justice. On the contrary, they were advised to stay away from that form of treatment. The number of drug addicted women in substitution treatment rose to 35 and now there are approximately 50 patients.

Substitution treatment is provided for those previously in treatment in the community and for those who are already imprisoned.

- Nearly all of those who get substitution treatment in the community will be able to continue when entering prison. In these cases, the nurses contact external doctors to confirm the dosage.
- No prescription is given to those who commenced treatment during the last 4 weeks before admission to prison (on the suspicion that they were just trying to get into the prison methadone program).
- No methadone is prescribed for those who are coming from the community or from another prison and for whom the reduction of the methadone dosage has already been started (either because they were “topping up drugs” or the prisoner didn’t turn up for his/her methadone in prison during the last days before transfer to the prison of Vechta).
- Those who were already receiving substitution treatment in another prison (i.e. Hanover) will be able to continue their treatment.
- Those who want to get substitution treatment whilst already in the prison are put on a waiting list. The limitation in numbers is due to a limitation in staff and other resources and /or limited places in accompanying psycho-social care.

Decisions regarding admission to methadone treatment

Every 4-6 weeks, a group of professionals decides who to take from the waiting list into the methadone programme. This co-operative group consists of:

- medical doctor,
- two internal drug counsellors,
- lead nurse.

All relevant problems (preparation for release, waiting list, expulsions, new treatments) are discussed within this interdisciplinary group. No formal medical treatment plan is drawn up. But, within the psycho-social care setting, certain targets are laid down together with the prisoner. This forms the general framework within which advances or relapses are discussed.

Co-operation with other professionals and institutions

The main co-operation partner is the psycho-social care manager of the prison. Only in exceptional cases are external drug counsellors included and, when this occurs, they come from an NGO to provide counselling and preparation for release and transfer to a therapy institution.

Contact with a doctor whilst on leave for more than 1 day, or on release, is made by the prisoner herself, supported by the psycho-social team. For a week-end leave, the prisoner can take methadone with her from the prison; the nurses will provide her with enough.

Main goals of substitution treatment in Vechta:

- Heroin abstinence, abstinence from all injected drugs
- Preventing the intravenous use of drugs
- Compliance towards other medical therapies:
 - Healing of abscesses
 - HIV/interferon therapy
- Everyday activities should be stimulated (work, qualifications, school, going to relevant institutions)
- Stabilisation in the area of family and social relations

These goals are also valid for the psycho-social care (see interview below).

Different patterns of methadone reduction in one state: In the penal institution in Hanover (capital of Lower Saxony with the biggest male prison in the state), methadone is reduced every week by 1ml (a decrease of 10 mg in 7 days). In the Women's prison in Vechta, a reduction of ½ ml (5 mg) is made every second day, so that, every 4 days, 1 ml (10 mg) less is given. This is a significantly faster decrease than in Hanover. Given a starting dose of 50 mg, the reduction rate applied in Hanover and Vechta means:

JVA Hanover	50 mg	10 mg less per week	down to zero in 35 days
JVA Vechta	50 mg	10 mg less every 4 days	down to zero in 20 days

The reason given by the doctor for not extending the length of the methadone reduction phase further is that, according to patients, they want a shorter period of reduction time. The doctor quotes his patients as often saying that they do not want a long period of reduction because then detoxification and the weekly dose reduction remain a dominating topic over a longer period. According to his experience over the last 10 years, most of the patients prefer the faster reduction scheme.

In cases of demonstrable withdrawal problems at the end of the reduction (sweat on the skin, widening of the pupils etc.), the period of reduction is prolonged according to individual needs. For instance, that might mean slowing down the dosage reduction to a rate of 5 mg every three days.

Although patients initially express fears that reduction steps may be taken too quickly (10 mg decrease every 4 days), the explanation given, together with the assurance that the dosage reduction steps will be adjusted according to individual needs, generally reassures them.

Co-medication

No other medication, especially benzodiazepines or barbiturates, is prescribed by the doctor. This is only done by the psychiatrist and then only on the basis of a diagnosed psychiatric disease. For sleeping problems, Atosil® is given by the prison doctor.

Although there is a “*Quality supervision group*” (meeting bi-annually) of prison doctors for Lower-Saxony and Bremen (two of the 16 states in Germany), differences in standards for substitution treatment and reduction schemes persist. This is not seen as a problem and is not a topic of discussion and so different practices and standards remain. One example is the prescription of Codein products as substitution means. This opioid is still prescribed by some doctors, although state regulations require that substitution treatment should be done with methadone.

Substitution Substance and average dosage

Substitution treatment is mainly done with methadone. Buprenorphine (Subutex®) is only prescribed to pregnant women. According to the doctor, Subutex® is sometimes demanded by drug users who want to test a new substance. But even outside (see figures above) it is not very widespread. In Vechta only dl-methadone is prescribed, not the stronger version levometha-

done (Polamidon®). To concentrate on one substance is easier in technical terms (i.e. the methadone suspension automate) than to prescribe two or three substances to the 50 patients receiving methadone. This is also the reason for confining the prescription of buprenorphine to pregnant women. Patients who have been prescribed levomethadone externally will be switched to methadone without any problems.

According to the nurses, the procedure of dispensing buprenorphine was just as complicated. The substance is given sublingually and, during the time the substance is dissolving, the inmate has to be observed. This is seen as too time consuming.

Externally, the average dosage of methadone is approximately 8 ml (80 mg) whereas the average dosage in Vechta prison is 7.8 ml (78 mg) (August 2003). The doctor stated that the dosages prescribed outside in the community are relatively high and are not needed in the prison setting. For instance, they had the case of a patient getting 230 mg outside and only 130 while in prison, without any problems. Sometimes these patients are given the dosage on a “take-home” basis and are tempted to sell a part of the dosage. But in the majority of cases the same dosage is prescribed inside as outside the prison.

Detoxification of multiple addiction

In the admission phase, a ‘fractionised detoxification’ is carried out: if alcohol is the dominant drug it will be reduced with “Distaneurin®” and methadone will be continued on a stable dosage as well as benzodiazepines (here Valium® is used). When the alcohol detoxification is concluded, methadone would be reduced and, after that is finished, benzodiazepines would play an important role. They are continued and reduced afterwards. In this process it is crucial to work with the patient. The doctor does not prescribe any other psychoactive drugs, if there is a psychiatric disease the psychiatrist will prescribe the drugs. For anxiety and other psychiatric diseases “Atonil”® is given by the prison doctor only.

Scheme for starting substitution treatment

For those prisoners who are applying for the methadone programme the following scheme is foreseen:

Day	ml/mg
1	2/20
2	3/30
3	4/40
4	5/50 – stop for one week, to see how the patient gets along with this dosage

Qualification of the doctor prescribing substitution substances

Since 1 July 2002, doctors who wish to prescribe substitution substances have to be qualified in addiction treatment in accordance with the guidelines of the appropriate state or regional medical boards. According to the doctor, this may be an obstacle for some prison doctors, who first have to undergo further training before they are allowed to prescribe. He also states that by asserting the lack of time needed to become qualified, doctors can use this as a reason not to provide substitution treatment.

Practice of daily methadone provision

According to nurses, organising the administration of methadone goes as follows: issuing starts at half past six at the main sluice-gate. Here prisoners from the nearby open prison arrive, those who are working outside (day release system), and those who are either coming into the prison or supposed to leave the prison and take their methadone. After that, prisoners from different wards come one after the other, ward by ward. The prisoners wait in the waiting room and will be called into the doctor's room one after the other. Their visit finishes by swallowing some water to ensure that they drank the solution. Inmates do not complain about the practice which is supposed to be fair. In the doctor's room there may also be time for a chat about problems. At weekends, the nurses report that methadone has to be dispensed by one nurse alone which might lead to difficulties in managing the volume of treatment.

Urine controls

Under national law, randomised urine controls have to be carried out. Several positive urine tests will lead to a loss of acquired privileges or even an exclusion from the treatment. The same is true for any other conspicuous misbehaviour. Both instances of controls (medical service and prison-code instigated urine controls) must remain separate in order to respect the confidentiality of the medical services. The results of prison urine controls may be noted by the medical department, but not vice versa. The urine controls rele-

vant for the substitution treatment can be ordered either by the doctor/medical department or by the psycho-social care manager on suspicion that other drugs are being used on top of the prescribed methadone. The urine controls are not announced in advance and are taken in the morning during methadone issue.

Methadone is weighed and portioned by a methadone dispensing automat which is computer-based and measures every individual dosage. According to the nurses, inmates express distrust concerning the purity and quality of the methadone dispensed. Inmates' comparisons with methadone received in other prisons show that the quality of the methadone dispensed in Vechta is much lower than elsewhere.

Methadone for day leaves

For day leave, confirmation of substitution treatment is given to the patient, and a call is made to the nearest external doctor. According to the nurses, the head guards of certain wards expect their prisoners to join the methadone programme. These prisoners can then increase their chances of getting a positive response to an application for home leave.

Financial conditions

The prison is taking part in a pilot project in which three out of over 20 prisons in Lower-Saxony are given their own budget across all relevant areas of activity. It is notable that there are no financial constraints for admissions to or continuation of substitution treatment.

Training in managing substitution treatment

Training in the management of substitution treatment is done by the doctor and the nurses of the prison for other staff.

Suitable prison setting for substitution treatment

The prison doctor of the women's prison in Vechta stated: "Even if maintenance behind bars is frequently seen merely as a slight improvement of 'misery management', i.e., only as a harm reduction tool and not as a suitable measure suitable for solving the dilemma of a prohibitionist policy, it is still useful and necessary on practical grounds alone. Since methadone maintenance is known and accepted in the community, drug-dependent people may

develop an interest in maintenance treatment during the phase of internment. Prison medicine should be responsive to such wishes. In principle, methadone maintenance is a form of treatment that is particularly suited to the correctional system. On the one hand, most of the resources needed for maintenance treatment and psychosocial support are already available. On the other hand, prisons are filled with precisely the kind of clientele that comes under consideration for methadone maintenance, i.e., intravenous drug addicts with prolonged drug careers and various unsuccessful attempts to achieve abstinence. Maintenance treatment could be a stepping stone for further treatment. It is extremely important with regard to the new treatment options for HIV/AIDS and hepatitis. Often, the phase of internment is also a phase of new health awareness in which methadone maintenance helps to achieve better compliance with the new treatment.”

Substitution Treatment as bridge function

The doctor assumes that inmates participating in methadone treatment will also become more receptive to other services provided in detention facilities. The treatment helps offenders to break away from the drug scene and eliminates the risks encountered when using injection equipment.

Methadone maintenance is a medically based method of treatment that should be pursued, regardless of the patient's whereabouts. Interruptions in treatment should be determined by medical or psychosocial considerations and not as control or punitive measures. Thus, methadone should not be handled as a “special treatment”, granted to those who have behaved well but rather as routine treatment for sick people. Given medical necessity, the offender is entitled to the treatment; the prison management may not refuse to grant it.

Psycho-social care team

According to German law, participation in the psycho-social care programme is obligatory. The Ministry of Justice requires that a “contact talk” should be conducted every two weeks and that urine controls are to be taken once a month.

Psycho-social services are offered on a weekly basis for individuals or groups. Prisoners may switch from individual counselling and support to the group sessions. Especially when starting substitution treatment, women often hesitate within a group context. They are offered the option of psycho-social

counselling to ascertain individual goals for 1-2 months and then enter the group. The group is good for training of certain skills which will not be achieved in an individual setting.

There is a basic problem with group settings in prisons. Women fear to express themselves in a group because everybody knows each other and it is impossible to avoid one another. This has resulted in talks being rather superficial. Therefore the social worker aimed to concentrate on certain topics that are relevant for the prisoners. Groups work on the basis of the concept of "Psycho-Social Education", designed especially for the heroin prescription pilot project. This training lasts 3 months. It aims to provide some basic skills (increase of self control, self esteem etc.) which are supposed to be useful after release. But, because there is a high fluctuation in participants, it is not easy to continue any particular group for more than 3 months. At the moment, there are about 35 women in this programme.

Special attention is attached to preparation for release. The programme aims to enable the women to contact and cope with external doctors, psycho-social care and other services on their own in order to improve their independence. The social workers provide the basic framework (for instance lists with doctors in the respective areas that the women will go to after release).

The social workers emphasise the length of their experience with substitution treatment in prison (since 1992) which has led to fruitful cooperation in the state of Lower-Saxony and with many doctors outside who are willing who continue substitution treatment after release.

Once a year, experiences and information are exchanged with colleagues from other prisons and all prison drug counsellors meet once a year as well. In this forum, new professional developments are discussed (needle exchange projects, new developments in addiction therapy). At the beginning of the 90s there was a controversial discussion of the pros and cons of substitution treatment. It became obvious that the existence of substitution programmes was largely the result of drug counsellors demanding such facilities in prisons. If someone working in the field was in favour of this treatment then it would be extended. If not, programmes may be reduced or abolished. It also depends on whether the doctor is convinced of the value of that treatment or not.

Another important factor for the existence of substitution treatment programmes is whether a medical doctor is based in the prison or comes in from

outside for limited hours. If a doctor comes in for 2 hours per day, the nurses may not feel they have the necessary backing, as it is primarily their responsibility to supervise the daily dispensing of methadone.

Cooperation is also important with the two external drug counsellors (NGO) whose basic task is to prepare prisoners for drug-free treatment instead of a prison stay ("Therapy instead of punishment" for prisoners with a sentence of less than 2 years). If they arrange a place in external therapy which has a waiting period (for instance one month), then it is appropriate to integrate those prisoners into the substitution programme until they can be moved to the therapeutic institution. In these cases, the prisoners are mostly but not necessarily in regular contact with the external drug counsellors (at the moment 3 out of 35). In these and other cases, internal and external drug counsellors cooperate closely.

Nemexin® is also offered but this constitutes a completely different approach towards addiction. This is offered to women who fail in the substitution programme due to topping up drugs. The women are told that the Nemexin® programme (which at the moment includes 6 women) is based on a different approach towards addiction. It is a more passive and medication-oriented approach. Furthermore, Nemexin® is an opiate blocker but, as most of the women are multiple drug users, it only blocks one drug and not others (e.g. cocaine).

Exclusion from the substitution programme

The social worker states that "*In the group including the doctor and nurse (mentioned above.) the success or failure of every single case is discussed.. Topping up drugs is not always the problem, sometimes it is resistance to work, dealing or other criminal offences. There are several factors which are criteria for a successful treatment. Sometimes this is not adequately communicated to the women. Often they do not understand why some inmates are allowed to stay in the programme while others are expelled. The prisoners often support having strict rules, for instance two positive urine tests will lead to exclusion from the programme*".

Criteria of success in substitution programmes

Obviously the criteria for successful substitution treatment vary between the services involved: "*The medical staff would sometimes appreciate stricter rules and clear limits. Our assessment of individual cases, and the success of*

their participation in the substitution programme, is sometimes completely opposite to the medical service's view. Sometimes, we can utilise the different viewpoints of the parties involved: for instance, we can tell the women 'Don't wait until you will have a positive urine test, discuss this with us now'. Then we can work with them on the subject of relapse. Of course, to be honest about that, it's not easy for somebody who's been in the drug scene for 15 years, there is a lot of distrust towards officials. And you are being 'tested' by the prisoners as well. In most cases, though, it is not an alternative to expel inmates from the programme, there is no other alternative for them in prison. Sometimes the warning to expel them is useful to get them to acknowledge the value of the substitution treatment. We don't want to punish the prisoners but to work out viable solutions for them and with them. On the other hand, there are inmates in the substitution programme who decide to start a drug-free therapy. The transfer to drug-free therapy institutions has been facilitated in recent times. Now, we can send prisoners to certain therapy institutions who are receiving as much as 60-70 mg. They are detoxified there within 5-6 weeks."

"If a prisoner is obliged to work in prison and she is resisting work, then obviously she has no interest in co-operating. This is seen as problematic for the success of substitution treatment because work simultaneously gives you a daily structure. And, when they're topping up drugs too, it becomes rather difficult to keep someone in the programme."

Keeping the Balance between the varying interests

The social workers do not regard themselves as lawyers of the imprisoned women. They define themselves as a clearing post, where solutions are sought, together with the women: *"I am trying to keep a balance between the interests of the prison, the interests of the clientele, the interests of the medical department. But it's not a classical lawyer's role that we play. Being a lawyer means being paid by your clients. We deal in a different currency, which is confidentiality and trust. In the meetings with the medical service, we bring in the social aspects. Sometimes, the doctor forwards information and then reports to us to get our opinions on certain problems. In most cases, we discuss what has been passed on to us with the prisoner and then give a final assessment back to the doctor."*

The substitution treatment programme is not a low threshold offer. This is due to the limited places (40 at the moment). *“The places should go to those women who really benefit from the treatment.”*

Urine testing

According to judicial demands, regular urine tests have to be done on a monthly basis and are ordered by the social worker. Other urine controls can be ordered by the prison in order to check on whether somebody is eligible for home leave. Sometimes, the women even ask for these tests because then they can send the negative results to the court or use the results as evidence of being abstinent.

Self help organisation

A user-group (JES-Oldenburg) and the Oldenburger AIDS, Hilfe, visit the prison once a month. These group meetings are frequented by many prisoners in the substitution programme.

Impact of participation in a substitution programme on the sentence and on release

Being in the substitution treatment programme may lead to some positive effects when it comes to court decisions and prognoses for the future. Sometimes the participation in a substitution treatment is seen by the court as proof of therapeutic effort. The same is true for the system “therapy instead of punishment”. Within this model, the judge may consider participation to be an essential step forward towards therapy. Moreover the court may release a prisoner after two thirds of their sentence. This usually is not done for drug addicted prisoners because of the negative social prognosis.

2.1.3 The view of prisoners

All six inmates have been imprisoned previously in the Vechta women’s prison; three had additional experiences in another prison. All are serving sentences between 4 months and several years. All have a long history in taking illicit drugs. Basically all prisoners (P1-P6) agree with the methadone programme and practice in prisons. There are no basic complaints.

Prisoner 1 was lying in hospital for two days prior to imprisonment. She was on a dose of 100 mg and within 14 days her dosage was reduced to 30 mg

because the doctor found her dosage was too high. After she had been reduced to zero, she was given methadone again after 4 weeks.

P2 complains that during her previous sentence she wasn't given methadone for the first two days, because she wasn't in an official substitution treatment programme in the community, although she had been on methadone prior to admission to the prison. After severe, 2 day withdrawal symptoms, she was given methadone again.

P3 reported that she was given the same dosage on transfer to Vechta from another prison and that the doctor increased the dosage from 80 to 90 mg. During a previous stay in Vechta she reported being without methadone. This ended up in a permanent search for drugs in the prison: *"Without methadone you really go nuts about any kind of drug you can find here."*

P4 told us of a case in prison where a woman went to the doctor and, quite by coincidence, discovered that her methadone had already been reduced (from 100 mg to 35 mg), she had not been told. On the one hand, P4 thinks this was justifiable from a psychological viewpoint but worried that something might have happened (high or low blood pressure) that might have conflicted with the reduction of methadone. None of the others have had similar personal experiences but all have heard of such a case.

P5 told us about her withdrawal from other drugs (benzodiazepines) upon entering prison. Her benzodiazepines have been reduced and she then asked for methadone reduction from 50 to 40 mg.

P6 has a long history of methadone consumption. Before admission to Vechta prison she was in an official methadone programme for less than the required 4 weeks. But she got methadone because of the extent of her past experiences. She is wondering about the speed of reduction, which she experiences differently inside prison: *"I've realised that the reduction steps are taken very fast, which is ok in a normal reduction scheme because you are going into a detox centre of your own free will. But it is different here inside, it is rather rushed here."* She complains about the varying times of methadone dispensing. *"While it is 7.15 in the morning on working days, it is 11 o'clock at the weekends. At 11 o'clock you're already starting to sweat, feel the cold and that's not normal. Maybe that means the methadone you're getting is poor quality."*

She suspects that the methadone is not of a good quality, because it is only effective for 8 hours and should be for at least 36 hours. She doesn't under-

stand the difference between d,l-methadone (racemic mixture) (d,l-methadone has only been available since 1 February 1994) and levomethadone (l-methadone, L-Polamidon®) both forms, containing different strengths of methadone, are registered as substitution substances (levomethadone is twice as strong as d,l-methadone). She has heard of the pharmacological term “racemic” and wonders whether the racemic mixture is a sort of waste product of the levomethadone. So, she isn’t really informed about the differences.

She insists that the methadone has side effects and that the patients are the experts who have the experience and competence to be able to compare treatments and substances. *“The doctors, they only know about the effects and side effects from book, but we are the experts. For instance, the doctor says that everyone who gets methadone feels the same thing but that’s not true.”*

For P5, it is not clear who should be excluded from the methadone programme. They all know the rules, but there are between one to three warnings before someone is excluded. Sometimes she finds decision making arbitrary. And she has the impression that arguing with the doctor may lead him to take it personally, for instance, when she says she will look for information elsewhere.

P1 tells us that urine has not been tested for THC for the previous three years but is now. That is still no reason to exclude someone from substitution treatment, or to not let prisoners out on home leave etc. It leads to a loss of privileges as well, like the consumption of cocaine, alcohol, tablets or heroin. Unanimously, the women confirm that there are enough warnings before someone is expelled from the programme. But they regret that there is no deeper understanding of their drug history, as they are dismissed as drug users having been dependent for more than 5-10 years. *“That’s the problem with the doctor, he thinks that being in the methadone programme means that there is no desire for other drugs. But that’s a mistake.”*

P3 says she hesitates to tell the prison social worker about her additional drug use, because it may get back to the doctor and she will suffer the consequences.

All of the women are using the psycho-social support on offer (weekly group sessions or fortnightly individual counselling). The participants are profiting from the sessions.

P2 has experience of other substitution substances, especially buprenorphine. She claims that detoxification with this substance is much easier than with methadone. She says she has been addicted for more than 12 years and that: *"I've tried lots of detox methods which were no good, but buprenorphine really worked"*. She says that if patients have to be detoxified, she would prefer to do it with Subutex®. She recommends it for those who are excluded from the methadone programme and who get into a drug reduction scheme.

P1 says that in her experience Codeine is a good substitution substance. She too would prefer the use of Subutex®. But at least detox is better with codeine than with methadone.

Unanimously, the women confirm the view that withdrawal from methadone is extremely hard. *"I never had cold turkey like coming off methadone, it's really shit."*

So, the prisoners would prefer a variety of substitution substances for different situations and purposes instead of only making use of one substance (here methadone).

Regarding the value of methadone maintenance treatment, P4 states that she wouldn't miss it. *"It definitely stops you wanting other drugs and I'm not scared of coming down off methadone. I've been using methadone for 6 years now and I don't want to come off it here in a fortnight. People should be allowed to decide for themselves."*

Regarding the daily practice of administering methadone, the women have no complaints to make about the procedure (described above). *"I mean, you always get envy, like: 'Why is she getting methadone and not me ..., but you get envy for a lot of reasons round here."*

Regarding the attitude of the staff towards prisoners who get methadone, the prisoners have varying views. Some say that the employees keep an eye on those receiving methadone. *"They pay more attention to those on methadone ... they watch out that you're not just hanging around or getting up to something ... well I've been on methadone over 4 years now, so I know how I'm going to react. I've got hep C as well and I always get these tired spells. But you get the impression the warders put it all down to the methadone, headaches, whatever ... and that's not true, but you can't get anyone to listen."*

Others say that the patients in the methadone programme are treated the same way as others. One prisoner puts it this way: *“It’s not like anyone gives us looks or anything, on our ward it’s not a big deal.”*

Methadone continuation transport from one prison to another

Prisoners state that the continuation of methadone prescription from one prison to another causes no problems: “... I was transferred from Hanover and it wasn’t a problem. I got my methadone in prison X, got it in the morning before we started off and the next day I got it here. Of course, when I’m released I’m going to try and get hold of my old doctor two weeks before I go and see if he’ll take me on again. If not, I’ll try another one. I’ve got two doctors and one of them’s bound to do something”.

“... right up till you’re released, like about 6 o’clock, you still get some; ... if you’ve got parole, they give you something in the morning and if you’ve got three days outside, you have to collect it at the nearest prison or go to a doctor ...”

2.2 Men’s prison Groß-Hesepe/Lingen/Lower-Saxony⁶

2.2.1 Short description

The closed men’s prison in Groß-Hesepe, between Lingen and Meppen in Lower-Saxony (near the Dutch border), is administratively part of the bigger institution in Lingen (some 25 km from Groß-Hesepe, with remand and sentenced inmates) and holds 350 men who are all sentenced. The proportion of drug users is considerably high: according to the doctor, approximately 70-80% have a drug problem (with hard drugs).

2.2.2 Goals and practical procedures

The doctor, also an external GP, is employed part time. According to him, substitution treatment started in that prison in 1994. At present, they are offering 40 places for maintenance treatment, of which 10 are reserved for those going into treatment and those who want to decrease their dosage. At the time of the visit (March 2004), 25 patients received substitution treatment (during 3 months in 2004 they had 30 new patients which demonstrates the

6 The field visits took place in February and March 2004.

coming and going): *“We started off with 10 on maintenance. But the whole thing escalated so fast, we had to come to an agreement with Admin and the Drugs Counsellors to draw the line at 40 to 50. And that’s about our capacity now. We’ve got 30 permanently on maintenance and there are always 10 who are gradually coming down off it or getting methadone support in preparation for therapy.”*

With regard to the need for substitution treatment, it is said that it would increase when restrictions were lifted. Substitution treatment is regarded as a sort of baseline intervention (with clear rules to follow for the patient) and not as an opioid treatment as such: *“If we lifted the restriction, the demand would increase too. But the question is, what can you realistically hope to achieve? Are you going to treat all the addicts? Put them in therapy? Or on maintenance to keep them quiet? We’ve found that most don’t want therapy. They just want to continue on substitution treatment to offset the addiction.”*

Another reason for the restriction is the increase in the prisoner population from 160 prisoners in 1988 to 350 in 2003 without a corresponding increase in resources and, at the same time, new restrictions (e.g. the notification system introduced in 2002). The drug problem is regarded as the major health topic in the institution: *“We don’t really get problems with illness as such, ... what we’ve got is problems with drugs. That much ought to be clear. The drug problem leads to escalating developments.”*

As the institution does not have an admission unit for new prisoners and has no remand prisoners, new inmates mostly come from the remand prison in Lingen. There, a substitution treatment is already provided and this is continued in Groß-Hesepe. According to the nurse, the policy with the drug counselling personnel is that there is a space of 4 weeks in which to determine whether the patient is eligible for methadone substitution, according to the criteria of the institution:

- Therapies already undertaken
- Compliance
- Urine tests
- Additional drug use
- Length of sentence (6-12 months)

Another differentiation is done regarding (i) whether they are suited to therapy, (ii) HIV positive or negative. This is the only disease when substitution treatment is always carried out.

Incidences of taking prisoners out of treatment reflects that guidelines have to be obeyed, which set some rules for adherence to the therapy (e.g. no additional drug use). Here the difference to the outside situation becomes apparent where prisoners have more choices to look for different options.

“Between 30% to 40% just want their methadone with no questions asked but we can’t work like that. They’ve got to get social support, they’ve got to take urine tests, ... They probably got it with no questions asked on the outside, and people out there take massive amounts of stuff on the side, I’d say 50% of them do. You can’t do things like that here, a lot of them are absolutely speechless when I tell them there’s no extra Benzodiazepam to go with their methadone, because it causes depression. They won’t listen. Diazepam is like eating a lump of sugar for them, that’s how they look at things.”

These strict rules reflect both the limited places and the legal requirements of adequate substitution treatment. The latter is seen as the major obstacle whereas the proportioning and the documentation would absorb much time.

In relation to whether the length of sentence limits substitution treatment differing statements have been given ranging from 6 months (doctor) up to one year (drug counsellor).

“Generally speaking, maintenance is customary procedure for short sentences under a year. If the sentence is longer, the Addiction Advice Service has to help determine what kind of role maintenance is going to play during imprisonment. Whether there’s an opening in therapy for them in the near future, and if not, then you just have to draw the line and say no.”

This is a different practice to the connected prison of Lingen (remand and sentenced), where the general line is to maintain prisoners who are in substitution treatment.

According to the nurse, urine tests are done twice a month and the sanctions are clear and understandable to prisoners (e.g. outlined in a leaflet): *“Generally, the first time they test positive, we hold up the yellow card. And the second time, we start phasing them out.”* (A nurse)

It is up to the prisoners to decide when to show up for a urine test. Despite this liberal practice, there are some prisoners who still have positive urine tests. *“We’ve organised the regular urine checks on a voluntary basis, either every first and third week, or every second and fourth. They can choose for themselves. If someone comes to our attention, then we do spot checks. It’s a lot of work. It means about eighty a month. [The interviewer: But in this system you shouldn’t really be getting any positive results?] We do though. One,*

two, four – the last one was positive. He came in off his own bat. He was positive” (A drug counsellor)

“...we always catch a few. They never know when there’ll be spot checks. The man who was here just now, he does one every week. As I said, we tolerate THC.” (A drug counsellor)

Generally, interviewees say that prisoners in substitution treatment are easier to manage.

“It depends on what you want. If you want to keep the patients quiet, you could increase the intake ... it just puts them out of action, it changes them, makes it easier for them to work”

Benzodiazepines are not prescribed to patients in substitution treatment. The detoxification scheme is a reduction of 10 mg every two days. It is reduced until 30 mg, from then on 5mg every two days, so if somebody is on 50 mg it will take 14 days. The daily provision so that prisoners are led to the medical unit, ward by ward, and supervised by the nurse who ensures that the dose has been swallowed.

Every single case is discussed with the drug counselling service in terms of the patient’s needs and perspectives regarding treatment (“therapy instead of punishment”) and sentence planning. The AIDS-help Group from Lingen is involved in the psycho-social support and is offering an open group every fortnight, which is attended by approximately 30 inmates. Apart from this activity, several other groups are accessible for drug and alcohol users (e.g. the self help group “Kreuzbund” with regard to alcohol, a therapy preparation group).

Provisions for home leave are administered either by the institution or by the doctor nearest their home. Here, patients have to pay for the prescription themselves. Before release, a search is made for a doctor to continue the treatment. The medical service writes an accompanying letter for the GP in the community. There is a problem with finding external GPs who are willing to prescribe because the interviewees identify a town-countryside gap, where it is easier to find a prescribing doctor in the city.

The methadone will be weaned off if the prisoner cannot find a doctor who will continue treatment after release: *“...we gradually withdraw their maintenance if they aren’t covered for further treatment after release. We always do it like that. If they can’t show us a letter from their doctor, then they’re always withdrawn.” (Drug counsellor)*

The drug counsellors stress the point that the movement of the prisoners (coming in for only short periods sometimes without having a doctor continuing the treatment after release) is posing severe problems in time management, in terms of having the time for gradual detoxification steps: *“Of course we warn them: If you want to stay on maintenance, bring us a doctor’s certificate. Otherwise you come off it. That usually works, but not always. We’ve got some who’ve only got another six or eight weeks. Some are over from Lingen. If nothing’s been sorted out, then we start reducing them right away, so as to stay inside the time line. You can’t reduce them from 10 ml [100 mg] to nothing in a week.”* (Drug counsellor)

The prison-based drug counsellor assist prisoner in finding a doctor willing to continue the treatment by offering a doctor’s lists all over Lower-Saxony. Post, fax and telephone calls can be organised in the office of the counselling team. So prisoners have to look for a suitable doctor in their community right in advance. This process of organising thing for release is seen as part of enabling prisoners to attend to their affairs. In most of the cases the search ends up successful.

According to the experiences of the doctor and nurses, they focus their prescription on methadone as central agent in substitution treatment. It is said the degree of being familiar with a substance is an important point:

The interviewer: ... You only prescribe methadone? Not Subutex?

We don’t like to. I suppose it all depends on how familiar you are with a certain drug. Luckily we’ve had no problems with methadone since 1994. I’ve only had discussions about Subutex with maybe 5 to 10 patients, no more than that. And in all that time we’ve had maybe 4 Subutex patients. Subutex isn’t part of our normal range of maintenance treatment. We only ever fall back on it in individual cases, when someone’s had it prescribed outside.

According to the experience of the drug counsellor, those prisoners who have been referred to an in-patient therapy outside (“Therapy instead of punishment”⁷), drop out there mostly return to the institution being in a substitution treatment in the community. These persons are generally weaned off.

7 This is possible for those drug dependent prisoners when their sentence is no longer than 24 months they can apply for a place in an inpatient treatment.

“Our problem is: the people who we’ve referred to inpatient therapy, all land back here sooner or later. And the funny thing is, they all come back with prescription methadone. We call them our therapy drop outs. First thing we do is, we reduce their dosage right down to zero. We say: therapy drop outs have had their chance, and for whatever reason, they’ve messed up. I just don’t understand why they put them back on maintenance. Somebody in Lingen, or wherever, can’t read. I think the doctors take the easy way out – the same people keep on coming back and coming back until they get treatment. But we always take them off it here. Sometimes we have our differences with the medical supervisor, but, in the long, run they all get taken off.” (Drug counsellor)

The drug counsellors point out three reasons to expel patients from the treatment:

“Three good reasons: dropping out of therapy, taking drugs on the side, and not bringing in urine samples. And I’ve got it all down on paper, starting from this year. I pass the information on to Admin, and wait for them to react. If they don’t, well that’s just too bad. Basically, the medical Admin team take the decisions. I just keep them up to date on substance abuse and missing urine tests. I do that every day.” (Drug counsellor)

The whole process is well documented and there is a daily exchange of information with the medical unit. Exchange of information between different wards regarding statements on prisoners is done via intranet, which can be accessed by the drug counsellor.

“Yes, that’s on our local intranet now, so we’ve all got access to it, XY always keeps it right up to date. Of course, you could always ring up and ask something in person, but we’ve even got a web page for exchanging information.” (Drug counsellor)

2.2.3 *The views of the prisoners*

Four prisoners attended the focus group who have had extensive experience in substitution treatment in the community as well as in other prisons.

Prisoners made comparisons to substitution practice in other prisons and complained about the fact that their treatment is not continued in Gross-Hesepe. Two points were criticised, a continuity of dosage, when compared to external practice has been given in the prison of Lingen (approximately 25 km off of the site) and that, even in two prisons of one institution (administratively one system), the practice is varies considerably:

“In Lingen, you usually get what you’d be getting outside, but the doctor here always starts from scratch.” (Prisoner)

“It’s different in Lingen. When I was there, I always got my Benzo. When I was transferred, I was getting say 13 ml of methadone and 10 Diazepam and here they started me straight off on 8 ml and no Benzo at all. It’s shit, they’re all part of the same prison really, so I never understood it. And there was them always telling us: don’t worry about transferring to Hesepe.” (Prisoner)

Prisoners perceive that there is an unspoken assumption that they will get hold of the drugs in order to get hedonistic instead of therapeutic effects. The mistrust in the doctor-patient relationship was expressed repeatedly:

“I think it’s rotten how they always act like you was just trying to get stoned.”

“I’ve met that too – I wanted a couple of Paracetamol for toothache and the chap said I was trying to get a buzz. That’s crazy. They don’t seem to know how anything works.”

With regard to psycho-social support, the prisoner stated that, although there is a drug counselling service, problems have to be solved by individuals themselves and that there is no formal structure, a place to go to once in a week, as there is outside of prison:

“The only people we could go to in here are the Addiction Advice Service. Basically, you’ve got to sort it out on your own. If you’ve got a problem, I assume you could ask them, – it’s their job. But it’s not very well organised. Outside, you’d see someone once a week.”

The prisoners are making proposals of how to deliver the methadone on a daily base, which offers advantages for the prisoner’s everyday organisation: *“If you don’t work it’s OK but, for the ones with jobs, the system in Meppen is much better. We haven’t got so many people on methadone here, 30 to 35 at the most. In Meppen, the medical assistant packs a case and goes round from block to block. He just gives it out in the front office, before everyone goes to work. Here, you get to your job at ten to seven, and then at five past you get sent over to the medic, so the whole lot of you get there at once.”* (Prisoner)

“And they’ve lumped it together with consulting hours in the sick bay, at five past seven, which used to be separate at ten o’clock. Usually, the warders let

us go later but, if you're not careful, you might get one who can't be bothered and then you're left waiting until the medics have finished up. Then you've missed breakfast, – or almost, – but anyway, they've got a nerve. There's always one on duty and it wouldn't hurt them to pack a case with the stuff and bring it round, say, at quarter past six. Only takes a second to drink. Wake up call is at six.” (Prisoner)

Some critics focused on confidentiality which is not sufficiently secured. Although most of the guards know who is getting the substitute, prisoners feel that they should not be present when the dose is taken:

“Being on maintenance isn't such a big deal. Most people know anyway. There's always a warder there anyway, that's how it's done here. In Wolfenbüttel you each went into the medical room separately to take your methadone. But here they just open the door to the toilets, put a board across the opening like a counter, the medic stands behind it and we're lined up on this side. It's none of the warder's business, he shouldn't even be there. Maintenance treatment is supposed to be confidential.”

“There's no privacy here. The warder sits in, but he shouldn't normally be there. It's no business of his what you're seeing the doctor for.

Even apart from the methadone, you can't discuss anything about your medical treatment here. As often as not the warder listens in and he can read your file too. It's not right.

Anyone who wants can read the results of my urine tests here. It's all wrong.

Prisoners don't know if it is an advantage for the present sentence to be in a substitution treatment or not

“I'm not really sure how they rate you when you're on substitution; if it's better or worse. Normally I'd say it ought to go in your favour, but there's no accounting for prejudice. You might get one who says: well, if he's still getting methadone, who knows what he'll get up to when he's released ... somehow you're still an addict.”

The practice to strictly prescribe methadone only is criticised by prisoners who are used to a diversity of substitution drugs outside:

“You might get turned down because Polamidon® is a few pence dearer (than methadone). I've reached the stage where I'd pay the difference myself, just so I know I was getting something that was better for me.”

3 Summing up

Substitution treatment in German prisons is heterogeneous in access and treatment modalities. The access is very patchy and the number of patients who might receive substitution treatment is limited by a lack of resources and budget constraints. This accounts for the number of staff, both in medical units and among drug counsellors, needed to provide more substitution treatment in prison. Moreover, resistance – linked to the widespread drug-free orientation – can be found towards substitution treatment which views the provision of substitution drugs as means of detoxification etc. In total, the demand of prisoners for substitution treatment is far bigger than the actual number of places.

Certain issues became apparent in the interviews in the two prisons:

- Enormous differences in policy and practice of substitution treatment between prisons in the same state (Lower-Saxony) but even between prisons of the same administrative unit (e.g. duration of prescription ranging from expected 6-12 months sentence in one prison to indefinite durations in others, disparities in urine tests).
- Practices and policies are not discussed and there seems to be no attempts to harmonise these different approaches.
- Inflexibility of the system in introducing new substitution drugs (e.g. buprenorphine) due to practical obstacles and lack of experience.
- Lack of adequate patients' information (leading to a mistrust about the substance dispensed).
- Assistance is given in both prisons with regard to finding a doctor after release, this is part of an education process to enable prisoners to attend to one's affairs.

Greece¹

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users

According to EMCDDA figures (2003), Greece reported the number of problematic drug users to be 25 512 in 2001. Looking solely at heroin users, the Greek focal point² estimated that there are between 15 000 and 22 000 heroin users between the ages of 15-64. The majority of these (between 10 to 15 000) lived in Athens and predominantly smoked heroin (“chasing the dragon”). According to experts, this is the main reason for the low HIV-prevalence in Greek prisons.

The total number of drug users in prison on January 1st 2000 and 2001 was 2 880 and 3 187 respectively (Sioti, 2001). A study from Koulierakis et al. (2000) showed that 33.7% of prisoners had injected drugs at least once in their lifetime, 60% of whom had injected while incarcerated. From those who had injected during incarceration, 83% had shared needles and other drug paraphernalia. The duration of imprisonment, previous convictions for drug offences, being convicted instead of being on probation and the number of sexual partners during the year before incarceration, were found to be the most significant factors leading to a risky behavior (Koulierakis et al., 2000). These trends have been confirmed by the study (N=80 randomly selected convicted and remanded prisoners in a prison in northern Greece) of self-reported substance misuse in Greek male prisoners (Fotiadou et al., 2004), who found 27.5% of prisoners were dependent on opiates, 26.3% on alcohol, while 13.8% were misusing both alcohol and illicit drugs. Additionally, the authors found 26.5% of prisoners to be HepatitisB positive.

There was no official estimate of the re-incarceration rate due to lack of data processing services in Greek prisons. Unofficially, the medical staff in

1 The field visit in Greece has been conducted by Heino Stöver and Birgitta Kolte (both “Bremer Institut für Drogenforschung”, Bremen/Germany), with help from Dr. Anna Tsiboukli, Educational Psychologist, Head of KETHEA, Department of Education.

2 <http://profiles.emcdda.eu.int>.

Korydallos prison estimated that the percentage of drug users, who have been re-incarcerated in a 3-5 year period, might exceed 70%. Official statements³ are based on an assessment of the prevalence of drug addicts sentenced for drug offences as one third of the prison population. This has been questioned by several criminologists (Spiro Stamatis personal communication, 8th March 2003 and Effi Lambropoulou) who identify 60-70% of prisoners as having been convicted due to drug-related offences.

1.1 Substitution treatment

1.1.1 Historical and legal background

In 1996, Greece was one of the last countries of the European Union⁴ to introduce methadone⁵. Douzenis reports that one of the reasons for this delay was the belief that the available treatment options (mainly detoxification units and therapeutic communities) were sufficient to deal with the problem. This quickly changed with the AIDS epidemic as well as with a dramatic increase in heroin induced deaths. Until 1990, there were 76 reported deaths but, by the end of 1995, this figure has risen to 179. It became clear that new treatment options had to be set up. When the methadone programme was launched, the response from intravenous was extremely encouraging. Within 2 weeks, O.K.A.NA. (The Greek Organisation against Narcotics) received approximately 500 applications for the 200 available places for the Athens unit. Currently, there are 1 500 applications from intravenous heroin users wishing to participate. There is no doubt the methadone programme needs to expand to cater for the demand for the methadone programme and alleviate the pressure that arose from the creation of a waiting list. The people who work in the programme are continuously confronted with requests for transmission and the Greek TV runs programmes of varying quality on a daily basis highlighting the predicament of users and their attempts to gain admission.

3 For instance, that of the previous Greek Minister of Justice, Mr. Petsalnikos, on the High Level Conference Towards an Effective Policy on Drugs, Athens, 6-8 March, 2003.

4 i.e. EU before enlargement.

5 In Belgium, before 1994, substitution substances were only accepted in detox and, although from a Consensus Conference in 1994, substitution therapy was largely accepted, the legal status of substitution therapy was only accepted by law in 2002 (see country report, Belgium).

According to Siouti (2001), OKANA is the only organization authorised to implement substitution programmes in Greece. There are five Methadone Substitution Programmes, (3 in Athens and 2 in Thessaloniki), a programme administering Naltrexone and a pilot buprenorphine substitution programme. According to Ms. Tsaklakidou, there are 1 000 places in substitution treatment all over Greece and enormous waiting lists: In Athens and Thessaloniki drug users are waiting an average of up to 3 years, in Athens 900 people are on the waiting list and in Thessaloniki 350. Regarding the Therapeutic Programmes' Network there were 2 474 people on the waiting lists for substitution programmes in 2000. The total number of intravenous drug users in methadone/buprenorphine substitution programmes is 871. Substitution treatment is paid for by the Ministry of Health, but financial aspects do not seem to impact upon the implementation of substitution treatment in prisons (see below).

1.2.2 Substitution treatment in prisons

Health care in prisons is in the responsibility of the Ministry of Justice. Several interviewees identified a lack of doctors and also an exchange of information among professionals among the different prisons.

Substitution treatment does not exist in Greek prisons. Those patients participating in a substitution programme in the community will get a 15-day detoxification treatment when entering the prison system. Methadone will be sent in daily portions from the community to the medical units and then the intake will be supervised by the medical staff.

Sioti (2001) points out that there is no established legislative procedure guiding this detoxification. Therefore, for the detoxification of each of the methadone patients a number of bureaucratic obstacles need to be overcome. Many of the imprisoned drug users receive psychotropic drugs prescribed from the prison psychiatrist.

According to the previous Minister of Justice⁶ the main goal is a drug free orientation in the prison setting, which leaves no space for harm reduction approaches. Consequently, drug free oriented work is supported in Greek prisons. Like KETHEA, an NGO, which has worked in prisons since 1985

6 Personal communication, Athens, 6-8 March 2003, High Level Conference Towards an effective Policy on Drugs.

and which provides counseling, motivation to access drug free therapies after release, education and information work. In 2001, 610 persons attended these programmes (KETHEA, 2002). A specialised prison for drug users, offering a drug free treatment program, was opened in Elaiona, Thiva (a place not far from Athens, see chapter field visit).

Reasons for not implementing substitution programmes in Greek prisons

According to Domna Tsaklakidou (OKANA) the public debate about substitution treatment in general is still at an early stage. It was only in 1996 that the first substitution programmes were integrated into medical care for opiate dependents in Athens and in Thessaloniki. Before that date, all offers have been abstinence oriented. The general public and the drug users themselves are familiar with drug free oriented services and, for a long period, accepted that substitution treatment was not offered. Thus, the majority involved in drug services remained sceptical towards substitution treatment. Only a few doctors are interested in this treatment form for opiate addicts and much resentment towards drug addicted patients persists. Finally, a lack of education and training is seen by Ms. Tsaklakidou as a main barrier for the introduction of such programmes.

Although several initiatives are looking at the provision of substitution programmes, the reasons just cited are responsible for a very low spread of this treatment form in many places. Moreover, there is an enormous lack of information, guidelines, communication and cooperation necessary for the introduction of the medical and social elements of substitution treatment. Due to a paralysing bureaucracy and political institutions, no supporting structures and initiatives have been implemented in order to introduce substitution treatment programmes.

Ms. Tsaklakidou emphasized the fact that the criminal stigma of drug addiction has still to be overcome in favour of a medical perception and an approach of acceptance. Under the presidency of Greece the High Level Conference Towards an Effective Policy on Drugs (Athens, 6-8 March, 2003) was organised, indicated that the previous government was very interested in a new debate about drugs policy.⁷ Greek participants and contributors supported the idea of a balanced approach, distinguishing between drug traffickers

7 The government changed in 2004 and until now the drug policy of the new government, the conservative Nea Demokratia, is not known.

and drug addicts, who should be offered more treatment facilities. It was acknowledged that the number of places in methadone programmes should be enlarged. As a first step into a treatment oriented approach in penitentiaries, the opening of the prison-based therapy institution “Eleonas” (see below) has been regarded as an essential step forward.

1.3 Prison Population

Table 12 Data on the prison situation in Greece (Source: King’s College London, International Centre for Prison Studies, Prison Brief for Greece)

Country	GREECE
Ministry responsible	Ministry of Justice
Prison administration	Direction General de l'Administration Penitentiaire
Contact address	96 Avenue Messogion, GR-11527 ATHENS, Greece
Telephone / fax / website	tel: +30 1 77 96 452 fax: +30 1 77 17 182
Head of prison administration (and title)	(Mme.) Sevasti Anastassakou - Papamitropoulou Directrice des Affaires Pénitentiaires
Prison population total (including pre-trial detainees / remand prisoners)	8,841 at 1.12.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	83 based on an estimated national population of 10.6 million at December 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	28.5% (1.9.2003)
Female prisoners (percentage of prison population)	4.9% (1.9.2002)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	6.9% (1.9.2001 – under 18)
Foreign prisoners (percentage of prison population)	42.4% (1.12.2003)

Number of establishments / institutions	25
Official capacity of prison system	5,584 (1.12.2003)
Occupancy level (based on official capacity)	158.3% (1.12.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 6 252 (61) 1995 5 887 (56) 1998 7 129 (68) 2001 8 343 (79)

2 The field visit

2.1 “Eleonas”/Thivas prison⁸

2.1.1 Description of the prison

The buildings of the drug treatment institution “Eleonas”, near Thiva some 70 km out of Athens, have been built up and were utilised for agricultural purposes by Jehova witnesses until 2002. The Greek government then bought this estate in order to build up this treatment institution.

2.1.2 Treatment procedure

In 2002, the treatment institution was installed as the “Rehabilitation Centre for Prisoners” (Lambropoulou, 2003) as a pilot project for the Ministries of Justice and Health. The installation of such an innovative treatment facility offers treatment options for incarcerated drug users whose rehabilitation process should be supported. The patients should recover physically and psychologically and these patients should be taken out of the overcrowded situation which are not regarded as fruitful ground for treatment processes.

The concept of the treatment institutions is similar to that of a therapeutic community. At the time of the field visit, 45 men were in treatment, this number should be increased to 60 and finally it is aimed to expand the capacity to 300 persons. The project is well equipped with security officers, social worker, a psychologist, 2 doctors and medical personnel. Medical as well as the dental medical provision is on a high level. The 2-year treatment

8 Visited on the 8 March, 2003.

programme is based on group and individual sessions, as well on facilities in various working areas (garage, joinery, kitchen, agriculture, assistance on the medical unit). On several thousand hectares of land, fruit and olive trees and vineyards are being cultivated. All these efforts are undertaken to increase the chances for the incarcerated men on the labour market.

Requirement for an uptake to “Elenoas” is (i) that a large part of the sentence has already been served and (ii) the intention of an absolute drug free orientation. Positive blood or urine tests immediately lead to exclusion from the programme.

The five prisoners interviewed seemed contented and expected to overcome their addiction. According to official information, neither relapses nor flights have occurred. There is no scientific evaluation for this programme. One of the difficulties is that only drug addicted persons are selected for the treatment programme and not drug traders. So, participants of the treatment programmed have been very well selected. On average, they are serving sentences of 10 years. Another difficulty is the high number of migrants in society as a whole and among the prison population. This leads to language problems and migrants often face hostile attitudes.

The director of “Elenoas” explained that this is a completely new approach towards drug treatment in Greek prisons and that additional institutions with similar concepts are being planned in northern Greece (Chalkidiki) and on Crete.

3 Summing up

Substitution treatment has only been introduced in the community since 1996. Policy and practice regarding this form of treatment must be characterised as high threshold with very centralised structures (only one organisation is offering substitution treatment) with limited places (there are consequently long waiting lists) and very limited access in the two largest cities (Athens and Thessaloniki). There is a higher demand for treatment places than capacity can accommodate. In prisons, no substitution treatment is implemented. On the contrary, the drug free therapeutic approach is supported and put into practice. This situation can be compared to other Western European countries in the 70s and 80s where, for a long time, the abstinence oriented approach remained dominant until the increase of substitution places changed policy and practice in prisons as well. Externally, there is a big

debate and predominantly a sceptical position towards the usefulness of substitution treatment. This must be regarded as the primary barrier to introducing this option into the prison setting. But, looking at the spread of drug use and infectious diseases in prisons, things may change in the near future.

Ireland¹

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users

According to the EMCDDA (2003) the number of problematic drug users in Ireland is 13 735. This is a middle range rate of 586 per 1 000 people aged 15-64 in the general population. 80% of all intravenous drug users in Ireland are infected with HCV. Studies show a correlation between length of imprisonment and HCV status: The more time spent in prison, the more likely the prisoner is to be HCV positive. Several studies in prisons have indicated a high level of risk behaviour in prisons. Long (2003) pointed out that injectors take risks that they would not take outside. Allwright et al. (1999) found that among 1205 prisoners, 21% reported having injected drugs in the medium risk prison and 58% in the high risk prison. 60% of the women prisoners reported injecting drug use and 21% of intravenous drug users first start injecting in prison. Another study states that the use of heroin is widespread among the prison population. According to that study, 30% of males and 56% of females have used heroin at least 3 times, 8% resp. and 12% once or twice (Centre for health promotion Studies 2000, p. 38).

1.2 Substitution treatment

1.2.1 Historical and legal background

Methadone is the only registered and authorised substitution drug in Ireland. According to interviewees, the first prescriptions of methadone date back to 1969. From the early 70s, methadone was used mainly for gradual detoxifi-

¹ The field visit in Ireland (10-14 December 2003), conducted by Heino Stöver, was facilitated by Dr. Enda Dooley, Director of Prison Healthcare and Frances Nangle-Connor, Coordinator of Nursing, Health Care Directorate, Ministry of Justice of Ireland who also provided national information and support with the finalisation of this country report. Inter were conducted with Probation and Welfare Service officers, nurses, guards, doctors, social worker, prisoners, consultant psychiatrist in substance misuse, Director of Prison Health Care, coordinator of nursing, health care directorate, scientists, NGO members.

cation and, in rare cases, it was used over a prolonged period of time to maintain addicts and stabilise their condition (UISCE 2003, p. 7). As a response to the HIV/AIDS crisis, substitution treatment was then introduced in the mid 80s. In 1992, there were 200 patients receiving substitution treatment. From then on, this treatment rapidly expanded. According to Brion Sweeney, there were about 6 000 drug users in substitution treatment in Ireland at the time of the visit. Methadone is available, free of charge, to everyone undergoing treatment for opioid dependence.

In 1998, the Irish Government issued the 'Methadone Protocol' which regulated access and the treatment modalities of substitution treatment. One of the major concerns was about the methadone black market. As a consequence, GPs were no longer allowed to prescribe methadone unless they signed up to the protocol procedures. These included limits on patient numbers, centralised patient records, training for GPs who wish to prescribe etc. Physeptone², which was thought to be less suitable in the pharmacotherapy of opioid dependence, has been replaced by methadone DTF³ (see Department of Health and Children). Service users, UISCE (Union for Improved Services, Communication, and Education) found out that the vast majority of users (88%) preferred Physeptone, because they felt that Methadone DTF was less effective. Although difficult to generalise from, this study expresses high levels of dissatisfaction with substitution treatment (respondents' had the impression of drug treatment service personnel as being impersonal and uncaring, too many sanctions used by health professionals, lack of confidentiality of service providers and a lack of complaint procedures etc.). O'Connor (2002) reported service users' dissatisfaction with several issues (amongst others having to comply with punitive contracts and having to consume methadone in a public space in pharmacy retail outlets). Dillon and Mahon (2002), who studied users' perspective on methadone maintenance (n=71), point out that participation on the methadone programme offered clients an alternative to the generally chaotic lifestyle they associated with heroin use. Respondents did not equate 'success' on methadone maintenance with becoming drug free. Success in this context was found to be relative and much more complex than a simple measure of abstinence. Instead, MMT service users felt that the programme had a positive impact on their quality

2 Referred to in the prisoner interviews as the "brown phy", which was supposed to be damaging to teeth due to sugar ingredients (UISCE 2003, p.11).

3 Referred to in the prisoner interviews as the "green phy".

of life in a number of areas: “In this context, clients valued the stability the programme offered and argued that it gave them an opportunity to get their lives ‘back on track’.” (Sinclair 2002, p. 7)

1.2.2 Substitution treatment in prisons

The Prison Service adopts a multifaceted approach to drug treatment, which includes provision of addiction counselling, education programmes, detoxification, drug therapy programmes, information forum, drug free areas and methadone maintenance. This variety of responses to the challenge of drug addiction in prisons has been recommended by the First Report of the Steering Group on Prison Based Drug Treatment Services (Irish Prison Service, 2000). This Steering Group proposed a coordinated and partly centralised approach to drug treatment services in the prison system with significant focus within the Mountjoy Prison Complex (see Department of Justice, 2002). Evidence for this approach has been delivered by the report of Allwright and others (1999) who found a high prevalence of infectious diseases and drug related risk taking among prisoners. They recommended: “One third of drug users were on a methadone programme prior to their imprisonment. Prisoners rarely maintained on methadone in prison. If a greater proportion of drug users were offered methadone maintenance in prison, this would have the effect of lessening risk of viral transmission. This is a matter of some urgency.” (p. 30)

In 2000, methadone maintenance was introduced into the prison system for those already on approved treatment programmes in the community. “As a result, offenders who had been on methadone maintenance in the community no longer have to terminate their treatment on committal. By December 2000, 184 prisoners were on methadone maintenance in 5 Dublin prisons.” (Irish Prison Service Report⁴ 1999/2000, p. 17) “*However, there are difficulties in placing prisoners on methadone programmes in prison who have not been on such a programme in the community as there is no guarantee from the Health Authorities that prisoners could be continued on these programmes on their release. The Group noted that the First Report of the Steering Group on Prison Based Drug Treatment Services envisaged that prisoners with a drug dependency could apply for treatment within the prison to*

4 See www.irishprisons.ie.

be commenced in a similar way as would apply in the community and with similar waiting times applying." (Irish Prison Service, 46)

In a general healthcare study of the Irish prisoner population (Centre for health promotion studies, 2000, p. 29), prisoners were asked to rate the prison health service. 40% of male and 29% of female prisoners reported that the prison health service was poor, while 23% of male and 45% of female prisoners thought it was fair. 23% of male and 27% of female prisoners rated the prison health services as very good or good. Among prisoners' suggestions on how to improve the service, more time was demanded for patients on the part of the prison doctors, better doctor-patient communication, retraining of health staff so that staff would identify and address the specific needs of prisoners, such as drug addiction and mental ill-health, as well as improved confidentiality in the health service.

In the 90s, the gap between substitution treatment in community and in prisons widened. Whereas the number undertaking substitution treatment in the community rapidly increased, there were only a few doctors to prescribe it in Irish prisons. Methadone was first introduced in Irish prisons in the early nineties. Until 1995, prisons offered a detoxification treatment to opioid dependent inmates including reduction schemes of 3-5 days. In 1996, substitution maintenance treatment in Irish prisons began in Mountjoy prison with a few HIV positive inmates and other persons in need (e.g. pregnant women). This developed and, in 1998, any HIV positive inmates received methadone. At the time of the visit, there are approximately 500 inmates receiving methadone with the intention to expand services. With a time lag of several years, substitution treatment expanded at the end of the nineties. In 2000, a policy was applied to continue substitution treatment from the community to prisons and vice versa. One reason for the belated introduction was the initial doctor's resistance to treatment due to a lack of resources in the prison health service. However, implementation of this policy has been delayed.

It was seen as illogical to confine this treatment to HIV-positive inmates and pregnant women. Those patients who were already on methadone maintenance treatment in the community, and who expected a short time in prison, were then provided with substitution treatment as part of a pragmatic approach. The time of maintenance therapy could be prolonged, predominantly in the Dublin area, but could not be ensured for other regions (e.g. Cork, Limerick), meaning that inmates were not transferred to other institutions there. In

Dublin, there are also differences in access to substitution treatment, depending on the district (East, North and South-West) that drug users come from. The length of waiting lists varies a great deal, depending on the resources available to each health centre, and, in some areas, a wait of up to one year is not rare. Only those drug users who are in treatment outside and who will be taken into treatment again after release are guaranteed treatment in prison. The situation inside prison mirrors that on the outside; services are restricted by limited resources and waiting lists remain in operation.

The expansion of methadone treatment happened under the guidance of and with advice from community experts and specialists. Apparently, several problems derive from the link between being on treatment in the community and securing a place for treatment in prison:

- The number of prisoners receiving methadone maintenance treatment depends completely on the resources and possibilities in the communities (either GPs or clinics). If there is no such infrastructure in villages and smaller cities then substitution treatment cannot be continued in prison.
- There are not enough counsellors in prison to support prisoners on substitution treatment although some input is given by probation and welfare officers and very few psychologists.

Furthermore, there are additional problems, which are quite common to regimes in other European prisons:

- There is a shortage of nurses and the relevant training (supervision of urine tests, dispensing, contact to the community, awareness of topping up drugs etc.). There is a particular need for senior nurses to coordinate the services.
- There are not enough specialised doctors (level 2⁵) to prescribe methadone in prisons.
- The staff saw substitution treatment as a harm reduction measure and the Officers Association is against this approach.

All in all, the prisons do not have enough resources. Staff shortages, especially of nurses, contribute to substitution treatment problems. This stated frankly by the Irish Prison Service: *“Unfortunately, the trained staff and*

5 Level 1 – GPs need little training and can prescribe for up to 15 patients. Level 2 – GPs can treat up to 35 people and have more extensive training.

other resources which would be considered necessary in the external community context to adequately address the range of problems and issues associated with a population of this size are not currently available in the prison context. This has presented on-going difficulties in ensuring the safety and stability of this treatment provision. In the context of inadequacy we must consider that we remain fortunate in avoiding any significant mishap in the provision of this treatment". (Irish Prison Service 2001, p. 30) At present, the potential for improving services and substitution treatment relies too heavily on the individual motivation of doctors and nurses. Most of the doctors are employed part time. It is difficult to recruit doctors, which accounts for problems of getting doctors of level 1 qualification in Limerick and level 2 in the Dublin area. Many doctors are not motivated to treat drug addicts. As it was said by one interviewee "Drug users are a difficult group to deal with, if you can you would avoid it". Experts say that "difficult prisoners" are sent to Dublin, where a better health care and expertise is expected.

The decision of whether to continue treatment is taken by the doctor. Routine detoxification is undertaken by the primary care doctor. The national treatment list⁶ can be accessed by the nurse to check whether a patient received substitution maintenance treatment in the community. The nurse will ring the respective clinic at the day of admission. Only a very small percentage of prisoners who have received treatment did so for the first time in prison.

Psycho-social care for patients on substitution treatment is optional. According to several interviewees, women with multiple problems and a lot of drug associated problems (see Carmody and McEvoy, 1996) do not receive enough psychological support. But, as it is a high need group more investments need to be made. There are links in the Dublin area with 'Merchants Quay Ireland', an organisation which is providing harm reduction measures and housing in the community and which gives support for prisoners who have been on methadone maintenance. There is also the possibility to switch to a Therapeutic Community, when certain requirements are fulfilled (negative urine etc.).

There is no specific legal regulation for substitution treatment in the prison setting. But, a treatment programme for the Irish Prison Service has been

6 A list to avoid duplicate prescribing.

elaborated and is serving as a basis for this treatment in custody. The following steps in methadone treatment are⁷:

- Individual committed to prison
- Assessment by nurse on first day
- Urinalysis (6 A. Morph)
- Verification with the central treatment list
- Doctors' assessment
- Treatment plan (maintenance, detoxification)

Contract signed (copy to service user) in which service user is given detailed information on the treatment and on the risk of using other drugs as well as a list of medications not to be used:

- Psycho-social follow up by Counsellor/Key Worker (where possible)
- Stabilisation period to establish the right dose
- Maintenance or detoxification regime
- Regular review to set new goals (depending on type of treatment)

1.3 Prison Population

Table 13 Data on the prison situation in Ireland (Source: King's College London, International Centre for Prison Studies, Prison Brief for Ireland)

Country	IRELAND, REPUBLIC OF
Ministry responsible	Department of Justice, Equality and Law Reform
Prison administration	Irish Prison Service
Contact address	Siac Building, Monastery Road, Clondalkin, Dublin 22, Ireland
Telephone / fax / website	tel: +353 1 461 6002 fax: +353 1 461 6027 url: www.irishprisons.ie
Head of prison administration (and title)	Sean Aylward Director General
Prison population total (including pre-trial detainees / remand prisoners)	3 602 at 28.4.2004 (national prison administration – of which 309 were on temporary release)

7 Methadone Treatment Programme Guideline for the Irish Prison Service, p.17

Prison population rate (per 100,000 of national population)	90 based on an estimated national population of 4.0 million at April 2004 (from Irish Census 2002)
Pre-trial detainees / remand prisoners (percentage of prison population)	14.8% (28.4.2004)
Female prisoners (percentage of prison population)	3.8% (28.4.2004)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	1.5% (1.9.2002 – under 18)
Foreign prisoners (percentage of prison population)	9.2% (28.4.2004)
Number of establishments / institutions	16 (2003)
Official capacity of prison system	3 313 (1.9.2003)
Occupancy level (based on official capacity)	99% (1.9.2002)
Recent prison population trend (year, prison population total, prison population rate)	1992 2 155 (61) 1995 2 054 (57) 1998 2 648 (71) 2001 3 025 (78)

2 The field visits

The field visit in Ireland (10-14 December 2003) was conducted by Heino Stöver and facilitated by Dr. Enda Dooley, Director of Prison Healthcare, and Frances Nangle-Connor, Coordinator of Nursing, Health Care Directorate, Ministry of Justice, who also provided general information and support with the finalisation of this country report. Two prisons have been visited: the new women's prison attached to Mountjoy Prison in Dublin and Wheatfield Prison for sentenced men (adjacent to Cloverhill) in Dublin.

In both prisons, interviews were conducted with nurses, social worker, focus groups of prisoners, probation officers and doctors. Additionally meetings were held with Dr. Brion Sweeney, Consultant Psychiatrist in Substance Misuse, and Rick Lines, Executive Director, Irish Penal Reform Trust

(IPRT). Finally, there was a meeting with Jean Long, Drug Health Research Board, Dublin.

2.1 Dóchas Centre

2.1.1 Description of the prison

The Dóchas Centre is the new women's prison attached to Mountjoy Prison. This prison has a daily population of approximately 90, 30 of whom receive methadone substitution treatment at any one time. The turn over is relatively high as 15-20 women enter the institution and/or leave it per week. The percentage of drug users among the inmates is considerably high and has increased in recent years. Almost 75% of all prisoners committed offences related to drug use. A considerable shift of patterns in drug use has been observed towards the spread of multiple drug usage.

The reduction scheme, if somebody wishes to detoxify or is not on the National Treatment list, is a reduction of 5 mg in 7 days, 40 mg in total. Interviewees stated that psycho-social support is lacking. Apart from an anxiety and a drug awareness group, additional counselling is provided by probation service and welfare officers and is not regarded as sufficient. The probation and welfare service conducts committal interviews. Methadone is dispensed from 8-9 in the morning. Daily problems relating to supervision and control were reported.

2.1.2 Goals and practical procedures of substitution treatment

The doctor stated that their goal was to continue methadone maintenance treatment from the community. What makes their work difficult is the widespread use of additional drugs, mainly benzodiazepines, which are often used in an addictive pattern. This co-addiction makes it hard to monitor. Recently, guidelines have been developed by Irish doctors that recommend not to prescribe benzodiazepines for a long term course. The widespread addiction of benzos makes it necessary for the doctor to develop reduction schemes. First, sleeping pills are given and then these are reduced over a period of 1-2 weeks. The prescription of sleeping pills will be adjusted to the individual's situation and could go up to 3-4 weeks. It is regarded as necessary to apply a clear policy on sleeping pills in order to avoid constant arguments with inmates.

The average dose of prescribed methadone is around 40 mg. The reduction scheme is 10 mg less per day over 14 days/ Individual approaches to treatment are necessary and, in 90% of cases, the stabilisation of former chaotic behaviour is achieved.

2.1.3 *Views of prisoners – focus group in Dóchas Centre*

All of the participants at the focus groups were receiving methadone and had several years of experiences with methadone programmes, outside and inside prison. Five prisoners attended the focus group.

One of the issues surrounding substitution treatment in prison is the consequences of topping up with other drugs, e.g. cannabis:

“... when you come into the prison, they give you so long to clean whatever you have in your urine, like if you have cannabis or...most prisoners come in, when they come in they have probably cocaine and heroin and all that in their urine, so when you come into the prison they give you a while...a month is it, or something? ... Yes. ... to clean it out and then, after that, if it's still in your urine you get docked ten milligrams, so ...”

The consequences were not clear to all respondents and doubts are remained regarding the exact protocol for reduction if cannabis is found:

“But, I think, I don't know, I think probably ten milligrams would be a bit much, you know. Especially if it's only for cannabis because it's not really a big, you know, it's not, it wouldn't be a Class A drug or whatever, ...”

The doubts regarding consequences of cannabis use might come from having experienced a different testing policy in the community:

“But, other than that now, in the community, I don't think ... I think you can sort of have it if you're just on your maintenance, on your methadone and with no other drugs you can kind of just get on as normal as...as, as anyone else, you know.”

Prisoners report that their cannabis use is becoming problematic as the consequence of a positive test is a reduction in their methadone dosage.

“You know, you're cut every day and, em, at the moment, like, even speaking of ... I'm having a bit of hassle with my maintenance, like. Like X said, I understand that cannabis is a Class A drug and, you know, legally, by right, we're not allowed have drugs in prison, d'you know what I mean? It's black or white, you know. You don't have ... although that's what I ... my argument was, 'Ah, but it's only cannabis' and I was told coming into prison that you

don't have, you know, drugs, it's that straightforward, and all. But drugs do come in, you know. It ... it's a natural occurrence and it is going to happen. And sometimes you can even see where the tension is so high, and then when drugs come in, like, it mellows it for a while and then it goes up again, and, you know. You do need a bit of a release, you know, there's not a lot of things that we have here for release. Now, I had a problem with ... I had cannabis four weeks ago, say. Now cannabis takes a long time to get out of your system. So, because I took cannabis, I was cut, and then the next week, because it was in my urine still, they cut me again, you know. And then I was cut again – so I was cut three times for one, you know. So, that's ... that's an issue, like, you know. They don't give you enough time for it to actually leave your system, you know. Where, instead of keep cutting it, you know, they say 'Well it takes a while. If you were taking heroin, that comes out of you quicker. You'd be better off taking heroin.'

As an important goal and an indication for stabilisation, the take-home regulation is named:

"... if you're clean, you know, you're just on your methadone, the clinics on the outside will give you ... your methadone to take home. So you can, like, you'd probably get, like, a week and you'd just go to the clinic, like, once a week. But you have... like, that's when you're kinda doing okay, you're feeling okay."

"So, you know, I think, ... if you're getting your methadone to take home, that's great because it'll, you know, make you kinda stay stabilised that little bit longer, you know, and get a bit further."

Prisoners do see difficulties and temptations to use substances other than methadone, not only in prison but also on the outside in the methadone clinic:

"... a lot of people would be doing okay, but when you go to the clinic sometimes it can be a downfall, you know, 'cause you meet other people there and you end up, probably, like, some people think, you know, when you go there you'd be doing okay, and then you end up going off and probably getting whatever sort of drugs you're into, you know ... You'd be more inclined to use when you're meeting people, wouldn't you? ... Sometimes, yeah. The clinics, I think the clinics on the outside would be a bit of a downfall, you know, in regarding that, meeting other people and, if you're easily influenced and easily led, you will go, you know you could get a bad day where you'd go and you'd meet other people and you'd end up going off,

probably getting cocaine or heroin or whatever you're into, you know. ... It's different here, yeah. Because, like, you're in the prison and you can't get at it really, you know."

The transfer from the community methadone programme to the prison-based programme was described as smooth and void of problems:

"... They ring up the clinic, you know, when you're committed and check what dose you're on, what other things you're on."

Prisoners stated that this is a development in the substitution programmes and, compared to previous stays in prison, an improvement has been seen:

"... it wasn't always the case. We used to only get a detox, years ago. Even if you were on maintenance and you were clean. If you were clean, you got maintenance of seven days – not a maintenance, a detox – cut every seven days and that lasted seven weeks. You got forty milligrams. Forty, yeah, and you were cut every seven days. Forty milligrams. And you were cut, like what was it, five milligrams? If you were clean on the maintenance at seven days, and five milligrams. Yeah, five milligrams every seven days but if your urine was dirty it would start on 35, wouldn't they, and cut you every five days, and five milligrams or three days, or whatever, and so on depending on if you used the smokes, wasn't it?"

[Interviewer: So, it's an advancement?]

"Yeah. Big-time ... Like, even if you were on a maintenance outside you were still, three years ago, you were just getting cut in here and that was it, you know."

Prisoners confirm that the prescriptions they get in the community-based methadone programme are continued smoothly inside prison:

"So, it's grand like that the maintenance is here now, so a lot of people, they ... it would be easier coming into prison knowing that you're getting your maintenance, you know, and your methadone and you're not getting cut."

Prisoners report that the standard dosage suitable for all prisoners will not be sufficient for all needs

"No. It wouldn't be. Not if you were on maintenance for a long long time ..."
"It wasn't sufficient, you know, you'd be in prison and you're still not getting proper sleep and you're not feeling, like ... it takes a long long time ..."
 (A prisoner)

The participants in the focus group also brought in their experiences from other prisons and the detoxification schemes there.

“That was very different. They kinda like – excuse me – they cut every day there, you know. It’s like a crash course, you know, it’s just boom, boom, boom and they’re finished then, you know.”

One of the key issues addressed in the focus group was the prescription, or rather non-prescription, of additional medication (e.g. sleeping pills). It became clear that drug use patterns for women outside contained multiple drug use pattern including sleeping pills. The prison prescribing policy is against the continuous prescription of these drugs. The women are very well aware of this double standard.

“You know, a lot of us are not really into cannabis anyway, you know. When you’re on the clinic, you’re getting your methadone and you’re getting your sleeping tablets, but when you come in here, like, they’d all be on sleeping tablets for years, you know, and when you come in here you get them for two weeks, fourteen days and that’s it after that. And because you can’t sleep, like ... I’m not here ... I don’t need ... I don’t smoke cannabis, not ... not very often, but when I came in here I did and, like, it’s years, probably about three years since I did, because I wasn’t sleeping when I came off my sleeping tablets, I ended up I did smoke cannabis and because it’s in your urine for so long you’re getting cut and cut. But, I think if they just gave like kept you probably on your sleeping tablets as well.” (A prisoner)

Furthermore the participants of the focus group regard the two weeks period for withdrawal of sleeping pills as too short.

“Say, maybe you got a five-year sentence and they’d give them something to, you know, relax, not Valium, but sleeping tablets, you know what I mean, but after, like, that would have been a few years ago and you were getting them for, as I said, the duration of your sentence. But now, it’s changing, and you come in and you’re only just getting them for two weeks, no matter how long you were on them – it’s just stopped. Not detox, but the same amount for the week.”

“And you’re coming in, like...when you come in at first you’d be probably strung out on heroin and strung out on cocaine and strung out on these tablets, them drugs, yeah. So, when you’re getting them for only two weeks in here you still, you know, with withdrawing from everything else, you know, you will, you will, if there’s cannabis around, because it’s, it’s ...”

The prisoners think that it is maybe a misunderstanding of the pharmacological effectiveness of methadone that leads medical staff to think it is powerful enough to ease all withdrawal pain. Prisoners argued for the continuation of the prescription of sleeping pills.

“I think they think the methadone is gonna, will overcome everything. Yeah, you know, withdrawal symptoms and everything, but it doesn’t.”

“I think if you were kept on your sleeping tablets, and just get sleeping tablets and your methadone, it would cut out all other drugs, you know like, it would cut out hash, cannabis anyway with a lot of people.”

Prisoners complain about the detox scheme for sleeping pills but risks of dependency were not mentioned:

“I’d say detox, you know, them drugs. See, they give you the same amount for two weeks and that’s it. They don’t even wean you down, like.”

“They don’t reduce you slowly, like, whatever, like.”

“They should be easier with your sleeper, like cut you gradually.”

Prisoners regard a good detox treatment as essential for well-being:

“If they’d give you a good detox, then you wouldn’t feel half as bad.”

“They are very dangerous when you get strung out on tablets, and coming off them too quickly, you can go into fits or anything.”

“When I came off them, when I was on them drugs and they just cut me and I was very, very sick for a long time.”

“And they think when you are coming off them drugs you can take fits and they give you anti-fit tablets.”

Cannabis consumption is seen differently in external clinics and within the prison-based methadone maintenance programme. Prisoners are very well aware of these different policies:

“[Interviewer: Is it the same outside – when you smoke cannabis that you will be expelled?]

No. No. No. They’re a bit more lenient. You know, as regards heroin and cocaine ...”

And different policies are perceived between the two with regard to the prescription of sleeping pills:

“I mean, they’re cutting you. It’s silly because they’re cutting you and then you go back out to the clinic and the clinic isn’t cutting you back there.”

“Yeah, ... in the community you actually have them from your maintenance, and then they cut you and you go back out and then you just say it to your doctor and he’ll put you back on them drugs.”

“There was a time, what your clinic gave you on the outside you got it when you came in. But now it’s only methadone you get the same as the clinic, you know. But anything else, they take you off, even Valium ... Like, some people are on Valium since they’re, like, thirteen and fourteen, you know.”

Different policies also exist in relation to urine tests:

“... you’d probably just have the one, like, within six weeks and then you’d have one dirty urine and then you’d have another, like, come in for six weeks or whatever. You’d be more inclined to give dirties on the outside than you would in here, so ...”

Urine testing does pose the problem that prisoners might switch from cannabis to heroin, which is to be detected only for a short period of time. Prisoners confirmed this view:

“Yeah, ‘cause it goes after four days, yeah.”

“You won’t be cut as much. ... You know the way the heroin doesn’t stay in your urine as long as the cannabis does? And then you wouldn’t be cut as much, you know, on your methadone. Yes, you know, like when you’re giving a dirty urine, you know.”

“Yeah. Various people that have said: ‘Well, I’m going back on heroin. If they’re going to be cutting me for hash, I’m going to go back on it. What’s the point in staying off heroin as well?’ Like, methadone substitutes heroin. If you’re feeling sick down to being cut, what do you take? You take heroin down, d’you know what I mean.”

Urine testing does play a role in the management of additional drug use (either cannabis or others):

“Some people don’t want to get clean, you know. If you’re getting, giving a urine on Monday and Saturday, people know, okay, I’ll have a turn-on on Monday night and it’ll be out of my urine for Saturday morning. You know, some people do want to get out of it, and then there are people that don’t, and they fuck it up for people who do want to, you know like, let’s be honest. You know, I’ve often said ‘Okay, I’ll give a urine on Monday and, okay, I’ll have a smoke Monday night, ‘cause it’ll be out of my system for Saturday. You know, people do do that, you know. That’s the way it operates. People

do give bogies, you know, you can ... you know, we can all use bottles and ... you know ... everything. You know, it can be ... there's a ways and means to everything, d'you know. I'm just saying this is the way it goes on, you know."

Prisoners are aware of the consequences of manipulating urine tests as controls may be increased for all prisoners and the situation may worsen:

"But what I'm saying, what I mean ... what I'm saying about people ... I mean it's hard at the same time because it messes it up for people who do genuinely want to get it together, you know what I mean. So, they're putting more rules and more rules and it's falling back on the people who want to get it together, because it's for the benefit of people who don't. Do you understand what I mean? Like, I'm trying to push people who don't want to get clean, and they're crawling back then."

"There's a lot of people who want to do well on the methadone and there are others who don't. For the group that don't want to do well, em, they're putting all these regulations and rules in place that are having a negative effect on the ones that are trying to work hard. Of course, yeah, yeah. So everybody pays for the small number that don't want to do anything about it that don't want to give up."

Prisoners reported difficulties in cooperating and communicating with counsellors inside the prison. One reason was that they have someone they trust outside and do not want to report twice as they do not trust the counsellors.

"A lot of people have counsellors in their clinics on the outside that they would have years and would know well, and would, you know like, don't mind talking to them when you have them so long. And then, if you want a counsellor in here, it's a different person and you have to go through the whole rigmarole, you know. And most people don't want to open up the way they opened up with this certain person, you know, because you're used to that person."

"It took me a long time to open up to the person on the outside, without having to start all over again with strangers in here, you know what I mean."

However, an inconsistency was evident. On the one hand, prisoners reject counsellors and, on the other hand, they express the need for more counsellors in the prison.

“They’re not like proper counsellors, like ... you’re supposed to go and get counselling off XY, you know at the station, but, like, you couldn’t sit there and talk to them about your problems.”

“There’s definitely counsellors needed.”

“In this system the Probation and Welfare Service provide a counselling service. But the girls are saying they wouldn’t trust them.” (A nurse)

“No. Because they work too close with the governor and the officers.”

“... If you’re looking for accommodation if you’re getting out, or a hostel or whatever, but you wouldn’t be able to sit down and talk about your problems with them or anything, you know what I mean. You couldn’t really talk to them. There’s no one, like, really there to talk to.”

Some prisoners raised the possibility of integrating counsellors from outside: *“But, I don’t think ... I wouldn’t trust a counsellor in here either, girls, you know. Unless, unless ... your one, whoever you have in your clinic would come in – you wouldn’t mind that. But I personally wouldn’t ...”*

Also self help groups are not easily accepted in the prison setting. One of the basic problems is the lack of confidentiality surrounding the information given.

“NA (Narcotics Anonymous) meetings ... Twice a week, they’ve started now. ... I think ... Well, I used to go to it, but when you go to it there are people in the group and then what you’re saying they carry it all round, you know, and the girls talk about it. It’s not the same as the meetings on the outside, either, do you know what I mean. Some of the girls wouldn’t really want to be there and they’d be just messing a little bit.”

Privileges (12 and 24 hour house) are only available for those who are stable on a methadone maintenance programme. Prisoners expressed that they feel disadvantaged against non-drug using women:

“Like, I was in a privilege house. I got into a privileged house because I was giving clean urine. And, you know, there was people in the house who wouldn’t be on phy, like, they’d be just in it, you know what I mean ... they weren’t on drugs, like, and the things that they could get in ... It’s only little things, do you know what I mean, but they’d be allowed more things into the prison than I’d be allowed in, you know, you know what I’m talking about. Things that the addicts weren’t really allowed, just in case we were getting

drugs into the prison, d'you know what I mean. You know, you know stuff that you wouldn't be allowed."

The fact that they are ex-drug users was obvious to the staff and the way in which individuals cope with addiction leads to privileges being granted or taken away:

"That's the only ammunition they have, is 'You take drugs', you know, that's all they say, like, you know."

"Or 'Is your urine clear now?' You know, they know. They know anyway."

Prisoners requested greater integration into *therapy modalities*:

"... whatever the patient feels themselves, you know. When they come, if they feel, like, 'Well I'm on them so many years, so ... you know, they should have the choice, like, I think, you know."

"Because it means if someone comes along with a bit of gear or whatever, you'd be more inclined to say, 'Well, fuck it, give us it. I'll probably get a sleep tonight with it.' You know what I mean, so ... you know, for that reason you would be tempted – just to get a night's sleep. Because you do ... you know ... it is ... you know ... it's mad."

Prisoners miss direct communication with the doctor himself/herself :

"So I have asked, even last week to see the doctor, and the week before last week, and I'm still waiting. You know, like, I think even on my last sentence I saw the doctor the day I was committed and that was it. I haven't seen her again since. It's so hard to get to see the doctor in here. It's unbelievable."

"... You know cell doors were open and you'd say, 'Will you put my name down for the doctor.' Now you need to be dying on your two feet. You tell a medic and they say, 'What's wrong with you?' They have to decide whether you're to see a doctor. Do you know what I mean?"

"The nurse decides whether you are sick enough to see the doctor."

"But, if you say to the medic, whoever is giving out the medication the night before, if you say 'I want to see ...' But, if I want to see a doctor I say it to the nurse or the medic and they say to me 'Why, what's wrong with you' they'll say to me, and I might not want to tell them what's wrong with me. But you have to tell."

2.2 Wheatfield Prison

2.2.1 *Description of the prison*

Wheatfield Prison is a large prison for sentenced men (adjacent to Cloverhill in Dublin). The building consists of 20 living units that open off main spinal corridors. Each unit has 16 rooms designed for single occupancy and has its own day room for indoor association. Every room has its own washbasin and lavatory. The prison holds approximately 380 sentenced men. There are 2 drug free units, one on the “protected” unit, one “ordinary”, each unit holds 16 places. The drug free environment unit is open to all offenders who volunteer to abide by the rules and regulations (Irish Prison Service 2002, 33f). One of the requirements is a contract between prison and prisoner to keep abstain from drugs. The unit is mixed 50:50 between former drug users and prisoners who have never been in contact with drugs. Successful stays are rewarded with some extra visits etc. The atmosphere is supposed to be more relaxed. The prison gets most of their inmates from Mountjoy Prison, at the time of the visit there were 45 lifers, the average age was 23.

2.2.2 *Goals and practical procedures of substitution treatment (access, rules, urine testing, provision on day leave, exclusion from the programme etc.)*

At the time of visit (12th December, 2003), 75 prisoners out of 374 were on substitution treatment. The prison has two dispensing sites, one in the segregated area and one in the ordinary prison. One half time doctor is responsible for the methadone treatment and the prison has more nurses than medical prison officers. It is aimed at replacing all “medics” by registered nurses. In total, there are 11 nurses and 3 medics who guarantee a 24 hour supervision of the entire health care provision.

As in the female prison, many male prisoners have had extensive experience with benzodiazepines. According to the nurses, the problem is that many prisoner don’t see benzos as a problem and need to be taught about their highly addictive potential. Several interviewees said that the structured substitution programme was responsible for the absence of a chaotic situation regarding drug use and misbehaviour. According to the enormous use of opiates and other drugs before admission, and the experiences of many inmates with drug culture, substitution treatment constitutes a major factor in making the situation in prison more manageable in terms minimising disruptive and dis-

ciplinary problems and self harm. Overall stabilisation takes lot of the pressure with less aggressive behaviour.

The prison could cope with more than 77 prisoners on substitution treatment but a lack of resources (nurses addressing any defaults, vaccination) makes it difficult. At the time of the visit, 10-15 prisoners would like to be on the substitution programme but the prison had reached its limits, especially regarding accompanying services such as education work. Nurses reported that they got the feeling that prisoners who take the detoxification option would be better off under the maintenance option for physical reasons.

The regulations for release and home leave have been improved recently and cooperation and community links have been placed on a broader and more strategic level.

2.2.3 *Views of prisoners – focus group in Wheatfield*

Four prisoners with several years of experience with prisons and different forms of substitution treatment (detoxification, maintenance) in and outside of prisons attended the focus group. The average dosage of the prisoners was 65 mg.

Prisoners in the focus group express their fear about detoxification of methadone in general and in the prison setting in particular. For this they complain about the lack of additional help.

“You know. I’m on it now seven years. Had a try with coming off it, and And, like, anyone that wants to come off methadone, I think there’s just fear and the whole lot around it. I think people are just afraid of being sick when they’re coming off it. And I think that’s why it is ... like, people don’t want to come off methadone because of the sickness. Because there is no other thing to cure the sickness ... Because there is no other thing that will cure the sickness, like, that you’re going to go through. You know, something that would stop the sickness, you know.”

“[If you were outside, you would probably find it easier, wouldn’t you?] Ah yeah, a lot easier. Because you’d be able to go out and you could buy a few sleepers and you could go through the withdrawal. Yeah. But in here, that’s why people are afraid to come off it because they don’t ... like, what, you get one sleeper and that’s it. Like, one sleeping tablet – it’s not even a sleeping tablet it’s a relaxing tablet – and they give it to you and that’s it. ‘That’s it’, you’re told, ‘that’s all you’re getting’ and you’ll have to do without. There’s

people in here now are coming in on large amounts of physeptone and they're getting handed the relaxer – there, that's all we can do for you – and you're on your way for the next six weeks to eight weeks, you're on your tod."

In the prisoners' views the development of pharmacotherapy in Irish prisons can be seen over the last eleven years: From a 3-day detoxification in 1992 to 7-days after 1995 to three week detoxification and then to maintenance treatment in the year 2003. From this, it is clear that restrictions to access to substitution treatment have fallen away over time:

"I had to go through it all. When I first went into XY-prison you used to get a three-day detox...thirty, twenty, ten, that was it."

"Between mid '92 and '95, yeah. You'd get a three-day. Then they changed the detox to ... You used to get – what? – a seven-day detox then. It was brown the methadone – it was a brown phy that time. That was a couple of years later, it was a seven-day. After that again, I think it was three-weeks, wasn't it?"

"Say, '95, 1995, we used to get, em, 60 mg of brown phy over a three-week period, you see, and it would reduce, gradually reduce, you know. But, and then, em, there was no such thing as maintenance programmes in prisons at that time."

"From back then, like, when I look at back then, a three-day detox. There was no such thing as maintenance programmes. The only people that were getting maintenance programmes were HIV prisoners, they were the only ones that were getting methadone treatment programmes."

"At the same time, the consequences become clear, if substitution treatment is only restricted to certain groups like HIV-positive inmates, they feel as outcasts."

"I'll tell you what way you were- big white boiler suits, gloves, masks ... and you'd be like a leper. There'd be a big long corridor from here to the end of the room and you'd have to walk out in your dizzle dazzle, you know. They didn't know what ... HIV was at that time."

Prisoners are very well aware of the fact that maintenance was only introduced a few years ago as a result of prisoners' struggles:

“Everything outside about the maintenance is better than it is in here. Because they’re only learning in here ... Like, it’s only all new here with them, do you know what I mean. They’re only starting to learn. They’re only starting. It’s only here, it’s only out a few years, isn’t it?”

“... Eighteen months, two years. Like people fought and fought and fought for maintenance and eventually people got it. But like there’s after being so many people overdosing and dying. People had to go to the extremes.”

Despite the changes and developments, a heterogeneous situation of methadone provision can be observed throughout Irish prisons. Some prisons still do not prescribe any methadone. This obviously has consequences for the provision of substitution treatment in other prisons, as the inmate is not known to be on maintenance treatment. Prisoners have to struggle to get into the maintenance treatment again:

“... when I got arrested I went to XX. So, I wasn’t offered anything even though I looked for treatment. I got no treatment, you don’t get methadone in XX Prison. ... nothing whatsoever, not even a pain-killer.”

“... So when I came out of that, I was after losing my maintenance then, d’you understand me? So I came from there to ZZ and I was looking for the maintenance and the doctor was trying to tell me that he never heard of me, you know what I mean. So, from 2000 ... I got the maintenance programme in 2002 – that’s how long I was looking for it. Up here I eventually got it in 2002. While I’d been in prison since 2000, but I only got it in 2002.”

At the same time, prisoners knew that they have to be in the clinic in the community in order to ensure continuity of care.

“Like I was on maintenance outside and I was told I wasn’t getting a maintenance when I came in to prison. You know, I was only on it for a couple of weeks before I came in.”

To get into a treatment programme takes effort on the part of the prisoner:

“He gave me the detox programme. While I was on the detox programme, I saw the methadone doctor and she told me, she was after telling me that there was a lot of red tape around my case and that when ... no one actually wanted to put me on ... no one actually wanted to start me. But when I was on the ... well, she said ‘You’re on a maintenance now,’ she says, ‘I’ll sort you with the contract. And that was it, I got it from then.”

“Now, I was fighting tooth and nail for this, for the maintenance programme, and I was getting nowhere. I brought the Governor to court three

times with an application, a mandamus [a directive from a higher Court to a lower] ... and, I don't think I'm going to go there, but it was all ... just refused anyway"

"... they said, 'Look, get a letter confirming that and it'll be taken up immediately upon his release and he'll be started straight away.' ... I was given a detox while we were awaiting the decision. So while I was on the detox they decided, seeing as the doctor put me on the detox, 'I'll keep you on it then. You'll be a maintenance programme now.'"

Prisoners try to reduce their dosage before release, because they don't want to go to the clinics anymore. Obviously they see the clinics as a symbol of being a drug addicted patient. Prisoners anticipate the situation and temptations related to the provision of methadone in the local clinics. So it is not the treatment in the clinic itself the associations which are disliked:

"I'm only after getting over it, like, ... I had it, like, for about six or eight months before I eventually, you know, copped on to it. And, anyway – different story. So, I'm after coming from the 90, I'm down to 30 mg now. I'm after detoxing down gradually and I'm on 30 milligrams now. ... I want it myself. I done it myself. Because I want to be off it. I need to be out. I've eleven weeks left out of five years, so, you know what I mean, I want to be, I don't want to be going to clinics. I want to be away from all that."

"I don't know. I'm fed up with it. Like, I've no desire for heroin any more. I've no desire for heroin whatsoever. And I don't want to spend the rest of my life on methadone. I don't want to go to clinics outside. When I leave here I want to go and get my life together."

The prisoners expressed their wish to choose a certain treatment (here substitution treatment):

"... prisoners should be offered maintenance programmes if they want it. Like, they can tell ... the prison authorities can tell by a prisoner's ... everyone has a file ... so they should know by the file if it's a case ... I think I speak for here, the majority of the group, you should be offered the choice if you want a maintenance programme or not, you know."

One prisoner observes that the decision of the doctor determines who is given treatment and, according to the prisoner, their views are not completely independent and reflect the Governor's policy:

"Like, in jail, in jail everyone ... like there's drugs ... everyone knows. I'm not going to bring it up, but it's open, it's everywhere ... there should be a

maintenance programme, and in your own ... when you're ready to come off it yourself, you know. Like, I know, I warned them 'cause I ... I needed that maintenance programme at the time because I was using heroin at the time and I was putting in all my mandamuses that I was at risk of contracting HIV and AIDS. But still, like, the Judge was saying he's not going to over-rule the executive arm of the government, in other words the Governor or the And the Governor was telling me he can't over-rule the doctor and the doctor was telling me if the Governor says 'Yeah' that he'll give it to me. Sure, I mean I was getting the run-around from Billy to Jack and I was getting nowhere. So, em, I got it in the end. But I think people, prisoners, should be offered it."

Prisoners expressed good intentions to stop using drugs when released with alternative personal strategies used to fight against the desire to continue drug use:

"... I know, like, there's been heroin around me all the time and I just ... like the lads will tell you there, I've been, I've been swapping it for hash. Do you know what I mean. I just kept away I just want hash, that's the thing, you know. Like, I don't bother with the gear we bought. I could have a bag of it, the gear, in my pocket and it wouldn't even tempt me to take it. Do you know what I mean."

Prisoners express their reservation against prison officers with training in health subjects (they call them "medics") and feel they are not adequately treated. One critique is that the medical officer decides who does and does not see the doctor:

"He came in and he seen so many people strung out and they were coming up and 'Look, we're looking for a detox, we're not looking for a maintenance, we're just looking for a bit of help here.' And the medics were 'Look, get away, he's only here, it's his first morning, like. Get away from the door. I told you already, none of you will be seeing him.' He was just picking and choosing who he wanted to bring in."

The role of the "medics" in the everyday life of the health unit is seen as very important. Prisoners express their fear of being excluded from treatment:

"The medics have a big say in it. The medics have a big say in whether you're seen, and what goes on. Now, the doctor was going to start me down there on a maintenance programme, only for a certain medic turned around and said, 'No.'"

“If I was arguing with a medic, without the doctor being there. Say you’re a medic, I’m a prisoner, that’s the doctor – the doctor’s not here. I argue with you and fall out with you; so you have a word with the doctor and I don’t get a maintenance.”

Participants reported the consequences of positive urine controls; topping up methadone with benzodiazepines will lead to a reduction whereas cannabis in the urine will not be sanctioned.

“If benzos are in your urine you get reduced on your amount ... Everyone smokes hash.”

“Anyone that’s on phy smokes hash. Everyone that’s on phy.”

The sanctions depend on the individual case:

“Don’t take that the wrong way. See the way this is, there’s no sanctions. Like, if the doctor wants it, if you give a dirty urine and there’s cannabis in it, if the doctor feels, like, right, he’s after giving... but the only odd dirty urines and we haven’t done anything like, and we’re grand now. Bring him in and we’ll tell him ‘Look, no more dirty urines, any more cannabis urines, and you’ll be cut. But they don’t mind up here. The cannabis is the, like, the way they look at it is that cannabis is ... it’s just cannabis. It’s recreational. You don’t have to go down and cook it up and stick it in a needle or anything; you don’t have to stick it on tinfoil and smoke it, smoking a roll. And the officers don’t mind it.”

“... if it’s coming from your urine, they don’t bother. It goes on, they know it goes on. If it’s in your urine... you haven’t got it in your hand.”

The outspoken sanctions vary considerably regarding the additional use of benzodiazepines.

“You get a punishment. You’re cut.”

“...If you’ve taken it on a visit, you’ll have no visits for two months.”

The participants understood and supported the messages that prison staff send out regarding the dangerous effects of constant use of benzodiazepines:

“... there are no strict sanctions on cannabis, but every other drug there is, you’re not allowed, you’re not allowed. Anything like a stimulant, say, anything from cocaine, tablets, from speed to, like, any barbiturates, any benzos – they’re not allowed. You get severely punished. Which, which is right, like, you know what I mean. But, at the end of the day, it’s stops. It’s better here,

that's why ... I'm only realising it now, like. If I was here twelve months ago, I'd be saying 'Fuck that, we should get, we should get both, we should get ...' you know what I mean. But now I know, like. Now, but don't get ... in here when you're coming off the methadone, the only thing I'd suggest is that, like, I know they're saying to you, 'Them drugs are barbiturates, they're highly addictive.'"

"Now they're afraid to give them out. They don't like to give them out, Roach, when you're on a maintenance programme for the simple reason being it's very dangerous. You could be like, what, choke on your own vomit or anything, like. There are too many people dying on it."

Prisoners are frank about the dosage of methadone provision and discuss that high amounts of methadone are not needed.

"When you're on methadone here, you know when they put you up to a certain amount, right? Like, see all that – 90 and 110 mg, that's bullshit, people don't need that, you know what I mean. That's greed, that's the drug companies."

Respondents point out that, according to their fears or experiences, they have to behave well and avoid any insults or other misbehaviour, otherwise they feel they are sanctioned around their substitution treatment.

"They have you over a barrel, you see. You can't mess, you can't give any trouble. You're on your best behaviour because they'll shift you down to Cork and you'll get no phy and you're just left in a cell ..."

"The way it works is, if you abuse a medic or a nurse up here, now. If I was to go out there and, say, they were calling me for my phy and I was sitting here and talking to you and I went, 'Will you fucking wait for a minute.' You'd be told, 'Right, that's it.' Bang. 'Close that door. Forget about him. Leave him there.' And, like if you're five minutes late and that, if that surgery closes, you won't get it that's it with your phy, you know. You may do without it for a day."

Prisoners point out that the supervision of intake needs more attention so that other prisoners, who know about the provision of methadone, wont them under pressure to get the prescribed drug⁸. They make clear that different staff groups apply a different practice (e.g. nurses and "medics").

8 see also Ó Loingsigh 2004, p. 14.

“They weren’t supervised because, like, because there was people like that were on meth or physeptone, ... and there was people that were strung out and they were coming over and, like, saying, like, ‘Give me your phy.’ You know what I mean. And these were only kids, like, coming in, strung out to bits, like, strung out on heroin. That’s their first time in prison, and they’re getting their phy took off them. And the medics are standing there watching it.”

“The nurses, like, now, they make sure you take your phy. With the medics, like, the medics ...they don’t care. When the nurses give you your methadone, you drink your methadone, you don’t walk away. You’re asked your name, your date of birth, where you’re from and where you’re going. They try and have a conversation with you when you’ve finished drinking your phy – just like they know it’s gone.”

Prisoners doubt the guarantee of confidentiality within the treatment process on an every day basis.

“... see the medics that wear white, like these are prison officers, like they are prison officers. Like, at the end of the day they go off at the end of the day with the prison officers ...and talk ... They’re sitting down in the pub, ‘Ah, wait till you hear about ((prisoner’s name)) today, Ah yeah, like.”

3 Summing up

In recent years, enormous improvements have been achieved around the broad introduction of methadone maintenance in prisons. In some institutions, the options (detox vs. maintenance) are offered to opioid dependent inmates. Although a lot has changed since 2000, the coverage of substitution treatment is (i) patchy throughout Ireland (there are several regions and prisons who do not prescribe at all) and (ii) is completely dependent on the advancements of this services in the community. Although the latter cannot be changed in the near future, the Irish Prison Service acknowledges the need to expand substitution treatment to all prisons in Ireland. This is demanded by the patients and recommended by scientific experts and NGOs⁹. Prisoners express their wish to be allowed to decide whether to have detoxification or maintenance treatment.

9 See Irish Prison Reform Trust & Merchants Quay Ireland (2002): A Call for Action: HIV/AIDS and Hepatitis C in Irish Prisons, p. 6; see also Ó Loingsigh 2004, p. 14.

Furthermore, the Irish Prison Service identified the need for more resources in terms of doctor hours and registered nurses who could replace the medical prison officers. At least in the Dublin area, community links with all involved in drug treatment are institutionalised via a special group¹⁰, which is about to focus on substitution treatment. Staff training programmes, designed to enhance and further the professionalism of Prison Officers involved in interpersonal work with prisoners undergoing drug treatment, are delivered by a specially appointed ‘Assistant Training Officer’ (Irish Prison Service 2002, p. 34).

Different policies were applied regarding the toleration of cannabis and benzodiazepines on several levels (i) between prisons (those two visited) and (ii) between the community and prison. This leads to different consequences in the two prisons visited. In the men’s prison educational work on the addiction potential of benzodiazepines has begun and seems to be successful.

For the Irish Prison Service a manual has been elaborated as a practical guide to all involved in substitution treatment (Methadone Treatment. Programme Guideline for the Irish Prison Service).

10 Special linkage group, the Prison Community Drugs Liaison Group, established in 2001 (see Irish Prison Service 2002, p. 34).

Italy¹

1 General data:

Drug use, substitution treatment and prison population

1.1 Number of drug users (and type of drugs used)

It is estimated that there are 155,096 drug users in the country. (Year Report for 2002 to the Parliament on Drug Addiction in Italy by the Welfare Ministry). EMCDDA (2003) reported that in 2001/2002 there were 86,778 persons in substitution treatment in the country. About 40,000 to 50,000 drug using prisoners are supposed to pass through the prison system every year. On 31 December 2001 there were 15,442 prisoners assessed as having a drug problem, representing 27.9% of the total adult prison population on that date. (Reitox Italy, 2001) On 31 December 2001 12,019 people (i.e., 22.8% of all prisoners for non-drug law offences: 17.9% Italian and 4.9% non-Italian) were assessed as drug users and held in prison for non-drug law offences. (Reitox Italy, 2001)

It is estimated that there are 1860 prisoners are on substitution treatment in prison on a given day (31 December 2003, www.giustizia.it/statistiche dap 2003) and approximately 5000 a year.

Surveys show that alcohol, tobacco and cannabis consumption remain common. Although heroin is the most problematic drug used, evidence shows that the use of heroin as primary drug has decreased and that heroin is increasingly sniffed or smoked. Cocaine use has increased to become the second mostly used illegal drug after cannabis. It is estimated that in 2001 there were 233,075 to 279,820 of heroin users. Regional variations are reported: cannabis and cocaine being available throughout the country, but amphetamine and ecstasy being predominantly offered in the northern and central regions. LSD use remains rare. (Reitox Italy, 2001)

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Dario Foa for the Milan area, and Susanna Falchini for the Florence area; who provided support with the writing of the report.

1.2 Substitution Treatment

Data comes from interviews and on-going review of research reports, websites and laws/ regulations.

1.2.1 Historical and legal background

Within Italy treatment services are provided either by the National Health Service managed drug treatment programmes – the Servizi Tossicodipendenti (Ser.T) or Drug users Service – or by private, not for profit organisations. In 2000 there were 555 Ser.T throughout Italy and 1,335 socio-rehabilitative structures. Staff in Ser.T. are mainly doctors and nurses, with some psychologists and social workers. (Reitox Italy, 2001)

Substitution treatment in Italy is almost exclusively provided by the Ser.T. (Reitox Italy, 2001). Substitution treatment was regulated with the D.M. of 7 August 1980 (Health Ministry Decree) regulating the ‘Discipline of the use of preparations with analgesic-narcotic action in the treatment of drug-addicts’², followed by the article D.M. 10 October 1980 regulating the ‘Use of basic preparation of methadone and morphine for the treatment of drug-addicts’³.

Article D.M. 23 October 1985 revoked the authorization for the experimental use of morphine in the treatment of drug-addiction, resulting in having methadone as the main treatment for addiction to opium-based substances in Italy.

The D.P.R. (Republic President Decree) 309/90⁴ concerns *the ‘collection of laws concerning the discipline of narcotics and psychotropic substances, prevention, care and rehabilitation of the corresponding conditions of drug-addiction’* and states that:

- The Department of Health is in charge of identifying individuals with a habitual use of narcotics (precondition needed for substitution treatment),

2 D.M. of 7 August 1980 Regolamento dell’impiego di farmaci ad azione analgesico-narcotica nel trattamento dei tossicodipendenti.

3 D.M. 10 October 1980 Impiego di preparato di base di metadone e morfina per il trattamento dei tossicodipendenti.

4 The D.P.R. 309/90 Testo Unico delle leggi in materia di disciplina degli stupefacenti e delle sostanze psicotrope, prevenzione, cura e riabilitazione dei relativi stati di tossicodipendenza.

and of giving instructions for diagnostic, care and medico-legal procedures to these identified individuals.

- The National Health Service managed public treatment services (Ser.T.) is in charge of defining the therapeutic treatment programme using substitution treatment, and of setting up the treatment modalities (mode, dosage, duration, check-up method).

There has been an increase in the number of Ser.T.'s patients receiving a substitution treatment resulting in over 50% of Ser.T.'s patients (excluding prisoners) receiving a methadone treatment (in 2000). Although the emphasis has been on prevention and abstinence and thus a detoxification-basis treatment, there has been an increase in long-term methadone maintenance (longer than 6 months) and a decrease in short-term treatments. Prescription of substitution treatment varies largely from one region to the other. (Reitox Italy, 2001)

There is no single model, set of guidelines, or good practice for substitution treatment in Italy. The Guidelines for Harm Reduction Interventions (Ministry of Health) state several different objectives of substitution treatment as (i) drawing and retaining patients in a treatment centre, (ii) harm reduction, and (iii) offering stability for interventions towards abstinence. Variances occur locally where different objectives are aimed. As with the objectives, there is little data about the criteria for admission into a substitution treatment. Medium length treatment is defined as 3 to 6 months, whereas long term is defined as over 6 months. (Reitox Italy, 2001)

A document was drawn further to the consensus conference held in Milan on 1 February 2000, organized by the A.S.L. (local health centre) of the city of Milan and the prison San Vittore (in Milan), stating intervention guidelines for the provision and initiation of the methadone treatment in prison.

The funding of treatment services for drug users comes from the general allocation to Regions for all health care provision, as well as from local taxation and from projects financed through the National Drugs Fund. Regions have autonomy in the provision of health care services, which are defined according to the local needs. (Reitox Italy, 2001)

1.2.2 Substitution treatment in prison

The development and provision of substitution treatment in prisons started with the D.P.R. 309/90, which was generally unapplied (for the treatment of

sentenced prisoners) until 2000, when the Legislative Act 230/99 became effective and all the duties, the responsibilities and the personnel of the drug services in prison were delegated to the National Public Health Service A.S.L.

The treatment of drug and alcoholic addicts in prisons is regulated by Presidential Law 309/90, which brings together the norms contained in Law No. 685/75, Law Decree No. 144/85, Law Decree No. 103/88, the Penal Procedure Code and Law No. 162/90 (Galetto et al, 1999).

Article 29 of Law 162/90 provided for assistance in the prison and states that: *'The Local Health Units, in agreement with the penal institutes and in collaboration with the Health Services within these institutes, should provide care and rehabilitation services for drug and alcohol addicted prisoners.'*

Health care in prison is provided by the Penal Health Service (Prison administration, Ministry of Justice), except for the care of drug users, which is provided by the Public Health Service (Ministry of Health) through the A.S.L. The Local Health Agencies, in collaboration with the Prison Health Service, are responsible for providing prevention programs and multidisciplinary rehabilitation and care services. They carry out awareness campaigns in the prison, prepare the individual treatment programs, and act as intermediaries between the operators in the Treatment Centers (auxiliary agencies – Art. 114) and the Ser.Ts, which have territorial jurisdiction for the prison in question. The Director of the Institute must act as “guarantor” for all the activities Ser.T carries out in the prison and ‘do his best’ to implement these activities (informing new prisoners, etc.) (Galetto, 1999).

The legal frame of substitution treatment in prison is provided in the D.M. 445/90 ‘Discipline concerning the determination of the limits and the mode of usage of the substitution preparations on the treatment programmes of drug-addiction stages: first directives⁵. With the circular number 20, dated 30 September 1994, the Health Department promulgated some guidelines for the substitution methadone therapies. Some Italian regions further defined the guidelines and the legal norms for the use of substitution treatment; for instance, the region Lombardy, which on 30 March 1995 produced the deliberation of the Regional Committee number 5/65411. This allows for substi-

5 D.M. 445/90: ‘Regolamento concernente la determinazione dei limiti e delle modalità d’impiego dei farmaci sostitutivi sui programmi di trattamento degli stadi di tossicodipendenza – prime direttive’.

tution methadone therapies to be offered inside prison further to specific rules by the Ser.T and the prisoner's informed consent.

The main substance of substitution treatment is methadone. Buprenorphine has only been recently 2002 initiated in the country. The prescription of other psychopharmacological drugs such as benzodiazepines is not advisable. The national and regional guidelines provide two different schemes for urine analysis, which are however not applied. Methadone is provided daily and is carried out by a professional nurse on the basis of a doctor's instructions.

There are no evaluation studies available about methadone treatments in prison. The protocol of Professor Icro Maremmani's for substitution treatment is used in the Lombardy area: 'Manual of the Ambulatory Treatment with Methadone' ('Manuale del trattamento ambulatoriale con metadone'). The procedure of the substitution treatment was certificated only by the A.S.L. of the city of Milan in 2000.

The general aims of the substitution treatment in the Italian prisons mainly concern health stabilisation. Substitution treatment is limited to the biggest institutions and prisons, with differences from one region to another. Treatment options essentially focus on detoxification, and in very few prisons focus on maintenance and initiation of substitution treatment starting in prison. The Ser.T is the external centre involved with substitution treatment, which is part of the whole strategy of the drug services.

The decision to initiate a substitution treatment in prison is made by a doctor. The most relevant clinical criterion is the evaluation of the withdrawal degree through a medical check-up and the scale of Wang (BUR Lombardia, July 22, 1995, n. 29). Before the beginning of the treatment, the patient is asked to sign a contract 'Informed consent to the methadone treatment', which underlines the problematic side of substitution treatment in prison, such as anonymity, daily practical problems, topping up drugs, etc.

To continue substitution treatment in prison (initiated prior to incarceration in the community) contact is established with the community doctor for official confirmation of the prisoner's programme (duration, dose).

Prisoners transferred to another prison will continue their substitution treatment if the treatment is available in the new prison. If so, the 'File-card' with details on the methadone treatment is transferred to the new prison and the treatment can be continued. The same procedure applies for prisoners trans-

ferred from remand to sentenced prisons. In order to continue substitution treatment after release, contact must be established prior to release with a competent Ser.T.; the request and plan to continue the treatment after release is sent by fax to the relevant Ser.T.

The general attitude of the prison staff is not particularly in favour of substitution treatment because of the apprehension for overdose due to prescribed medicines being topped up by smuggled drugs and alcohol.

The methadone treatment has always produced controversies. Even though it was widely employed in the community, a great number of organizations, in particular the therapeutic communities underlined that methadone can create new 'addiction' and not heal previous dependence. That attitude seems to be resumed at present thanks to the governmental political forces, which emphasize more drug free treatment. The main objection in prison concerns the initiation of methadone treatment rather than a long-term maintenance methadone treatment. The argument against the initiation of methadone treatment in prison lies within opposition to certain harm reduction policies from the Ministry of Justice without the promotion of alternative evidence based approaches.

Substitution treatment in prison is paid for by the A.S.L., covering expenses related to staff, doctors, nurses, and laboratory analysis.

Psychosocial care and training

Prisoners in substitution treatment do not receive specific psychosocial care. If the treatment is inserted into a global therapeutic programme, then there is a systematic link between the doctor/ nurse and psychologist/ educator. However, the psychosocial support is offered on a voluntary basis and available to all (not just substitution treatment patients). (Reitox Italy, 2001)

There is no specific training on substitution treatment offered to prison staff as training for professionals depends on individual regions and local health authorities (Reitox Italy, 2001). Professionals working in Ser.T tend to be specialised in drug issues and treatment of drug use. Although a few have acquired this specialisation through training as part of or after their vocational training, the majority tends to learn while working with drug users.

1.3 Prison Population

Table 14 Data on the prison situation in Italy (Source: King's College London, International Centre for Prison Studies, *Prison Brief for Italy*)

Country	ITALY
Ministry responsible	Ministry of Justice
Prison administration	Department of Prison Administration
Contact address	Largo Luigi Daga 2, I-00164 ROME, Italy
Telephone / fax / website	tel: +39 06 66 59 13 21 fax: +39 06 66 16 51 39 url: www.polizia-penitenziaria.it
Head of prison administration (and title)	Giovanni Tinebra Head of the Department of Prison Administration
Prison population total (including pre-trial detainees / remand prisoners)	56,761 at 1.9.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	99 based on an estimated national population of 57.4 million at mid-2003 (United Nations)
Pre-trial detainees / remand prisoners (percentage of prison population)	20.9% (1.9.2003)
Female prisoners (percentage of prison population)	4.4% (1.9.2002 – plus 40 females in juvenile institutions)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0% (1.9.2002 – under 18, but 461 are held in juvenile institutions)
Foreign prisoners (percentage of prison population)	30.1% (1.9.2002 – plus 231 in juvenile institutions)
Number of establishments / institutions	205 (31.12.2001 – 163 remand prisons, 34 institutions for the execution of prison sentences, 8 institutions for the execution of security measures – plus some penal institutions for juveniles)
Official capacity of prison system	41,798 (1.9.2002 – plus 622 places in juvenile institutions)
Occupancy level (based on official capacity)	134.5% (1.9.2002 – 74.1% occupancy in juvenile institutions)
Recent prison population trend (year, prison population total, prison population rate)	1992 46,152 (81) 1995 49,642 (87) 1998 49,050 (85) 2001 55,136 (95)

2 The field visits⁶

Time frame. The field visit took place at the end of June 2003.

Location. Visits were conducted in two prisons: **San Vittore Prison** (in Milan) and **Soliciano Prison** (in Florence).

Map of Italy



6 Methodology. Interviews were conducted with the individuals in and out of prison in the Milan and Florence areas. Four focus groups with a total of 28 prisoners were also conducted. The tape-recorder was used with 3 out of 4 focus groups. The researcher conducted all interviews/ focus groups on her own, accompanied by a freelance and neutral interpreter. All participants were briefed and told about ethical issues.

2.1 San Vittore Prison⁷

2.1.1 *Description of the prison*

San Vittore Prison, built in 1878, is a remand prison located in the centre of Milan. Due to overcrowding, it also holds sentenced prisoners. At the time of the visit there were 1 321 prisoners, of which 126 female prisoners (held in a separate wing), for a total capacity of 800. The prison population counts around 50% foreigners, mainly illegal immigrants.

The prison has 6 wings, of which one is for female prisoners (with only female guards) and one is for 'El Nave' (the ship) where specific rehabilitation and reinsertion projects for drug using prisoners are offered. La Nave was created in January 2002 and has a capacity of 43 but at the time of the visit held 38 prisoners for sentenced and remand prisoners. It is a 'special' section of the prison where prisoners who have shown good behaviour and progress have access to psychosocial support, cultural, artistic, leisure and computer classes. Benzodiazepines prescriptions are not allowed in this section, but prisoners can be on a substitution treatment. At the time of the visit, 4 prisoners of La Nave were on methadone and 4 on buprenorphine.

2.1.2 *Goals and practical procedures*

It was reported that a consensus of treatment and guidelines of ASL are used by the prison and the ASL specifying the dose of substitution treatment and benzodiazepines. This clarifies the provision of health treatment and facilitates the collaboration with the prison staff.

It was reported that substitution treatment (buprenorphine and methadone) is mainly provided as a detoxification treatment and is delivered by the medical team of the ASL. Doctors working in prison for the Ministry of Justice do

7 Data comes from interviews conducted with:

- The prison governor
- A GP and director of the Penitentiary Area Service for the ASL
- A psychiatrist, ASL
- A GP, ASL
- A psychologist and criminologist, in charge of the clinical and treatment aspects at 'La Nave'
- A psychologist
- A counsellor, 'La Nave'
- A guard, head of section.

not provide the treatment. On the whole, drug users are under the care of the ASL and not the Ministry of Justice or consultant psychiatrists.

At the time of the visit, there were 125 prisoners on substitution treatment of which 15 women and 40 foreigners (such as from North Africa).

After medical examination, the treatment is provided on a continuation basis for prisoners who started the treatment prior to incarceration. The treatment may also be initiated in prison after medical examination. In general, substitution treatment is provided towards detoxification. However, for some cases, it may be provided as a maintenance treatment when doctors estimate that such treatment is necessary; a link is created with external services in the community to ensure the prisoner can continue her treatment once released. Some prisoners on substitution treatment only stay in prison for a short period of time and are then transferred to a SerT centre in the community. When transferred, the prisoner's medical file follows.

Substitution treatment is often initiated in prison for illegal immigrants. However, such treatment cannot be continued once they are released since, having no papers, they are not entitled to health treatment in the community. Therefore, such prisoners are usually given a detoxification treatment.

Methadone is provided on a daily basis in a liquid form. The intake is easy and easily controlled; and the doses can be reduced easily. The starting dose is usually 20 mg on the first day and is often increased the following day after medical examination to 40 mg. This dose is considered as sufficient to stop any withdrawal symptoms. However, if the prisoner needs more, his/her dose will be increased. An individual approach is provided to all prisoners.

Buprenorphine is not well known in prison and in the community. The supervision of the intake is more difficult and sometimes not fully supervised by nurses who do not wait until the pill has dissolved in the prisoner's mouth. It was reported by the doctor that buprenorphine is provided in a powder (sub-lingual) to avoid any type of traffic. Because its effects are slower than methadone, the doctor said that prisoners tend to favour methadone to buprenorphine.

It was reported that nurses distribute substitution treatment first to those who work or who need it urgently (for instance, those with physical or psychological specific problems); then, nurses distribute it to male and female prisoners in the morning. There is no specific time and depends on nurses' availability.

In the COC area nurses set a table on 1st or 2nd floor. The guard opens the cell (one at a time) – guards therefore see which prisoners are on ST (NO medical secrecy).

Guards are asked to cooperate and work with discretion with the medical team. Nurses distribute the substitution treatment; a GP is always nearby in case of health issues arising from the intake of the treatment. GPs and nurses therefore work together as a team. Guards are involved to ensure security and protection of nurses. Guards may be asked to interfere when prisoners put pressure on nurses for higher methadone doses. Guards take part in team meetings with the medical staff and tend to be informed on prisoners' health situation. The medical staff believes that it is important to include guards in the substitution treatment process. Nurses who provide substitution treatment tend to be willing and sensitive to drug issues. A guard reported that a designated guard works with the nurse for the distribution of substitution treatment and makes sure the dose is taken and no traffic occurs. He further said that guards are not reluctant to substitution treatment since methadone helps to manage, stabilise and calms them down.

Prisoners are given clear information (verbal and leaflet) and a contract when getting on a substitution treatment in prison.

The governor stated that he was in favour of substitution treatment because it helps to stop and reduce withdrawal crisis; it can also be provided as a detoxification or maintenance 'therapy', or as an alternative to benzodiazepines, which are subject to a lot of traffic in prison.

Advantages and disadvantages of substitution treatment

Medical staff reported that they were very pleased with the provision of substitution treatment, which is working well. The advantages reported for substitution treatment are that it helps to stabilise the individual. A doctor reported that the advantage of methadone treatment is that it facilitates detoxification. A psychologist stated that she was in favour of substitution treatment because it stabilises prisoners' mood and balance. However, specialists are needed to manage the follow-up and it may be difficult to know how to process the dosage, when the dose is too high, when to decrease, etc.

A counsellor reported that she is not in favour or against substitution treatment. She said that it depends on how and where the treatment is provided and distributed, whether the prisoner takes other drugs or not. She stated that

methadone is a very serious medicine and is often not taken seriously in prison. Because San Vittore is a large prison, it is difficult to follow and respond to all individual differences and needs. Moreover, there are misunderstandings and illusions from prisoners as regards to substitution treatment.

The disadvantages of the methadone are linked to the possibilities of traffic, which occurs in prison as well as in the community.

It was reported that various issues must be taken into account when delivering substitution treatment.

- (i) Nurses are often over-qualified for a job that is limited to the provision or distribution of methadone. Costs to employ these nurses are high when methadone could be delivered by an 'assistant nurse' (operatore santaria) who could be specifically trained for the delivery of the treatment. A more motivated and human approach may be accepted from such staff.
- (ii) An evaluation and validation as well as scientific criteria and guidelines regarding the transfer from buprenorphine to methadone (or vice versa) is needed.
- (iii) Acupuncture as a complement to substitution treatment should be offered as it reduces craving, the desire and need for benzodiazepines, smoking, drugs and treatment.
- (iv) The use of substitution treatment should be defined and not widely provided with no objectives in mind. Abstinence is the best end-goal but each case, individual needs and differences must be taken into account.

2.2 Soliciano Prison (Florence)⁸

2.2.1 *Description of the prison*

The Prison Soliciano, built in the 1980s, is a remand prison (with about 25% of sentenced prisoners), that holds about 850 prisoners of which about 70% are foreigners (the majority are illegal immigrants and mostly come from Morocco and Algeria). The prison is mainly for male prisoners, although it has a separate wing for female prisoners.

The prison is located in the city of Florence. Next door is the prison Gozzini that acts as a reinsertion alternative sentence area for 50 detoxed prisoners who have had a problematic substance use.

2.2.2 *Goals and practical procedures*

Substitution treatment is provided by the SerT centre. The SerT is located in one wing of the prison and does not have access to the whole prison. The SerT counts 3 GPs, 2 nurses, 2 social workers and 4 psychologists. There is also collaboration with the guards and the prison health centre. Prisoners are escorted by guards to the SerT centre for health care. After the medical evaluation conducted at prison entrance with all new prisoners or upon self report, any prisoner said to be or to have been a drug user is sent to the SerT as drug users are taken care of by the SerT. A guard reported that sentences are shorter and less severe for drug users: prisoners always try to play on this and declare themselves as drug users.

8 Data comes from interviews conducted with:

- The assessor of social policy for the Tuscany Region.
- A judge of the application of the sentence, Youth Tribunal Florence.
- The governor of the Gozzini prison, Ministry of Justice.
- The medical doctor and expert on drugs and substitution treatment in prison, SerT, Ministry of Health.
- A social worker, SerT, Ministry of Health.
- A nurse, SerT, Ministry of Health.
- The chief doctor, manager of the Health Care Team, Prison Service, Ministry of Justice.
- The educator, manager of the Team for prisoners' social activities, Prison Service, Ministry of Justice.
- A Psychologist, Prison Service, Ministry Justice.
- A prison officer, Ministry of Justice.
- A pedagogue, NGO 'CEIS Firenze'.
- Officer of the Probation Service, Ministry of Justice.

A prison staff reported that one third of all new entrants are drug users, although the actual figure may be higher. Support and treatment can be offered to prisoners who declare themselves as drug users on arrival or at a later stage. However, a prisoner who hides his drug use is likely to go through withdrawal without the SerT's support and at best with the prison psychologist's support.

The two substances used for substitution treatment in prison are methadone and buprenorphine, although the latter was only introduced 2 years prior to the field visit and is only offered to prisoners on a buprenorphine treatment prior to incarceration and is thus not initiated in prison. The maximal dose of buprenorphine is 24-32 mg.

At the time of the visit, out of the 40 prisoners consulting the SerT centre, one received buprenorphine on a continuation programme started outside prior to incarceration. The doctor reported that this prisoner was very young. He was incarcerated for the first time and is not content about 'getting clean soon'. Approximately 45 prisoners received methadone at the time of the visit: 40 men and 5 women.

It was reported that prisoners on a methadone treatment prior to incarceration continue their treatment while in prison but on a smaller dose than that offered outside and usually on a detoxification basis. Outside, doses are higher (100-120 mg) and maintenance is provided, whereas in prison it is not as methadone is mainly used to reduce withdrawal symptoms and for detoxification. New entrants may receive a maximum of 50 mg of methadone (and a maximum of 35 mg on the first day). A higher dose may be provided if they need more, although the focus is on managing withdrawal symptoms and craving.

Each prisoner has his own treatment programme. Although a doctor reported that it can be a struggle to decrease the dose, some prisoners ask for a detoxification programme themselves. Some prisoners ask for a slower decrease (1 mg every 2-3 days). The decrease is a maximum of 2 mg every day. The rule of thumb the SerT uses is to decrease 1 mg every day and do a pause of 3-5 days every 5 mg.

The nurse reported that although substitution treatment is given mainly as detoxification – and not as maintenance – the GP decides when to decrease or stabilise the dose on individual cases. The methadone dose is not decreased for HIV prisoners.

Methadone comes directly from a pharmaceutical company located nearby. Methadone orders are managed by the ASL. Methadone is prepared in bottles. The nurse prepares the doses for each prisoner and writes the name of the patient on each bottle. Designated and trained guards bring prisoners in groups (around 8 at a time) to the SerT unit for substitution treatment. One prisoner at a time enters the nurse office where his treatment is given in the presence of the GP, the nurse and a guard. The latter controls the prisoner while the GP and nurse focus on providing health care.

A prisoner on a substitution treatment is usually not transferred to another prison. If he is, the SerT will communicate his treatment details to the SerT of the new prison.

There are no reported cases of overdoses of prisoners on substitution treatment.

During the night and over the weekend and holiday, the SerT is closed. The Prison health service takes over and covers for the SerT ensuring that new prisoners arriving at the prison when the SerT is closed are taken care of, although substitution treatment is only provided by the SerT.

Advantages and disadvantages of substitution treatment

A social worker reported that substitution treatment acts as a means to attract prisoners to the SerT centre and to discuss a rehabilitation project. It was reported that substitution treatment has a tranquillising effect and allows prisoners to gradually reach abstinence. A nurse stated that substitution treatment allows a special contact and relation-dialogue to develop with prisoners, and allows for the treatment of infectious diseases. The nurse also said that substitution treatment helps prisoners to overcome the detoxification phase more easily and with less pain. The educator stated that methadone maintenance gives him some of his 'dignity' back and methadone allows ending the use or misuse of drugs. A doctor reported that the number of overdoses has been decreased with substitution treatment and prisoners' quality of life has improved.

Further advantages were reported by a GP. Foreign prisoners have no access to SerT outside the prison, but they do in prison. They can receive methadone for the first 10 days of incarceration to help with the detoxification process. Moreover, substitution treatment is a link to bring prisoners to the SerT and create a contact with the SerT outside as it encourages them to consult.

Once released, there is a higher chance that they will visit a SerT, which they have often never done. Finally, substitution treatment allows for clinical intervention and thus for the prevention of infectious diseases. Prisoners used to be reluctant to engage into health treatment, whereas now they are not and they tend to agree to have a health examination, even for HIV.

SerT staff reported that the disadvantage of substitution treatment is that there is a strong link between the prisoner and the substance and a certain dependence towards the SerT centre and staff, which limits the autonomy of the choices. There is a kind of 'maternity' from the SerT and a habit (and dependence) from consulting. Once a prisoner has finished his substitution treatment, he no longer visits the SerT centre and may find this interruption disturbing. When a substitution treatment is finished, the SerT conducts a check up once a week for one month, and then once one month after the end of the treatment. The prisoner's health care is then transferred to the prison GP as he no longer needs the specialised support from the SerT.

It was reported that substitution treatment may work better in prison than outside because patients outside may top methadone up and there are more risks for traffic. In prison prisoners are more controlled and are 'pushed' to 'get clean' using substitution treatment.

A guard reported that the problem with substitution treatment outside was a lack of structure to help released prisoners. *'After spending 3 years in prison, where do prisoners go? There is nothing out there'.*

Training and psychosocial support

No training on substitution treatment is provided. However, the SerT medical doctor explains how methadone works. It was reported that this was sufficient for the nurse to work properly.

The guard involved in the SerT activities and substitution treatment distribution said he must follow some specific courses in prison (through work) and outside (on a voluntary basis, through courses, team activities, etc.). He reported that each guard is assigned to a specific role and tasks. Guards in the SerT develop a close collaboration with the GP.

3 Prisoners' experiences

Interviews were conducted with 4 groups of prisoners, aged between 28 and 51, with a mean of 37 years old:

- One focus group with 5 female prisoners – San Vittore (Milan)
- One focus group with 8 male prisoners – San Vittore, La Nave (Milan)
- One focus group with 7 male prisoners – San Vittore, El Coc⁹ (Milan)
- One focus group with 8 male prisoners (4 of foreign origins) – Solicciano (Florence)

There were no differences between what men and women reported.

Most prisoners reported being on a detoxification methadone based treatment. The decrease path varies from one person to the other but tends to be 1 mg at a time, every 2 days or sometimes 5 days. Most of the prisoners have been in contact with a SerT outside and some have had a substitution treatment through that service. Prisoners reported differences between treatment offered outside and inside. Methadone maintenance is frequent outside whereas it is not in prison. In prison, only a few prisoners said they were maintained on a low dose, although they had decreased on a detoxification type of treatment previously. Many prisoners reported wanting to decrease the dose while in prison as the prison environment facilitates being drugs free, contrarily to outside. Some refused to take a substitution treatment because they said they did not want to be 'dependent' on another substance.

'In prison I have stopped using drugs but the psychological dependence still exists. It's ugly to be in prison but it's in prison that I could really stop. Prison helps, puts you in a detoxification system, but afterwards, once in the community, it is more difficult to stay clean.'

'You can only stop here in prison [to use drugs]. Outside it's not possible.'

'Some can stop [drugs] in prisons, others can't. It depends on each individual and it's personal. It depends on your psychological state.'

'Methadone is to help someone detox from drugs. If it is used appropriately, it helps. Methadone is not made for maintenance. The same goes for benzodiazepines.'

9 The COC is the centre of observation for new entrants who are/were drug users.

Some prisoners agree with a 'fast' decrease of methadone, but it may be not be appropriate.

'I wanted to decrease immediately but the doctor disagreed with me and wanted me to decrease more slowly. I wanted to decrease and stop immediately because I have never really agreed with methadone, which is a dependence on another substance. My treatment has been finished for 2 weeks now and I am not feeling well. I don't sleep, I shake, I have muscular pains, I am very tired. I have decreased my methadone doses very fast actually.'

Some prisoners said that they did not get substitution treatment because they lacked information and were scared. *'I didn't know the service, I didn't know anything. I trusted nobody. I was scared. I didn't have the information.'*

Prisoners stated that the equivalence of care and health care over the weekend and throughcare (on release) were lacking.

'In here, they tell us what we need to do and they decrease the dose. But outside, we must follow treatment programmes and a lot of people are on a maintenance treatment programme. They can't do things in and out [of prison] differently because you are here, in prison, today, but maybe not tomorrow, so it's better to all agree, otherwise it doesn't make sense.'

'The only problem is that if you get arrested on a Friday, you are Friday, Saturday and Sunday without methadone. You suffer and you must wait until Monday to see a doctor at the SerT.'

'I think that the psychological problem linked to drugs is very important. Drug dependence cannot be treated in prison – that is not possible I think. The sentence is not all that important but the treatment must matter for the person. I think that the only way to stop [drugs] is to have a psychological support on an individual basis in order to understand the problem we have, because each one of us has a different problem. And to be followed by someone in the field who know these things well.'

'When we are released, we don't get regular treatment, we get nothing. There are a lot of problems surrounding you. Even if you decrease in prison, when released, if you are clean, it helps, but if they put drugs under your nose, how can you refuse?'

'I think that we should get support when we are released. Prison cuts you away from the world. When you get out, you must face life, work ... It's always more difficult to reintegrate.'

They also claimed that too many differences exist from one prison to another within the country regarding substitution treatment.

'Why are there so many differences between all these prisons? I don't understand why they are so many disparities between prisons. We are still in Italy though. I have seen that in prison [...] they don't give methadone. They should actually have one penitentiary treatment.'

Prisoners reported that psychosocial support was insufficient and that support was provided in emergency cases.

'On my first day I was asked whether I wanted to receive psychological support. I said yes but then never got any. If you open your veins, then they call the psychologist and the whole team who give you support.'

Some prisoners said they felt stigmatised and perceived differently in the public eyes but also by other prisoners and prison staff, who name them the 'irrecoverable'. They stated they did not like being identified as a prisoner on a methadone treatment.

'I am married and my wife does not know I have used drugs. I get a psychological stress (...) you need to queue in front of everyone to get the methadone and everyone can see you. I don't like if when others can see me getting methadone. Because I know that it is not great. They all take us for drug 'addicts' anyway. We are stigmatised two times: drugs and methadone. And I know they lack of staff.'

3 Summing up

The provision of substitution treatment in Italy, and in prisons, vary extremely from one region to the other. However, there is a tendency to offer methadone treatment for detoxification. Maintenance (long term) treatment and buprenorphine are also offered but to a more limited number of prisoners.

In prison, health care to drug users is provided by Public Health Service (Ministry of Health) through the A.S.L. Ser.Ts are specialised centres for the treatment of drug use.

Prisoners reported that differences in the provision of treatment from one region and prison to another were striking and problematic. Although many prisoners wanted and were on a short term, detoxification substitution treat-

ment, they also questioned whether it was appropriate and successful in the long run.

Medical and prison staff valued substitution treatment. Although they received very little training, they stated that they felt they managed the treatment. They reported that health care and support is provided through Ser.Ts, but little is provided once out of the Ser.T structure. The lack of through care (i.e. psychological care within the same prison after a detoxification substitution treatment, health care on release or when transferred to another prison) is problematic for long-term rehabilitation.

Luxembourg¹

1 General data:

Drug use, substitution treatment and prison population

Compared to the country reports for the other 17 countries that this research covers, data for Luxembourg only comes from a review of research reports, laws, regulations and websites. No interviews were conducted at all.

Requests for authorisation to conduct the STEP research were made repeatedly through emails, letters and phone calls over a period of one year. Regrettably, the Ministry of Justice – and specifically the International Relations Office said to be in charge of approving research – did not respond. The Prison Administration stated that the research had not been approved by the International Relations Office, mainly because of a lack of time to facilitate the research. The Prison Administration explained that they played no role in this decision which was taken by the International Relations Office alone.

1.1 Number of drug users (and type of drugs used)

The estimated prevalence of problematic drug use is 1 900 to 2 200 people (EMCDDA, 2002, Briefing 1). The number of drug users on substitution treatment is 864 (164 in the official programme and approximately 700 who are prescribed methadone in pill form by GPs (EMCDDA, 2002).

There are approximately 18% (n=191 in 2003) of drug users in prisons. (de Surveillance du Sida Luxembourg, 2003). All these drug users in prison were on a substitution treatment in 2003. (Comité de Surveillance du Sida Luxembourg, 2003)

The most common, illicit psychoactive substances in Luxembourg are cannabis, hallucinogens (for the younger population), ecstasy, heroin and, to a lesser extent, cocaine. Poly-drug use is widespread (Relis, 2002). Among

1 As described in the methodology chapter, Laetitia Hennebel was in charge of Luxembourg. Special thanks are offered to Caroline Lieffrig, Prison Administration, who tried to help with the conduct of the research in Luxembourg.

problematic drug users, using mainly heroin, approximately 1000 receive substitution treatment: 75% of them get substitution treatment from a private GP whereas the others get it in specialised centres within the frame of a public treatment programme.

1.2 Substitution Treatment

Because Luxembourg is a small country with a total of 2 prisons, a description of these prisons is provided towards the end of this chapter.

1.2.1 Historical and legal background

The law of 19 February 1973 (*‘Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie’*) is the basic national drug law. It regulates the sales of prescribed medicine and the response to drug dependence (Reitox Luxembourg, 2001).

The methadone substitution programme only delivers methadone in a liquid oral form. Buprenorphine has been delivered since 2000 (Origer, 2001).

After the 1999 legislative elections, the Ministry of Health was made responsible for the general coordination of actions in the drug use and dependence arena. In 1989, the Ministry of Health and the JDH Foundation (*Jugend- an Drogenhëllef*) set up a Methadone Substitution Programme. In 2001, 158 patients received substitution treatment (Relis, 2002). This methadone substitution programme was replaced by the ‘Surveillance Commission on Substitution Treatment’ following the January 2002 decree (Reitox Luxembourg, 2002).

The 1973 law has been successively amended², recently by the law of 27 April 2001 which includes decriminalisation of cannabis use, alleviation of penalties for simple drug use, a differentiation of penalties according to the type of drug offence as well as foreseeing a legal framework for harm reduction measures, such as drug substitution treatment. No legal framework regulating substitution treatment existed prior to this law (Origer, 2001).

Two decrees focus specifically on substitution treatment. First, the *grand ducal decree of 7 December 2001* regulates the duration of validity for some

2 Law of 23 February 1977; law of 7 July 1989; law of 17 March 1992; law of 11 August 1998.

prescribed drugs and sets the lifespan of the prescription to 3 months for methylphenidate, 21 days for oral morphine and transdermic fentanyl, and 14 days for methadone (Reitox Luxembourg, 2001).

Second, the *grand ducal decree of 30 January 2002* (*'Règlement grand-ducal du 30 janvier 2002 déterminant les modalités du programme de traitement de la toxicomanie par substitution'*) regulates the modalities of substitution treatment at the national level, such as the quality and control management of substitution treatment. This decree gives an official definition of substitution treatment, states the substances used for substitution treatment, as well as admission criteria and information on the national treatment providers (GPs, specialised agencies, pharmacies). Furthermore, the decree foresees that the Ministry of health will manage mandatory licenses for substitution treatment providers and training needs, as well as setting up a surveillance commission on substitution treatment. This 'Surveillance Commission on Substitution Treatment' replaces the former 'Methadone Commission' (Reitox Luxembourg, 2001).

The 'Surveillance Commission on Substitution Treatment' was established in 2002. The Commission is made up of delegates from the methadone programme, the Directorate of Health, the AST, two pharmacists and two GPs affiliated to the methadone programme. Its objectives are to control and coordinate all aspects of substitution treatment at the national level: it oversees admissions, releases and the exclusion of patients from substitution treatment. One of its tasks has been to set up, within the Directorate of Health, a central database register for substitution treatment. Information is updated on a daily basis, avoiding duplication of prescriptions. Indeed, a new substance has been fuelling the black market due to multiple prescriptions of methadone in the form of a pill (Mephenon® prescribed by GPs) (Absil et al, 2003).

According to the 2002 Decree, substances used for substitution are mainly methadone and buprenorphine. Morphine-based (salt) medications can also be prescribed when the medical authority estimates that the other substances are inadequate. In addition, heroin prescription is allowed within the framework of the implementation of a pilot project coordinated by the Directorate of Health (Ministry of Health).

Substitution treatment is provided as a means to detoxification aimed at abstinence (the trend until 2001), or maintenance aimed at harm reduction. As defined by the 30 January 2002 Decree, substitution treatment is a medically

assisted treatment aimed primarily towards the psycho-social and medical stabilisation of the patient. Individual assessments are conducted to determine the development and outcome of substitution treatment on the basis of the patient's condition and the reduction of public nuisance (Absil et al, 2003).

As well as specialised drug substitution centres, substitution treatment is provided by private GPs for patients on a waiting list for the national drug substitution programme or for those wishing to receive substitution treatment for detoxification or maintenance. In 2001, 147 GPs prescribed Mephenon®, Methadict® and Subutex® to 849 patients (Relis, 2002).

Only GPs and authorised drug substitution centres to provide the treatment. In contrast to the mandate of GPs, centres must ask for authorisation for each new treatment. GPs were opposed to having to request authorisation for each new treatment as it questioned their prescription rights (their argument was granted). The most serious cases are seen in centres, justifying the need for more control. Annually, centres manage approximately 160 patients, whereas GPs manage 900 cases (Absil et al, 2003).

Although the majority of drug-related deaths involve heroin (76% of the cases), since 2000 there has been an increase of overdoses with methadone or buprenorphine, mainly when topped up with other substances (Origer, 2001).

Psychosocial support and staff training

The treatment provider is said to ensure a psycho-social follow up, including support to the patient, referral to a pharmacist, regular toxicological evaluation and possibly a job and housing search. According to the 2002 Decree, doctors prescribing substitution treatment must engage in an ongoing specialised training on the treatment and multi-disciplinary exchanges.

1.2.2 Substitution treatment in prison

There are no formal guidelines for substitution treatment in prison (Reitox Luxembourg, 2002). The substitution substances prescribed in prison are methadone (Mephenon®), buprenorphine (Subutex®) and, to a lesser extend, codeine. Benzodiazepines are widely prescribed (Reitox Luxembourg, 2002).

Substitution treatment is offered in prison as (i) a detoxification treatment, (ii) a maintenance treatment, or (iii) a measure of harm reduction (Comité de Surveillance du Sida Luxembourg, 2003).

Substitution treatment is provided to:

- (i) Prisoners who were on a substitution treatment prior to incarceration. The prescribing doctor or programme is contacted to verify the accuracy of the information that the prisoner has provided. If confirmed, the treatment is continued. Eventually, notwithstanding the type of treatment provided outside, it may be offered as detoxification or maintenance.
- (ii) Substitution treatment may be initiated in prison although this is less frequent and mostly applies to those who started using opiates in prison.
- (iii) Prior to release (6 weeks) prisoners can apply to a substitution treatment programme in the community to continue their treatment (Reitox Luxembourg, 2002).

The law of 27 July 1997 regulates the creation of specialised medical units for drug users and psychiatric patients in prison. Detoxification treatment is provided by these medical units or by the external detoxification units of general hospitals. Psychosocial and therapeutic care is provided by prison staff members and staff from external specialised drug centres. Such care is said to be insufficient. (Reitox Luxembourg, 2002)

Since 1998, the number of prisoners of foreign origin has largely increased and now makes up 50% of the total prison population (Relis, 2002). Portuguese patients compose the majority of non-Luxembourg natives in substitution treatment in the community (Reitox Luxembourg, 2002). The largest immigrant population in Luxembourg is of Portuguese origin. *Most Portuguese prisoners are residents in Luxembourg.*

At the Centre pénitentiaire de Luxembourg à Schrassig (CPL Prison) no urine tests for illicit drugs are conducted in order to mark the boundary between the health care and security issues. Indeed, the Prison Administration regularly requests such tests. The prisoner decides on the type of substitution treatment (and the dose) he wants, which is then revised with the GP. Nearly all opiate users decide to be on a substitution treatment. (Comité de Surveillance du Sida Luxembourg, 2003)

In 2003, 191 patients received substitution treatment at CPL: 177 had methadone and 15 were on buprenorphine (compared to 30 in 2002 (Comité de Surveillance du Sida Luxembourg, 2002)). Three quarters of the patients on substitution treatment reduced the dose while at CPL, compared to half of the patients in 2002. (Comité de Surveillance du Sida Luxembourg, 2003)

In 2002, the average dose of methadone was 50 mg per day although the dose varied from 5mg to 220 mg. In 2003, the average dose of methadone was 35 mg per day although the dose varied from 2.5 mg to 110 mg. The average length of treatment was 97 days in 2002 and 99 days in 2003 although it varied from 3 to 365 days. (Comité de Surveillance du Sida Luxembourg, 2002 and 2003)

The average dose of buprenorphine was 6.25 mg per day, varying from 0.4 mg to 32 mg in 2002, and 3.25 mg per day, varying from 0.2 mg to 16 mg in 2003. The average length of treatment was in 2002 115 days, varying from 4 to 365 days, compared to 176 days, varying from 4 to 365 days in 2003. (Comité de Surveillance du Sida Luxembourg, 2002 and 2003)

Compared to 2002, in 2003, the average dose of methadone or buprenorphine has decreased by half. In 2003, the number of patients on buprenorphine has also decreased by half. (Comité de Surveillance du Sida Luxembourg, 2003)

1.3 Prison Population

Table 15 Data on the prison situation in Luxembourg (Source: King's College London, International Centre for Prison Studies, Prison Brief for Luxembourg)

Country	LUXEMBOURG
Ministry responsible	Ministry of Justice
Prison administration	Direction Générale des Etablissements Pénitentiaires
Contact address	B.P.35, L-5201 Sandweiler, Luxembourg
Telephone / fax / website	tel: +352 47 59 81 348 fax: +352 47 59 81 395
Head of prison administration (and title)	Vincent Theis, Directeur
Prison population total (including pre-trial detainees / remand prisoners)	498 at 1.9.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	111 – based on an estimated national population of 450,000 at mid-2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	43.6% (1.9.2003)
Female prisoners (percentage of prison population)	6.1% (1.9.2002)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	2.4% (1.9.2002 – under 18)
Foreign prisoners (percentage of prison population)	63.9% (1.9.2002)
Number of establishments / institutions	2 (2002)
Official capacity of prison system	369 (1.4.2000)
Occupancy level (based on official capacity)	110.0% (1.4.2000)
Recent prison population trend (year, prison population total, prison population rate)	1992 352 (89) 1995 469 (114) 1998 392 (92) 2001 357 (80)

2 The field visit

No field visit was conducted in Luxembourg.



Map of Luxembourg

There is a total of 2 prisons in Luxembourg: Centre pénitentiaire de Luxembourg à Schrassig (CPL Prison) and Centre pénitentiaire de Givenich (CPG Prison). On 31 December 2001, the total prison population was 341 (CPL 285 and CPG 56) (Reitox Luxembourg, 2002) with a capacity of 270 and 90. (Ministry of Justice website <http://www.mj.public.lu/>)

The CPL prison is a closed prison. The CPG Prison, located in the countryside and opened in 1938, is a semi-open prison where prisoners work during the day (job or workshops) in or out of prison. At night they are locked in their cells.

In fact there are agreements with the Hospital Centre of Luxembourg (CHL) who sends GP, specialists and nurses to the prison for somatic treatment. There is also an agreement with the Neuro-psychiatric Hospital Centre of Ettelbruck to provide psychiatric service (psychiatrists and nurses) in prison.

Prisoners' experiences

No prisoners were interviewed.

The Netherlands¹

Structure of country reports

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users

According to figures of the “Nationale Drugmonitor (NDM, 2002) the number of opium users is between 26-30 000, of whom 17 500 are treated, giving a treatment coverage of 70%. At the moment only methadone is registered as a means of substitution²

According to the National Health Council of Netherlands, one third to half of all detainees have some form of addiction problem, between 5 000 and 7 500 prisoners on any one day. On an annual basis, this amounts to 15 000 to 23 000 individuals (excluding Youth Custody Centres and placements under a hospital order). “In two thirds of those inmates of standard penal institutions who have addiction problems (10 000-15 000) these problems can be defined as ‘serious’. Such individuals have often been addicted for many years.” (Gezondheidsraad 2002, p. 20). Most of the addicted detainees are poly-drug users, injectors are in the minority.

The average stay in prison for drug addicts is shorter than the period of detention served by the general prison population: “Fifty percent of them serve as little as two months, while 75% re-enter society within four months. There are relatively few women among the group of detainees who are addicted to drugs. More than half of this group of drug-addicted detainees were born in the Netherlands”.

1 The field visit, conducted by Heino Stöver, was facilitated by Jan Flikkema, Ministry of Justice of The Netherlands, who also provided general information and support with the finalisation of this country report.

2 Personal communication with Prof. Wim van den Brink.

1.2 Substitution treatment

1.2.1 *Historical and legal background*

Substitution treatment was introduced in the community in at the end of the 60s/beginning of the 70s and first introduced into the prison setting in 1972. Since the beginning of the 70s methadone has been dispensed as the main substitute drug for outpatient opiate using clients in The Netherlands³. It is dispensed in special programmes of addiction treatment services (a total of about 50 teams; in Amsterdam half of the GPs dispense methadone). Since 1994, the number of methadone clients increased by 29%. Out of 11,383 patients, 98% of the clients are on a maintenance programme, 50% of the clients are older than 40 years, most clients (70%) have a multiple use pattern, those clients using cocaine and opiates and alcohol and opiates both increased since 1994 and the mean methadone dose was 57 mg in 2002 (the mean dosage level increased from 37 in 1994). It is part of the national drug policy to make methadone widely available for those in need of it.

1.2.2 *Substitution treatment in prisons*

The responsibility for medical care is in the hands of the Ministry of Justice. Prison inmates do have the same right to health care as any other citizen in The Netherlands (principle of equivalence). “On the basis of the Custodial Institution Act, detainees have the right to adequate medical care from the physician associated with the institution in question” (Gezondheidsraad 2002, p. 21). This includes psychological and psychiatric care and the treatment of drug addiction. The “Medical Treatment Agreements Act (“Wet Geneeskunige Behandlingsovereenkomst”, WGBO”) is also applicable to the relationship between the penal institution’s physician and the detainee.

There are early reports from 1972 concerning the start of substitution treatment for opiate addicts in prisons in Haarlem (Roorda, 1989). Roorda, an advisor for drug addiction in the penitentiary system in the Ministry of Justice and former physician in Haarlem prison, states that methadone prescription in prisons was a controversial issue in the 70s and 80s. During this period, methadone was used for detoxification purposes by the majority of doctors in the prison setting. A minority, however, rejected methadone and so the range of treatment for drug users in prisons went from ‘cold turkey’,

3 Data taken mostly from the LADIS bulletin, June 2004, see www.sivz.nl

i.e. detoxification without any supplementary therapeutics, to a free choice between detoxification or methadone maintenance treatment (1989). Roorda was of the opinion that "... the termination of an addiction can only be the result of an intra-psychological process. If someone is forced to a detoxification, this internal process is terminated on the surface, but the enemy has been projected to outside (the doctor). The idea that a coercive detoxification has deterrent effects has been proven as false". (p. 90)

The substitution treatment is paid by the Ministry of Justice.

In The Netherlands, drug services for addicted inmates are structured on three levels:

- Drug Services in the general prison setting;
- Addiction Support Sections (VBAs): These sections have been specially set up for addicts, who are motivated to give up their drug habit. Currently, the use of methadone is a contra-indication for placement in such a section. Every year, approximately 1 200 detainees are admitted to these sections. In 2002, the VBA's were under-utilised by around 25% (available places in drug-free units are approximately 250);
- In 2002, the penal care facility for addicts (SOV: Strafrechtelijke opvang Verslaafden) had a total capacity of 221 places in three sites: Utrecht, Amsterdam and Rotterdam).

The latter two are more or less dominated by an abstinence oriented approach which does not include the use of methadone.

The modalities for substitution treatment in prisons have changed over time. According to an interviewee at the Ministry of Justice, views on addiction and the impact of methadone prescription have undergone essential changes among health professionals in the last decade:

"Some doctors said from the start say 'you are now in prison so we stop the methadone'. After six months they go out and start again. So, the discussion about the methadone 'handreiking' (guidelines) and the methadone 'circulaire' made a little movement in prison and with the doctors to get the methadone continued, that does benefit. Not only this circulaire but the circulaire before; there is a new one, but the most of this circulaire already exists. But now we are making them better and try to get more doctors to make consent with this circulaire ... it takes years and it is also the view of a kind of scientific movement in the addiction world. Most people in prison saw addiction as a bad custom and they are now changing: addiction is a

kind of disease and the patient, a kind of diabetic. A diabetic gets all his life insulin so addicted persons need lifetime methadone. A new kind of movement ...”

The elaboration of the most recent guideline (“Circulaire”, see below) reflects the nature and character of the phenomenon of addiction as a chronic disease.

“... and when we think it’s a chronic disease you get another programme, other measures than for a bad habit to stop it. And I think the surrounding view around us about addiction is more a hypothesis of a disease with lifetime methadone or lifetime heroin or lifetime other treatment. In prison, we get used to that idea and so we change a bit.”

The development of substitution treatment has been subject to ministerial letters, circulaires and regulations. The Ministry of Justice issued letters and guidelines for methadone prescription to inmates already in the mid 80s. Dr. Roorda (see above) sent a letter to all institution’s practitioners recommending that they should distinguish between short and long-term prisoners. The short-term prisoners should be kept in a methadone programme, for those in long-term substitution, the goal should be detoxification and abstinence. This advice should have been contributed to a more homogenous practice at that time.

In the mid 90s, another letter was sent to GPs in the institutions (brief van de Dienst Geneeskundige Inspectie van 13 December, 1996, dM/96268), and another version of guidelines dating from 2001 (“Methadonverstrekking aan gedetineerden” (17th of August 2001, No. 5113734/01/DJI). Here, the maximum length of sentence for which substitution treatment has been continued was three months. These guidelines currently have been reconsidered and have been changed as a response to the advice of the National Health Board’s report (“Treatment of drug addicted inmates”, see Gezondheidsraad) on substitution treatment in Dutch prisons.

At time of the field visit to Holland (June and September 2003), the Ministry of Justice was in the process of drafting this version of the methadone prescription guidelines which was finally released in April 2004. These guidelines, disseminated in the form of a ministerial “Circulaire” to the doctors and medical units in all Dutch prisons, do not have the status of formal regulations, but serve as guidelines for the physician prescribing methadone. One of the reasons for issuing these guidelines on methadone prescription in

prisons is the varying practice in Dutch prisons and the need to deliver a protocol of best practice. The physicians still have therapeutic freedom.

“According to guidelines issued by the Ministry of Justice, methadone can be administered to short-term detainees provided that they have been prescribed the drug prior to their detention. In practice, however, some institution’s physicians contravene these guidelines by cutting down the amounts of methadone provided or by suspending such provision altogether” (Gezondheidsraad 2002, p. 22). The reason for this might be that the penal addiction policy aims at abstinence and promotes a drug-free environment.

The guidelines recommend that maintenance treatment should be continued for those inmates in methadone programmes prior to their incarceration and if they plan to resume such a treatment after a short period of detention. A ‘short period’ is defined as ‘less than 4 weeks’, for example, this point of the guidelines has led to some discussion in The Netherlands. In June 2002, the National Health Board, on request of the Minister of Health, Welfare and Sport and the Minister of Justice recommended to extend the four week period: “Scientific studies have shown, however, that abstinence programmes must be followed for a given period of time if they are to have any effect. The Committee therefore recommends that this four-week period be considerably extended. In this context, the Committee draws a distinction between those detained on remand and individuals who have been sentenced. Methadone maintenance should always be continued for those on remand, provided that addicts indicate to the physician that this is what they want. This is because the duration of detention for those on remand is, by definition, uncertain. The Committee feels that an abstinence programme (involving reductions in the dose of methadone) should only be considered if the period of detention is to exceed six months. The latter would apply to very few addicts in normal detention. The institution’s physician requires the addict’s informed consent in order to initiate an abstinence programme.” (Gezondheidsraad 2002, p. 24)

Moreover the National Health Board emphasises two issues:

- Continuity of care in the methadone prescription (which is interrupted when it comes to detoxification and which may lead to an increased danger of overdose for those patients/detainees detoxified).
- Risk of overdose, when the prisoner is continuing his opiate habit after release.

On the institutional level, the details of treatment are discussed by professionals of the psychological and medical services in a special multidisciplinary meeting group (PMO: “Psycho-medisch overleg”).

Detoxification

One of the key issues in the debate on the appropriate prescription policies in Dutch prisons is the point of detoxification of those, mostly long-term sentenced inmates who don't wish to reduce their dosage themselves. According to the National Health Board, this can only be done on the basis of informed consent with the patients. Otherwise, it would be a compulsory treatment. The background is that the National Health Board defines methadone treatment as a treatment of care for stabilisation and if it becomes a treatment or cure (with the focus on abstinence) it needs to be supported and requested by the patient himself/herself.

These recommendations have been discussed by the Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport (5 December 2002) which led to a response of the National Health Council (23rd December 2002). Generally, the recommendations of the Health Council are supported (especially the suggested six months period). However, the Ministry of Health, Welfare and Sport disagrees with the term “compulsory treatment” in case the methadone maintenance treatment is stopped (detoxification treatment) with the goal of abstinence without the informed consent of the patient. According to the Ministry it is up to the responsible doctor to decide whether to stop or continue in each individual case on the basis of an approved evidence-based protocol (guidelines for the methadone prescription).

The Health Council, in its response to the Ministry of Health, Welfare and Sport (23rd December, 2002) is still of the opinion that, according to the agreement between provider (medical doctor) and user of the provision of medical services “Wet Geneeskunige Behandlingsovereenkomst” (WGBO), stopping treatment is a form of medical treatment and therefore requires the informed consent of the patient/inmate – especially when a medical decision (from maintenance to detoxification treatment) marks a fundamental change of treatment from care to cure.

Despite the guidelines set out by the Ministry of Justice, the therapeutic freedom of the doctors allows them to either follow the six months of sentence rule or to expand this time line. The doctor has to justify his/her decision on

paper to the headquarter of the Dutch NACI. As an interviewee at the Ministry of Justice stated, the start of methadone prescription is possible for those who are not already in the methadone programme in the community:

“... When you are not in the programme you can debate with the prison to start a programme; but when your imprisonment is longer than six months then one doctor says ‘I Stop because it’s more than six months. Another doctor will say there’s medical interest to continue the programme or to start a programme and then he can continue the programme. There will be a discussion. Each doctor has his own opinion about this. And, at this moment, most of the doctors will stop the programme because it says that it gives them a possibility to stop.’”

The question of continuation of methadone treatment cannot be solved easily. An interviewee at the Ministry of Justice discussed the possibility of providing methadone to lifers:

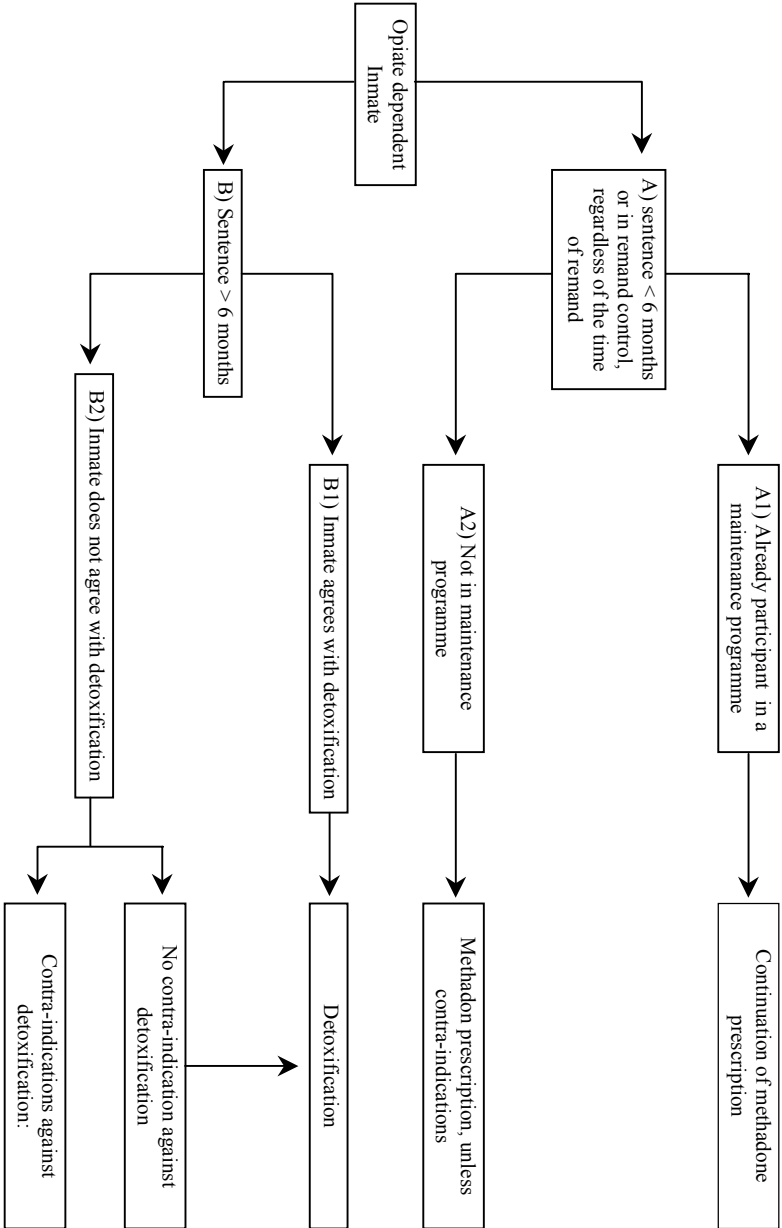
“Some doctors will accept the six months but it’s not their vision, they would stop immediately. ‘But alright, when the pressure is big enough I accept the six months.’ But after that there is a phase to introduce lifetime methadone.”

The role of methadone within the SOV penal care was not fully discussed: *“SOV is one experiment where you can start with a complete treatment for the addiction with or without methadone. That’s also an experiment when you can say ‘Alright when we try to continue the methadone on a lower level than you came in, as a maintenance dose.’”*

Conclusion and recommendations of how to improve the quality of methadone provision in The Netherlands

The Committee set up by the Health Council to examine the treatment for drug addicted prisoners concludes that Dutch penal institutions vary markedly in terms of the methadone treatment that they provide. “The Committee feels that this situation is far from ideal. The members of the Committee have explored the problem of how to promote consensus on this issue. They consider that the professionals involved should themselves develop a consensus in order to draw up a guideline for methadone medication for these professionals to follow. Given the large numbers of professional associations and institutions that will be involved in drawing up a common guideline, the Committee believes it is vitally important to coordinate the relevant activities. This, the Committee feels, should be undertaken by the Steering Committee for the Development of Multidisciplinary Guidelines in the mental health care service.”

Table 16: Guideline on methadone prescription



It should be noted that the six month regulation is only relevant for inmates who are already sentenced and not for remand prisoners. 80% of drug users whose sentence is less than 6 months could theoretically benefit from this regulation. But according to an interviewee in the Ministry of Justice:

“... in practice there are still too many doctors who say, ‘We reduce methadone, despite the fact they have only a short sentence’. We are struggling against that, and times are changing – although slowly follow. More and more doctors start to prescribe according our advices. But still there are prisons in which methadone is not prescribed although there is the indication to do so. The Inspector, who is inspecting the health care in prisons and is based at the Ministry of Health, is also supporting us in this question of methadone treatment.”

In the Netherlands, inmates can complain about a medical treatment which they think is inadequate. According a member of the Ministry of Justice, the proceeding in these cases is as follows:

“If a prisoner complains with regard to the cessation of the methadone prescription, we are the ones who try to mediate between doctors and prisoners. In these cases we try to motivate the doctors to follow our advice to continue methadone prescription. If the doctor refuses to follow this advice then the complaint will be dealt with by a judge and it happens that inmates receive a small compensation of about 50 € because he didn’t receive methadone.”

One of the reasons to fix the timeline at 6 months for the continuation of the methadone treatment is based on scientific evidence pointing towards the prevention of overdoses after release. *“These six months are based on scientific data saying that if methadone is coercively reduced within a sentence of less than 6 months, the consecutive period is dangerous and relatively many may die of overdoses. This hasn’t been known in former times when setting up regulations.”*

The guideline on methadone prescription is aimed at informed consent. When somebody has a sentence of more than six months and doesn’t agree with the reduction of methadone (see group B2 in the graphic above) then a second opinion (carried out by the Ministry of Justice) is integrated in the decision making process.

“We do have very old opiate users, and when somebody has a career of already 30 years then it is most likely that it doesn’t make any sense, just the opposite, maybe it isn’t possible for him to produce endorphins so he should have methadone compared to insulin.”

One of the problems with the provision of health care, and especially the question of methadone in prisons, is that is that there are not enough doctors in the general community and especially those who are willing to work in prisons. So the choice is not that great.

Regarding the prescription of benzodiazepines, The Ministry of Justice follows a strict policy and has communicated it to the prison doctors. If these substances have been used for more than 3 weeks they should be reduced to zero. Instead of benzodiazepine anti-depressants should be introduced.

Aftercare

Within interviews at the Ministry of Justice, aftercare is identified as a problematic area with respect to methadone treatment. Due to a lack of personnel the connection can not always be organised without gaps.

“At the end of the prison time there has to be aftercare; but the aftercare is not very well organised so here at the end of the prison there is no continuity. You leave Friday, you can start Monday at the clinic. That’s two days, so they get lost. So we have to manage when they leave the prison at Friday that they are taken to the clinic at the same day. These are very small things but it’s the only way to ensure continuity. We don’t have the money or we don’t give the money to organize the care; the clinic says they have not the personal to get them, so he gets lost. With a small amount of energy you can get it connected.”

1.3 Prison Population

Table 17 Data on the prison situation in The Netherlands (Source: King’s College London, International Centre for Prison Studies, Prison Brief for The Netherlands)

Country	NETHERLANDS
Ministry responsible	Ministry of Justice
Prison administration	National Agency of Correctional Institutions (NACI)
Contact address	P.O. Box 30132, NL-2500 GC, THE HAGUE, Netherlands
Telephone / fax / website	tel: +31 70 370 2771 fax: +31 70 370 2910

Head of prison administration (and title)	Peter Jägers General Director of NACI (Director of Prison Service: Peter van der Sande)
Prison population total (including pre-trial detainees / remand prisoners)	16 239 at 1.9.2002 (Council of Europe Annual Penal Statistics - includes 2 009 in juvenile institutions and 1,230 in TBS psychiatric clinics)
Prison population rate (per 100,000 of national population)	100 based on an estimated national population of 16.16 million at September 2002 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	44.2% (1.9.2002)
Female prisoners (percentage of prison population)	6.8% (1.9.2002)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.8% (1.9.2000 – under 18)
Foreign prisoners (percentage of prison population)	36.4% (1.9.2002)
Number of establishments / institutions	79 (1.9.2001 – 50 adult prisons, 13 TBS psychiatric clinics, 16 juvenile institutions [places also in 6 other institutions / clinics])
Official capacity of prison system	16 686 (1.9.2002)
Occupancy level (based on official capacity)	97.3% (1.9.2002)
Recent prison population trend (year, prison population total, prison population rate)	1992 7 397 (49) 1995 10 249 (66) 1998 13 333 (85) 2001 14 968 (93)

2 The field visits

2.1 Penitentiare Inrichting Over-Amstel (PIOA) – “Het Schouw”

2.1.1 Description of the prison

The Amsterdam prison Penitentiare Inrichting Over-Amstel (PIOA, popular: Bijlmer Bajes), here “Het Schouw” was visited. Het Schouw is a remand prison for males with 144 cells over 6 floors, structured in 12 sections and each section has 12 cells (single cell occupancy). As it is a remand prison, substitution treatment is generally continued from the community. But, there were more controversial issues (prescribing policies etc.). It became evident that problematic drug use outside (mainly characterized by poly-drug use) is entering prison and that the prison has to find its response to that challenge. So, increasingly the prescription policy on benzodiazepines is of interest as well as the prescription of methadone.

2.1.2 Goals and practical procedures of substitution treatment (access, rules, urine testing, provision on day leave, exclusion from the programme etc.)

History

At time of the visit, 30-40% of prisoners were on methadone when admitted, with 8 out of 10 on one floor receiving methadone, a figure that differs from week to week. Since 1980, the substitution prescription policy in the prison “Het Schouw” has changed over time. In the first phase, methadone was just used for detoxification purposes. From approximately 1993 onwards, maintenance was the dominating strategy with dosages of 30-40 mg used and, more recently, the dosage has been increased to up to 100-120 mg. These changes are due to developments in the drug using patterns of users and changes in the methadone provision policy in the communities. The GG&GD recommended higher dosages and there has been a corresponding increase in dosage in prison as well:

- Pressure from outside has led to a shift from detoxification only to maintenance treatment in prisons,
- Methadone prescription facilities in the community have prescribed higher dosages in the last decade.

- More and more psychiatric problems have led to co-morbidity, where methadone is used as a basic medication. Here methadone works as anti-psychotic drug
- Withdrawal of methadone may exacerbate the physical state of the prisoner. For users for 20-30 years, it is unrealistic to detoxify from methadone.

Additionally, nearly every incoming patient from a methadone programme is using tranquilizers. So the drug using patterns and the prescription policies in the community have changed over time and the prison methadone prescription policy is responding to that.

The supplementary use of benzodiazepines has become a major problem in the substitution treatment, because of demands from prisoners to get adequate doses like outside in the community.

In interviews with provider and users it became clear that there are substantial differences in the prescribing policy from prison doctor to prison doctor.

The goal of methadone prescription is stabilise inmates and to adjust the dosage to the prison setting. It is said that the dosage should be lower for the prison setting than outside, where inmates have to face the whole range of the drug market. If the dosage is very high (80-100 mg) the reason for such a high dosage is questioned. Discussions are led with the inmate and, if necessary, with outside clinics/physicians.

The prescription of benzodiazepines has become a big issue, reflecting the situation of poly-drug use of methadone, heroin, benzodiazepines, alcohol, cocaine/crack outside prison. It has become an important debate between doctor and patient over the years. In former times, sleeping pills have not been prescribed at all. Now sleeping tablets are given when methadone has been stopped. The aim is to reduce the consumption of sleeping tablets so they are only prescribed for a few days as there is no medical indication for prescribing sleeping tablets on a long-term basis. Prescribing it for longer would mark a shift in purpose towards the psychoactive effects of the sleeping tablets. The problem seems that not many of those taking benzodiazepines regularly accept that they are addicted to it. Sometimes inmates, bring a letter with them from the methadone post indicating that they are prescribed benzodiazepines outside.

Methadone provision is not based on a formal contract or a fixed agreement.

Practical procedure

If inmates are already in a methadone programme, this will have been continued in police arrest, they will bring a letter with them and the nurse will give them the same dosage they got in the treatment before. If the patient doesn't bring the letter, the nurse will call the methadone post (GG&GD) in the community to confirm the treatment and dosage. The only problem is when prisoners come from other cities (like Utrecht), in the evening. For these cases special arrangements are foreseen. The day after admission, the patient is seen by the doctor. If he expects a longer sentence then detoxification will be indicated, if he expects a short sentence then the dosage will be kept adjusted accordingly.

The prescriptions are sent to the pharmacy by the nurse, and the guards get it and provide the methadone to the inmates at 8, 12 or 5 o'clock. The exception is on week-end when the warden brings the methadone to the cells directly. The guards hand out the methadone (in 5 mg tablets) and the patient has to swallow it under supervision of the guard. The average dosage is around 40-50 mg.

The medical decision to continue or to stop substitution treatment, or to reduce the dosage, is the responsibility of the medical doctor. But there are weekly discussions about in inmates among an interdisciplinary team with psychologist and psychiatrist (PMO, see above). Sometimes prisoners ask for detoxification treatment themselves, because they can then abstain from drugs during their detention.

The methadone reduction scheme is done in decreasing steps of 5mg every two days followed giving 5mg a week more, depending on the needs of the patient. Being on 10 tablets (50 mg) ("Symoron") means detoxification over 20 days (one tablet every two days).

In some cases, the inmates can start methadone treatment while in prison in order to stabilise their behaviour. The building up process is done very carefully (for instance every week 5mg more), and it is individually adjusted and discussed between doctor and patient.

If prisoners go out for home leave or a weekend (generally not more than 3 days) they take methadone with them. The same applies for the release situation. If they are not known to a methadone post in the community, they are told to continue the methadone.

Urine controls don't play any role in substitution treatment so as to facilitate the process of honesty between health care staff and prisoners. Urine controls are only ordered by prison staff.

According to some providers, the perception of substitution therapy has change from having negative connotations towards treatment being accepted as a medical, supervised and controlled therapy by the personnel.

2.1.3 The views of prisoners

The prisoners acknowledged the change in substitution treatment from merely detoxification towards maintenance. Other experiences of the prisoners indicate that the practice in different prisons varies significantly.

In relation to the detoxification process, inmates wished to be more involved in the decision making process and to be asked about the steps of reduction. The plea is for leaving the decision to the inmates, whether or not and if, in which steps they want to reduce their methadone. The practice is perceived as inflexible and not adapted to the wishes of the inmate/patient. This applies particularly to those drug users who are addicted for twenty or more years and for whom methadone became a sort of basic therapeutic for many years. The detoxification procedure has been perceived as too rigid with not enough space to negotiate. This was considered to be an inferior characteristic compared to the provision of methadone in the community. Interviews made clear that there is a struggle with the doctor about benzodiazepines and the right dosages.

2.2 Stadsgevangenis Rotterdam

2.2.1 Description of the prison

The second prison visited is the Rotterdam town prison (Stadsgevangenis Rotterdam). It is a men's prison with two units – a regular unit with 120 places and a treatment unit "SOV" with 72 places. 70-80% of the 120 inmates are drug users and only 60 inmates receive methadone in the regular unit. In the SOV unit, 60 out of 72 get methadone. According to the staff, there is little drug use in prison (crack/cocaine) with almost no "intravenous drug use". A scientific evaluation of drug policy is currently being carried out and will be finalised this year (2004).

2.2.2 Goals and practical procedures of substitution treatment

The staff and the doctor were well aware of the new recommendations of the Dutch Health Council (Gezondheidsraad, see also the scheme above). The scheme to prescribe methadone to new detainees was as follows: Every day, 5-10 new prisoners are admitted to the prison. They are asked if they are drug users and if they are on some kind of therapeutic regime already. Everybody who has been in substitution treatment before at the CAD (Consultatiebureau voor Alcohol en Drugs, consultation office for alcohol and drugs) in the community and whose sentence will not exceed 6 months, will get have their dosage continued. If his sentence is longer than 6 months, he will be reduced so long as there is no contra-indication. Contra-indications include the fact that somebody is a chronic drug user and suffers from multiple diseases (co-morbidity). In these cases, the methadone treatment can be prolonged.

If there is somebody who is only in the prison for 2 or 3 weeks, and they are not known in the methadone clinics outside, he will receive some 20 or 30 mg of methadone in order to keep him stabilised. But,, in all cases the prison doctor decides on an individual basis.

The staff appreciated the new scheme which was introduced by the Ministry of Justice in the form of a 'handreiking' (guideline, circulaire, see above). One reason for this new regulation is that if somebody is a short-term prisoner and will be reduced this will disturb the relationship between doctor and patient and will create some kind of tension and stress. Staff and nurses said that there had been some complaints about detoxification treatments and this new regulation will lead to a higher degree of transparency. So, in all cases, there is communication between the doctors/nurses inside and outside and prisons, a relationship which is characterised as very good.

The goals of methadone prescription are:

- not to disturb a balanced system,
- viewing real drug addiction is an illness that has to be treated.

Methadone is brought to the cells by a special guard at 12 o'clock, together with all other prescribed drugs, e.g. co-medication. The intake is supervised, patients have to drink some water afterwards in order to be sure they swallowed the methadone and possible other drugs.

The average dosage of methadone is 50-70 mg. All other drugs are brought to the wards at 5 o' clock. If the guard notices that someone is intoxicated in the cell he will call the nurse in charge.

Benzodiazepines and sleeping pills are only prescribed by the psychiatrist. There is very little discussion with the prison doctor about the prescription of benzodiazepines, because the policy and practice is well known among the inmates. Benzodiazepines are prescribed only to ease insomnia – inmates who suffer from this disease will get benzodiazepines three times a month. If an inmate is known to a psychiatrist outside and gets medication from him, then this would be continued inside prison. This is not the case when he gets the drugs from a personal doctor. In all cases, there is communication with the doctor outside about indications for prescriptions.

The reduction scheme for benzodiazepines is: reducing 1 tablet per week: Diazepam 3, 2, 1,0.

At the time of visit 6 men in the SOV got methadone and 60% of the detainees in the main unit.

Special issue SOV

The special treatment inside a SOV unit is drug free oriented. After a detoxification period of up to 3 months patients do not receive any methadone although, if there are medical reasons (counter-indication), the methadone prescription will be continued. To wean drug users off methadone is not a coercive treatment because SOV provides additional psycho-social care to support prisoners (psychological, psychiatric, medical health care). In the interview with staff of the SOV, the difficulties of reducing methadone became clear:

“It’s [methadone] the most important thing we have here because they are all addicted for a very long time, some of them haven’t been clean for almost 20 years. So even in times they used heroin and cocaine they always have methadone. If you want to take that from them, they panic. So in the first stage it’s the most important thing you have to communicate about it then. And it’s the most difficult part to motivate to keep them ... because taking off the methadone is take off the security, their image, stability, it’s almost all they have. So it’s really very heavy. So we start reducing that they have their border. And then it starts getting difficult here. All the people who have methadone are there. Then they are clean and stabilised then they go further.”

Because if you have methadone in that part of the treatment it becomes very difficult. So we try to reduce that.”

According to the staff, most prisoners have experiences of weaning off methadone in a prison setting, because this is common practice in Dutch prisons when the sentence exceeds 6 months. But, in the very first period, this has some strong effects on the relationship with the staff:

“When you are reducing methadone they really are scared, they are afraid they don’t feel good, sometimes they are a bit aggressive, they are sad, their body is aching. So they have lots of complaints there. But it’s clear that everybody has to reduce, that’s ok, they see it that way. They accept it. And it’s in all prisons in Holland. If you are in for longer than half a year they reduce your methadone. That’s not new for them. Most of them have had a prison time before ... and outside they experience clean periods too. It’s not the first time they are in reduction. It’s the first time they can nothing do about it. That’s what scares them.

Those who are sentenced for 2 years, they always get three weeks for it. So they don’t love us when they come in. So their actions are part of their fight with us. They don’t like the SOV because it’s too long for a too small offence.

The reduction scheme and the whole process is described in detail by a staff member of the SOV treatment unit:

“They go to the medical service and they tell them how to reduce, how it’s going to happen. And it’s always the same: one tablet [5 mg] in four days. In the beginning that’s not to bad. They blow something and they have something in reserve, that’s not a problem. The problem starts below ten. When they come below ten tablets then they start- at least I think – they start suffering. When they go to four tablets then they really go suffering. I guess that the last parts are the hardest ... they hang to it, really cling to it and they really have pain. So we don’t try to ask too much. They have a little bit more privileges to go on their cell or cry a bit louder, they are given a bit more space to freak it out.”

The length of the detoxification process is reported to be different according to the individual case. The starting point is the dosage they are come in with, it’s not a general scheme that fits all:

“... one tablet in four days, that’s a fairly long time, – its about four weeks –, yes, it’s not too long, he has two years, he is not running out of time. We

don't hang on to that scheme because if they have so much methadone, we try to make a pause in between. Halfway we stabilize on a dose for a week or two weeks if necessary. Then we go further. If you have to come from 30 tablets it's really a long way to go and they are really afraid, if they have so much ... we do one tablet in four days everybody unless someone is really suffering. And suffering is not only because the withdrawal but everything is lying beneath the methadone is going to wake: headaches, pain in the legs, in the teeth, all kinds of pains are coming back, memories, flashbacks, its all awaking. And they know it's waiting there. You are driving them into a room where all their pain is waiting for them. You must be crazy if you like that. So they don't. And they fight. And they get space. That's why we don't drive them up. We give them a bit space, they are allowed to do just a little more than in other times."

The staff see the withdrawal of methadone as an inevitable process which forms the basis for the individual (having achieved the first goal of treatment) and the therapeutic intervention:

"If you drive them mad then you cannot work the 2 years after together. So you have to try to be in contact, within the knowledge they have to reduce. So that's clear, the first stage is 6 to 9 months. In the first 2 or 3 months we try to do the diagnosis and reduce the methadone. They have psychological search, ... we try to recover them...sometimes they are really in a bad shape when they come in, physical ... this all we try to do ... it's really going fast, the turkey, a kind of restlessness, it's really easy going, you don't have to fight you don't have to score, you have your dinner at time, your breakfast at time, it helps a lot. Sometimes they double and then they look like nine months pregnant."

The inmates are very heavily involved in the process of reduction of methadone. The detoxification process is very much in their mind and is explained as part of the dynamics of addiction.

I think there is not much other in their mind, life is situated around drugs, methadone and dope. That's the point they are circulating around. And they still are here. So if you have methadone you have a lot of money over there and now it's gold, one methadone tablet is really gold ... So they know they can't manage outside as they have the freedom to use, they have the freedom to choose, they wont manage."

From the treatment point of view, and on the basis of experiences, staff members doubted whether inmates are able to control or if they can be given more control over their substances or even reduction schemes.

“Be sober is just a nice idea. That’s the fight they have in their cell, their fight they have with us. And once that fight is over, I think 80% of the people are really glad. That doesn’t mean they stay clean ... some of them say: it’s ok that you take the decision ‘cause I can’t.”

Evaluation of the outcome and social prognosis of the treatment programme is needed:

“When they are over in that department they all think: I don’t use drugs outside. When they are outside, it’s a different story. When they are here it’s safe, they have work, they go to school, training courses, they really feel good and strong and healthy. It changes dramatically when they have the possibility to get outside the ward. I think two years is too short. But how many years do you need? I don’t know, we have 5 people in here who asked: can I live here? Can I stay here for the rest of me life? People are so scared to go outside because they know they wont manage all that and they feel good without dope ... I think those people are so damaged- it’s not the lack of skills, and society is complex, and we have people here around the age of 40. So they don’t have the experience of how nice life can be. When they come outside it’s really difficult for them to find a place in social networks. It’s difficult for us, so it’s so much more difficult for them, lack of self-esteem, the only way they know are the prison ways and the street life ways.”

At the time of the field visit an interviewee at the Ministry of Justice stated that there is a discussion with doctors and the staff about whether it would be better for the patient to continue the programme because he is so much more stable during the measure.

2.2.3 Views of prisoners

The prisoners interviewed in the SOV were discussing the topic of weaning off methadone and how it is done. They reported that there should be more space for negotiation between doctors, nurses and inmates about methadone schedules. The prisoners demanded more participation in the steps of dosages. They especially point out that for drug users with a drug career of more than 20 years, weaning off of methadone is a basic decision, because methadone has been served as a coping strategy in times of heroin scarcity. They said they were able to manage craving and adverse effects of their drugs with

methadone. Although it came out that there is a “love and hate” relationship to methadone: it is not the substance of first choice. The prisoners valued methadone in the double sense: on the one hand methadone is seen as a therapeutic medicine, on the other as a psychoactive drug and it depends on the situation in which it has either the one or the other quality. Furthermore, the structure of the SOV is criticised in that way that motivated inmates are together with non-motivated. Finally, they criticised the selection of the personnel which, in their view, consists of too many guards and only a few health care workers.

3 Summing up

Methadone maintenance has been a stable part of addiction care in The Netherlands for almost 30 years. For those in a community-based programme before admission, it is possible to continue the treatment. But obviously this is not true for all Dutch prisons as there were several complaints from prisoners to continue treatment. The National health board then set up an expert committee with the aim of increasing access for prison-based substitution programmes. This resulted in changes of the prescription policy in prisons (e.g. increase of time to be served as eligible for maintenance treatment from 3 to 6 months) and the situation is likely to improve over time. Both show flexibility within the system (i) prisoners ability to complain which constitutes a major improvement and (ii) the way in which the health council is identifying a problem and is demanding changes accordingly.

The one exception was the Penal Care Facility for Addicts (SOV: Strafrechtelijke opvang Verslaafden) where methadone was detoxified at the beginning of the treatment. Interviewed prisoners reacted with dissatisfaction to this decision because they were used to methadone for many years, which enabled them to cope with opiate addiction themselves. Coercive treatment and detoxification here has to prove its effectiveness (a study is currently being carried out). But, again, treatment modalities are changing and a turn towards the provision of methadone in these treatment units is discussed and in some facilities has already been realised.

Poland¹

1 General data: drug use, substitution treatment and prison population²

1.1 Number of drug users

According to the EMCDDA Poland Report (2001), the number of ‘problematic drug users’ (those with regular and problematic use) varies from between 32 000 and 60 000 users. According to the National Bureau for Drug Prevention, Cocaine use is rare. There has been an increase in the use of amphetamines and cannabis. Amphetamines are available in tablets and powder that can be inhaled or drunk. Injecting has a bad image and this has led to a decrease in injecting and an increase in multi-drug-use patterns. In Poland, opiates remain the main drugs associated with problematic use. ‘Brown sugar’ heroin is increasingly available whereas the Polish ‘compot’ (home made from opium straw) is becoming rare on the streets. It is possible that the poor image of this drug, because of its connection with death and social deprivation, is responsible for this trend. According to Mr Janusz Sieroslawski of the National Bureau for Drug Prevention, drug using patterns have changed over time. Whereas, in 1987, injecting compot users constituted the majority of drug dependents in the community but, by 2003, only 20% are injecting.

For 1995-2001, data on the prevalence of HIV among reported injecting drug users (IDUs) suggests some stabilisation. In 2001, 0.68 % per 100 000 population were HIV positive. Trends for the number of new HIV cases among IDUs show a slight downward trend during the period from 1997 to 2001. In absolute terms, there were approximately 300 new HIV infections per year and this trend has been stable since 1990 (see EMCDDA figures).

1 The field visit, conducted by Heino Stöver, took place from 17th to 23rd November, 2003 and was facilitated by Marek Bujak / Marzena Ksel, Healthcare Department, Polish Prison Service and Maria Salivonenko, International Projects' Co-ordinator, MONAR, NGO, who also provided national-general information and support with the finalisation of this country report.

2 For further information see also MacDonald (2004).

The incidences of Hepatitis C vary significantly. As of 1999, Hepatitis C rates reached 1.4 per 100 000 people, as indicated by the World Health Organization (2001). Since 1993, the incidence of Hepatitis C decreased by 80% and maintains a lower average of incidence than in the European Union (pre-expansion).

Drugs are considered to be more easily available in Polish prisons than alcohol. The prison service acknowledges that there are drugs in prison. According to the President of the Polish Association of Probation Officers, the reason for this is that, on the one hand Poland has become a country for drug trafficking and, on the other hand, the demand for drugs is high, especially among young people, because they are living in an extreme transition process. At the time of the visit, the proportion of drug users in prison was estimated to be 30%. Another 30% of prisoners were estimated to have alcohol problems.

According to Sierosawski³ (2003), the drug problem in the Polish penitentiary system was of marginal importance until the late 80s because of limited drug use in general and liberal drug legislation. It was only at the beginning of 2000 that a research project, carried out by the Institute of Psychiatry and Neurology in Warsaw, provided evidence about the scope of the drug problem in Polish prisons. A representative sample of 1 186 men held in penitentiary institutions all over Poland demonstrated that almost every fifth inmate had been an occasional user of drugs such as cannabis, amphetamines, ecstasy or cocaine, prior to imprisonment. This figure increased to 30% for those between 17-24 years. The results of this study showed that, within the prisons, 22.5% of all prisoners interviewed (33% of those being between 20 and 24 years old) used drugs, predominantly sedative drugs such as tranquilizers, cannabis-based products and amphetamines. 3.3% of prisoners confirmed intravenous drug use, while 1% reported sharing of syringes. According to those being interviewed, it is easier to access illicit drugs than alcoholic beverages.

Sieroslawski (2003, p. 21) states that it is necessary to undertake activities to both limit the demand for drugs and to reduce the harm; supply reduction measures alone are not sufficient because drug users in prison are predominantly young people, under 25 years, who engage in high risk behaviour. Sieroslawski (2003, p. 21) concludes:

3 Institute of Psychiatry and Neurology in Warsaw.

“Although intravenous use of drugs does not happen very often in penitentiary institutions, the lack of access to sterile needles and syringes poses the serious threat of infectious diseases, including HIV/AIDS. Programmes that involve administration of methadone as a drug substitute seem to provide the best response to the increasing threat.” (p. 21)

1.2 Substitution treatment

1.2.1 Historical and legal background

The Polish National Programme for Counteracting Drug Addiction, 1999-2001, prioritises increased treatment, rehabilitation, prevention and harm reduction (both availability and quality of provision), strengthening law-enforcement activities to combat illicit drug trafficking as well as development of drug problem monitoring and international cooperation. The new Programme for 2002-2005 is currently being developed (EMCDDA, 2003).

In 1993, substitution treatment was introduced in Poland by the Department of Psychiatry and Neurology in Warsaw. The dominating concept behind drug services in Poland was drug free orientation (Sieroslawski, Focal Point Poland 2003). As a result, substitution treatment was conceptualised as a high threshold programme with strong controls and limitations. In November 2003, at the time of the visit, attempts were being made to change the regulation of substitution treatment in order to open it up to a higher number of opiate addicts. There has been a marked drop in the number of opiate users in Poland; from 900 to 700 over the course of 2003. (Rudalski, Regional Director of Prison Health Service, November 2003).

Drug treatment is offered through drug-free programmes conducted in residential centres and usually managed by NGOs. Methadone substitution programmes are offered by ten public health care facilities and reached approximately 4 per cent of opiate addicts in 2001. Amongst the acceding and candidate countries to the European Union, Poland has the longest tradition of therapeutic groups working towards rehabilitation and prolonged abstinence. The role of these communities has superseded the position of psychiatric institutions, which are dominant in most other CEECs.

1.2.2 *Substitution treatment in prisons*

Since Sierosawski's study in 2003, which recorded drug and opiate use in Polish prisons, prison staff have been trained in dealing with drug users and raising their awareness of drugs and related issues. However, the main focus of the Prison Service drug strategy has concentrated on supply reduction and control measures (i.e. urine testing). Neither of the sample prisons had a written prison drug strategy.

Substitution treatment is not available across the whole of Poland. This has caused problems for the introduction of this treatment in prison as it cannot be guaranteed that prisoners will be able to continue their treatment in the community once released. This is the key argument of experts and practitioners from the outside who argue that it is only justified to provide substitution treatment if it is possible to continue it in the community.

Despite these arguments, substitution treatment programmes have been established in some prisons. Montelupich prison is one example, where, prior to the methadone programme being established, there was extensive negotiation with the community providers of the methadone programme and thorough training of prison staff. The main problem with the implementation of the methadone programme in prison is the lack of a national strategy. For example, when participants in the pre-trial prison are sent to other prisons in Poland, the continuation of the treatment is unlikely or impossible but they will be definitely detoxified.

1.3 **Recent developments – an update of the introduction of substitution treatment**

Since January 2003, when the first pilot on substitution treatment was introduced in the Kraków Remand Prison (see chapter 2.2.2 below), three more programmes have been started in pre-trial institutions in Warsaw (April 2004). Wojciech Rudalski, M.D., Regional director of Prison Healthcare Service, Polish Prison Service, is reporting recent developments⁴:

The *NOVA-Methadone Substitution Programme* is aimed at opiate dependents, imprisoned in Warsaw penitentiary institutions – Remand Prison War-

4 For full article see: Wojciech Rudalski (2004): Methadone behind bars – the implementation of the first methadone program in Warsaw penitentiary institutions, 'Connections' May 2004.

saw-Mokotów, Remand Prison Warsaw-Białoleka and Remand Prison Warsaw – Służewiec. The number of participants was set at a maximum of 15 people per year. It is intended to be an extension of the available health services for imprisoned dependent drug users and is planned to continue for many years. The duration of individual cases will depend on the level of the patient's rehabilitation. The programme will be implemented in close cooperation with existing external methadone programmes (including The Institute of Psychiatry and Neurology in Warsaw, the Judicial Psychiatry Ward of the Prison Hospital in Remand Prison Warsaw-Mokotów, the National AIDS Centre and the Drug Prevention Office). The programme offers an alternative to imprisoned drug users where other methods of treatment have failed.

The programme is targeted towards individual gains for each participant. It will allow them easy access to reliable medical, psychological and therapeutic information and thereby influence social attitudes and education regarding moral, social and health issues. It will allow the participants to realise the mechanism of dependence, "look into themselves", find out means of reacting and behaving in different situations and conditions. This will also improve the health and social functions of the imprisoned patients taking part in the programme.

In the NOVA programme, Methadone is used as a medium for improving the contact with a drug dependent prisoner, which in turn offers the possibility for psychological stabilisation, the treatment of HIV infections and other serious diseases, improving the somatic state and achieving desirable socialisation and psychological goals.

In the first 24 hours of his stay, a doctor will examine every opiate-dependent patient brought to the remand prison in order to evaluate his psychological and somatic state. If the patient meets the qualification requirements, set by the Polish Ministry of Health and Social Care in a separate decree, the programme director will accept the individual into the programme and inform the proxy of the prison service regional director. Additionally, the participant must have prisoner status. For a new patient, the possibility of continued methadone substitution treatment, after leaving the penitentiary institution, must be secured before they can start the programme. However, in special cases, the doctor can waive this requirement for health reasons.

The fundamental principle of the NOVA programme, is the complete freedom to take part in it. Two forms of the programme are planned:

- Form A – continuing methadone treatment to patients in substitution programmes outside prison who, due to breaking the law, have entered penitentiary institutions.
- Form B – including into the program new opiate dependents, who, due to breaking the law, have entered penitentiary institutions and fulfil the programme criteria.

In Form A, participants of substitution programmes outside prison will receive methadone according to the rules of their original programme. The therapeutic team will contact the director of such a programme in order to gain the necessary data and a guarantee of returning to the programme on release from prison. During imprisonment, the patient will receive methadone from the prison medical supplies.

The first part of Form B qualifies the new patient to take part in the substitution programme. Those patients who meet the criteria of acceptance are given a preliminary examination – which takes place during the first 48 hours and is based on the evaluations of the psychiatrist, the internist, the psychologist and the therapist – before the programme director accepts them onto the treatment.

The second part of Form B concerns the implementation of the programme, namely, the everyday administration of a certain dosage of methadone, participation in the therapeutic group, counselling, examinations, medical procedures and, possibly, detoxification. The patient will also be given the opportunity to work on prison grounds and receive education. During the meetings and therapy groups, the participant will take part in group psychotherapy and individual consultations with a therapist, a psychologist and an educator. Participation in these meetings is mandatory and is an integral part of dependence therapy. Psychological and therapeutic care will be provided to NOVA participants by teams of specialists employed by the penitentiary institutions. Participants' duties include taking part in random urine testing, which is intended to detect the presence of drugs other than methadone. Should the use of other psychoactive substances be detected, the participant will be subject to individual and specific therapeutic influences. Should the abstinence test be positive three times, the patient will cease to undergo methadone therapy. The decision to exclude a patient from a programme will be made by the programme director, after consultation with other staff. If a

patient is excluded, they receive medical and therapeutic care throughout their stay in the remand prison.

The patient may voluntarily opt out of methadone substitution treatment. In such a situation, in outreach conditions or in the prison hospital, a gradual detoxification is administered, with the use of methadone, until complete abstinence is reached. Should complications appear, it is possible to hospitalise the patient in the following Wards: Internal Diseases, Intensive Care and Psychiatric, as well as other wards of the Prison Hospital of the Remand Prison Warsaw-Mokotów.

Participants in the programme will be provided medical care, centred on the diagnosis and treatment of infections and illnesses connected with intravenous drug use (HIV, HBV, HCV, bacterial infections, thrombotic vein inflammation), as well as others including tuberculosis, venereal diseases and mental disorders. If required, prisoners may ask for consultation and care from the HIV/AIDS consultant, the contagious diseases consultant and other specialists employed by the ambulance and the hospital in the Warsaw-Mokotów prison and in the ambulance of other prison institutions where the programme will take place. Those people who do not agree to protracted methadone therapy after leaving prison will undergo gradual detoxification during their stay in the prison and, when they leave, they will be directed to institutions offering rehabilitation for addicts.

The NOVA programme is a form of protracted methadone substitution therapy. However, after the patient leaves the penitentiary unit they continue substitution therapy in their area of residence on a voluntary basis. For that reason, only those patients who, due to where they live, gain a guarantee of continued substitution treatment (in both existing and newly created methadone programmes country wide), will qualify under the first part. Finding such a places for patients in external programmes will be among the duties of NOVA staff.

As mentioned previously, it is critical to consider methadone substitution as an extension of prison service healthcare for opiate-dependent prisoners. They provide continued treatment for some and offer a chance for those who have not met the requirements of other methods. We cannot forget that drug users are an inseparable part of the community, even if they are, at present, isolated from it.

1.4 Prison Population

Table 18 Data on the prison situation in Poland (Source: King's College London, International Centre for Prison Studies, Prison Brief for Poland)

Country	POLAND
Ministry responsible	Ministry of Justice
Prison administration	Central Board of Prison Service
Contact address	Ul. Rakowiecka 37A, PL-00975 WARSAW, Poland
Telephone / fax / website	tel: +48 22 640 8311 or 8355 fax: +48 22 640 8312 or 8332
Head of prison administration (and title)	Jan Pyrczak Director General
Prison population total (including pre-trial detainees / remand prisoners)	80,093 at 31.12.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	210 based on an estimated national population of 38.20 million at end of 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	25.6% (31.12.2003)
Female prisoners (percentage of prison population)	2.7% (31.12.2003)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.7% (8.5.2003 – under 19)
Foreign prisoners (percentage of prison population)	1.5% (31.12.2003)
Number of establishments / institutions	156 (2004 – comprising 70 remand prisons and 86 prisons. There are also 32 external departments (minimum security units), 14 hospitals and 2 facilities for mothers with small children)
Official capacity of prison system	69,330 (1.9.2003)
Occupancy level (based on official capacity)	116.4% (1.9.2003)

Recent prison population trend (year, prison population total, prison population rate)	1992	58,619	(153)
	1995	62,719	(163)
	1998	57,382	(148)
	2001	70,544	(183)

2 The field visits

2.1 Sluzewiec prison

2.1.1 Description of the prison

Sluzewiec prison has a capacity for 680 prisoners but, as of September 2003, held 858; an occupancy level of 126%. Prison cells are a maximum size of 2.53 square meters⁵ and sometimes groups of between six to eight prisoners are housed in one cell. According to the prison director, the custodial conditions in his prison do not yet meet European standards.

2.1.2 Goals and practical procedures of substitution treatment

In the prison visited Sluzewiec, Warszawa, the prison director Mr. Rostkowski, reported that prisoners are assessed upon admission. The doctor describes dependency symptoms. If there is a person with withdrawal symptoms, he will be referred to community services or the prison hospital (Rakowiecka Str.) for detoxification. During their first three days in prison, they are supported by an educator who provides basic support. The educator plays a key role in working with inmates: 20% have a higher education qualification and have run special programmes with addicted inmates. Their work covers legal aspects, helping to re-build or support family contacts and offer individual counselling to inmates.

At Sluzewiec prison, drug dependents are treated in one of the ten specific therapeutic units in Polish prisons. These units are connected in that they are all abstinence-oriented. The structure of these units is underpinned by the Executive Penal Code (1997, §117). However, the working of the units can be flexible to meet local circumstances and needs. Representatives from the ten units meet twice a year to exchange information and experience.

5 The official minimum space specification per prisoner is 3 square metres (Penal Executive Code 1997, Article 110).

The Therapeutic Unit at Sluzewiec prison is the only one in Warsaw and house 34 prisoners at the time of the visit. The unit sees approximately 70 prisoners over the course of a year. The unit is for opiate and amphetamine users who have no psychiatric illnesses. The average age of the prisoners is 24 years. The unit is run by a therapeutic team consisting of a director (who is a psychologist), a nurse and another psychologist.

The prisoners on the unit must be diagnosed as drug dependent and they must have been sentenced to compulsory treatment as part of their sentence. The treatment provided by the unit is underpinned by the Executive Penal Code (1997 §117). According to the treatment team, it doesn't make any difference whether the prisoners come to the unit on a voluntary basis. Prisoners from other prisons can also attend the unit.

Within the programme, withdrawal is seen as a good starting point to increase the prisoner's motivation to change their behaviour. The treatment is in three phases:

1. Introductory phase (approx. 1 month): The goal of this introductory phase is to identify and raise awareness of the symptoms of dependency. Basic education is provided on issues relevant to drug users: HIV/AIDS, Hepatitis, how to deal with withdrawal symptoms and so on. HIV testing is offered to the prisoners.
2. Phase two: Group meetings where the social and individual costs of drug use are discussed with particular emphasis on the impact on individual prisoners.
3. Phase three: A mixture of individual and advanced group work that concentrates on topics like emotions, feelings of shame, anger, dealing with the nature of the illness, perspectives after release. In this phase, individual treatment plans are elaborated and meetings and therapy groups with drug dependents from outside are organised in the form of peer-groups with patients and ex-prisoners.

The unit is linked with community service staff who come into the prison once a week to provide individual counselling. The prison co-operates with the NGO MONAR who care for prisoners on a conditional release (see below).

After completing six months in the therapeutic unit, prisoners return to other sections in the prison. On average, the prisoners stay six months in the unit. The work of the unit has not as yet been evaluated. The unit has a waiting list

of 100 people until May 2005 (from November 2003). Originally, the programme lasted 1 year but, as more and more prisoners wanted to take advantage of the programme, it was reduced to six months.

At Montelupich prison, in Kraków, the peer group for drug users is led by a psychologist who works both in the prison and with an outside organisation called 'Formaticja'. The peer group is an open group that meets for one and a half hours each week. In the group the prisoners receive information about alcohol and drug use, after this the prisoners can attend an outside group organised by 'Formaticja' which focuses on motivation building.

Individual counselling is also provided for drug users by a psychologist at Montelupich prison. According to a new law every prisoner who is younger than 21 and has a sentence longer than six months will have an obligatory diagnosis of drug use. From 2001, it is mandatory to have diagnostic units in every regional directorate. In Montelupich prison, the psychologist involved with the diagnostic unit stated that he found that approximately 70% of the juveniles had had contact with illegal drugs.

MONAR Association

The main goal of MONAR Association activities in prisons is to build an integrated assistance system for counteracting drug abuse, marginalisation and social disintegration within prison system. They also work to build a bridge between this system and the services available in the community.

According to the President, Jolanta Lazuga-Koczurowska, and her colleague, Masha Salivonenko, MONAR has been active in the prison field for more than 15 years; long before anyone else was working with prisoners and drug use. In the beginning, they worked in 15 prisons conducting educational activities. One key element to their programmes is the self help perspective and the use of ex-addicts and ex-prisoners to talk to prisoners.

At the beginning of the nineties, as prisons started to think about treatment after release, the process of therapy instead of punishment was started, that meant the rest of the sentence was suspended (after 1 year). Starting in Gdansk prison, peer groups and self help groups were established. In the course of the nineties, in response to HIV/AIDS, cooperation between MONAR and the prison system intensified. Externally, there was a parallel development as social work targeted those with HIV/AIDS as well and prison staff started to visit these facilities in the community.

Now, MONAR is looking for better funding from the Polish Prison administration in order to support prisoners needs more systematically. An agreement between MONAR and the Polish prison service will be signed in December 2003. This will provide solid grounds for more centralised and structured prevention work and the awareness training that MONAR will carry out in prisons. It would also provide MONAR with official permission to go into all prisons. The work plan includes:

- Therapy motivational work.
- “Half and Half” – after half a sentence is served, a transfer to a therapeutic community becomes possible.
- Treatment in therapeutic communities.

MONAR proposed a special therapeutic community (Lipianka, 150km north of Warzawa) as a place for all ex-prisoners. In addition, MONAR is providing training for prison staff in order to better their understanding of the needs of prisoners and to improve connections between services inside prison and those outside. However, due to budget cuts, MONAR will not be able to continue this work.

In Warsaw, Adam Nyk, sociologist, volunteers to provide individual counselling and group meetings with all addicted inmates. One of the aims is to motivate prisoners to continue their therapy after release. A substantial number of prisoners have continued therapy in the MONAR centre after release (20 in 2002).

2.1.3 Views of prisoners

The focus group consisted of five male inmates, who all reported previous stays in prison. First of all, the inmates reported that, in AS Sluzewiec, there are 3-6 inmates per cell. Some hygienic problems were related to cold and hot water from the tap. Each cell has a toilet room of its own but basic hygienic equipment (toothbrush, soap, toilet paper) is of a bad quality. Access to a shower is granted twice a week, better than the normal rule of once a week. Access to a fitness club is permitted every day (table tennis etc.) for 1¼ hours. Access to education is confined to education on drugs, HIV/AIDS and infectious diseases. Access to medical care is via the nurse, who can be contacted daily and in emergencies. The doctor is open to visits twice a week, for a few hours. Medical records are kept. Because of the nature of the therapeutic unit, psychologists can be contacted daily.

Prisoners stated that there is no drug use in the therapeutic ward but that it does exist on the other wards where marijuana is smoked if available. According to inmates, they were not offered a professional detoxification treatment before entering prison. Some told about long waiting lists to get into a qualified programme. Others said that they paid the doctor for prescribing them pills at home prior to their incarceration (approximately 500 Zloty for 10 days). None of the respondents underwent a qualified detoxification programme in the prison hospital. 3 out of the 5 prisoners are in the unit on a voluntary basis and 2 are obligatory cases who tried to make the best out of it and have become more self motivated. Everybody said that living conditions in this unit are much better than normal.

In the therapeutic unit, prisoners receive information on HIV/AIDS and other infectious diseases from the nurse. Regarding condoms, prisoners stated that there is no need to provide them in prisons.

One of the key issues raised in the prisoner focus group was the question of whether patients felt prepared, having run through the therapeutic unit, to go back to the normal ward and whether they would be able to resist the temptation to use drugs again. Most of them were unsure about this. Other issues included the need for:

- Better food, bigger rations.
- Bigger cells, overcrowding.
- Temporary/conditional releases.
- Better attitudes of prison staff towards prisoners.
- More activities for prisoners.
- Hot water.

In 1998, social rooms in the prison had been rebuilt as cells due to overcrowding.

2.2 Montelupich prison

2.2.1 Description of the prison

Montelupich prison, according to its director, has a capacity of 702 prisoners but currently holds 815, of which 329 are sentenced and 486 prisoners are pre-trial. The rooms in the prison hold from between 1 to 15 prisoners with an average space per prisoner of 2.53 square metres and, in the hospital, an average of 4 square metres.

2.2.2 *Goals and practical procedures of substitution treatment*

According to Mr. Potoczny, Director of the Kraków prison, Montelupich, the following procedure is applied when new drug users come into prison: the person talks to the educator which includes previous drug history. There is no tendency to hide; if they are drug users, prisoners will admit it. In the first phase, they will also go to the medical department – as a rule within the first 3 days but most go on the same day as admission. If present, the doctor will notice withdrawal symptoms. If there are symptoms of severe addiction, the person will either be treated in prison or in the prison hospital. They are working closely with Kielza, a big prison hospital with a therapeutic unit (the waiting list for this unit is about 4 months). After the detoxification phase, prisoners can enter a peer group. A social worker (Marek Hanusz) leads this group. Some prisoners are allowed to meet in this, and other, groups but some remand prisoners are not permitted due to juridical constraints. For them, individual counselling is organised.

The peer group is a mixed one, with alcohol and drug addicts, and consists of approximately 20 participants. The psychologists think that meeting only once a week with a group is too seldom. The prison is also cooperating with MONAR, who also take care of drug addicts in the prison.

At the time of the visit, the only substitution treatment programme in a Polish Prison was in Montelupich prison in Kraków. Montelupich prison provides substitution treatment for 10-15 prisoners but, at the time of the visit, there were 6 prisoners on the programme. According to the doctor in charge, Dr. Katarzyna Leśniak⁶, interested inmates have to fulfil three conditions to be accepted onto the methadone programme:

1. They must be at least 21 years old.
2. They must have a 3 year history of injecting drug use.
3. They must have undergone 3 unsuccessful treatment attempts and give assurances that they will take the methadone.

6 Head of Internal Diseases Department, prison hospital, Montelupich, Kraków. The following description of the methadone programme is based on her presentation to the CENTRAL AND EASTERN EUROPEAN CONFERENCE ON DRUG & INFECTIONS SERVICES IN PRISON: “Dealing with Drug Use in Prison: Reviewing the European Experience and Sharing Good Practice” (18-20 September 2003, Popowo, Poland).

These conditions are based on a Ministry of Health regulation (6/9/1999)⁷ about substitution treatment. Additionally, the person attending the substitution treatment has to sign a contract with the doctor. The methadone programme is not available for prisoners without medical insurance because they cannot be transferred to programmes outside. The high threshold is a tribute to the drug free orientation in Polish drug treatment. The substance used in the substitution treatment is methadone.

Currently, there are 6 inmates in the first methadone maintenance therapy which has 10-15 places for drug users. The prison hospital in Montelupich is able to test the presence of opiates in urine within its analytical laboratory (urine controls are taken once a month). The presence of opiates have to be confirmed before the start. The tests are also used to control abstinence from other drugs during methadone therapy.

“I think I’ve been in good contact with drug users from the treatment group. Other members of my team feel the same about themselves. I determine an optimum dose and decrease in dose in concert with the drug user. We’ve observed satisfactory change which takes place in our patients after weeks or months of treatment. Some of the prison staff, outside our team, confirm our observation.” (K. Leśniak)

Methadone is given, under supervision of a nurse, before 12 o’clock. There is a central register of all methadone users. Views among the staff vary; some staff members think that prisoners are calmer when prescribed methadone.

Substitution treatment was first initiated in Kraków because they fulfilled all the requirements mentioned above and, in May 2002, their set up was accepted by local authorities, this included:

- Team (psychologist, a psychiatrist, a sociologist and a nurse)
- *Infrastructure*
- Methadone supply
- Proper facilities

After the one year pilot programme (from January 2003 to Jan. 2004) an evaluation must be made. This assessment has to be done within a very short

7 According to Marek Zygadlo, MONAR, Kraków, these regulations will be discussed in a meeting in December 2003.

period of time. It will contain a statement that the programme should continue. Since the beginning of the programme, the treatment team has cooperated and has been in permanent contact with the Public Health Center for Drug Addicts in Kraków which runs methadone therapy in the city and the region. The team members are also in close contact with social institutions like MONAR. They have the telephone numbers of all medical institutions in Poland so that prisoners on the methadone programme can be referred to other prescribing institutions. At present, there are nine such institutions in Poland. The doctor has access to patients' data within these programmes when they are sent to prison.

The following reasons were given for disqualification from the programme:

- The person didn't fulfil the condition of three unsuccessful attempts at other treatment.
- He or she didn't have the medical insurance.
- Before coming to prison, the person had been disqualified from the methadone therapy by the medical institution conducting methadone therapy externally.

As most of the prisoners are on remand, the medical center closest to the drug user's residence is informed that he or she should be included in the substitution programme, as well as the date of release if known. One central problem for remand prisoners is the possible transfer to other prisons as, at the time of visit, there were no other prisons providing substitution treatment.

The doctor in charge, Dr. Katarzyna Leśniak, concluded from the pilot project:

“My modest experience induces me to present the following conclusions:

- *methadone therapy in prison is really needed,*
- *its realisation is not too difficult for prison medical staff.*

I'm strongly convinced that clear conditions for participation in the programme are indispensable. I'm sure that some requirements for drug users such as abstinence and submitting to the other methods of therapy (e.g. workshops, psychotherapy) are necessary. I think that, in Polish conditions, participation in methadone programmes inside and outside prison should be regulated so that there wouldn't be obstacles for drug users to cross between centers. On the other hand, prison authorities should consider possibilities to form more centers of methadone therapy and to determine therapeutic

units which would also run methadone therapy. In conclusion, I'd like to say that, if proper regulations are introduced, prison may be a place where a drug user could stay not in a passive way but in an active way. It means to listen what's going on in himself or herself, to feel and to understand what had happened in his or her life and how to fight with addiction."

According to Marzena Ksel, Director of Medical Service, Central Board of Prison Service, prison doctors need to be more qualified and Governors' knowledge of and views about drug problems should be developed. According to Dr. Ksel, one of the key problems is the continuation of the methadone programme after release. One of the preparations for a better understanding of substitution treatment is a meeting with prison doctors in Torun, June 2004.

The role of the prison hospital in the enlargement of substitution programmes is crucial: It is well equipped, has lots of specialists and experience in detoxification at least. Difficulties are still experienced regarding the high thresholds for methadone maintenance treatment in the current regulation.

When introducing substitution treatment in prisons, giving prison doctors experience through visits to other prisons is also important.. This has been done in Canada with two doctors. There they could direct their questions and insecurities to the staff and prescribing doctors; they returned convinced of the benefits of substitution treatment.

According to Wojciech Rudalski, the following requirements have to be met by every prisoner:

- They should receive information that methadone is a drug.
- They should participate on a voluntary basis.
- They should abstain, absolutely, from all other drugs.
- They should have participated actively in a scientific examination.
- They should agree to be tested for other drug use.
- They should have received temporary counselling from a psychologist.

Meetings will be held with all relevant institutions (Institute for Neurology and Psychiatry, National Office for Drug Prevention) to get the approval for more prison-based programmes.

The Polish Prison Health Education Society is involved in training doctors (40) and envisages training for nurses in matters related to substitution treatment. NGO representatives will be involved in this training.

As the Director of the Kraków Montelupich fears a pull towards the programme – of large numbers of prisoners – the pilot is running without publicity or active recruitment.

The central medical department of the Polish Prison Service has given financial support for training conferences. NGO representatives will be involved in this training. With this first pilot, the specific problem with methadone maintenance is that the prisoners cannot be sent to other prisons or drug treatment institutions.

A close cooperation has been established with the Public Health Center for Drug Addicts in Kraków. The institution gave the green light to treat the prison programme's patients after their release. But, this is not an easy task, as the number of places in external programmes is limited, it is likely that there will be cases where a place for the continuation of a patient's treatment cannot be found externally.

At Rydygier hospital, in Kraków, 80 drug users are in a substitution programme. It is estimated that there are 4 000 drug injectors living in the region of Kraków. Most of these are in contact with MONAR (Chrostek-Maj and Kosecka, Rydygier Hospital, November 2003). The methadone maintenance programme in the community has been running for three years. It is a high threshold programme according to the regulations set by Polish law. When the programme was first set up it was not anticipated that some clients receiving methadone would end up in prison and so no links were made with prisons at this time. This changed after the programme had been running for a year when both doctors from Rydygier Hospital saw the need for a substitution programme in prison.

2.2.3 The views of prisoners

The focus group consisted of 4 male persons (one sentenced and three remand prisoners).

One of the key issues addressed was the fear that the substitution treatment pilot could be ended and that they would be brought down to zero in the prison setting. Though there are no plans to end the substitution treatment in prison (on the contrary, much energy is directed towards qualification and training to support the pilot in Montelupich), this is anticipated by prisoners with long sentences. The prisoners understood that substitution treatment is continued in prison when the sentence is not longer than 6 months. So, espe-

cially for those prisoners who are not yet sentenced, – and may get a sentence for more than 6 months – and are receiving methadone, this is a significant fear. This lack of information is contributing to the uncertainty of patients.

Detoxification from methadone is described as a big problem. The prisoners describe it as a central fear, for which they do not find any understanding from the other inmates. The prisoners want to maintain the same dosage as they received outside. It becomes obvious that the dosage, and feared attempts to reduce the dosage by the medical unit, is a key issue for the inmates. Unanimously, if they underwent detoxification in prison, they wanted to get into the methadone programme after release.

Offers of psycho-social care (group meeting mentioned above) are not known about by all inmates. The inmates express their feelings that, in the group meeting, there is a lack of understanding of methadone treatment and the goal that is pursued there is abstinence. When asked about their previous detoxification experiences, they all stated that detoxification happens in the cell.

3 Summing up

The combination of overcrowding and that the need for refurbishment impacts on the possibility of addressing the health needs of prisoners and the possibility of providing equivalent services to those found in the community.

In November 2003, at the time of the visit, the Polish prison system offered substitution treatment in one prison. This initiative is very rare due to the abstinence oriented approach towards drug treatment in Polish prisons, which is in line with most of European prisons. The main problem identified with the implementation of the substitution programme is the lack of a national strategy on the implementation of substitution programmes. If participants in these programmes are sent to other prisons in Poland, the continuation of the treatment is unlikely or impossible. This results in the fears and uncertainties of the patients interviewed in this programme, and perhaps the pilot itself.

But, the substitution programme is a good example for introducing, and developing, treatment in a setting which is not in favour of this form of treatment as it is well prepared with exchanges of information and expertise with other experts and community links.

The drug treatment programmes in both sample prisons were cooperating closely with community based treatment agencies where professionals from the community were involved in the counselling and support of the prisoners.

Portugal¹

1 General data: drug use, substitution treatment and prison population

1.1 Drug use

The most commonly used psychoactive substances are cannabis, heroin, cocaine, prescribed drugs, amphetamines, ecstasy and hallucinogens. (Reitox Portugal, 2002) Poly-drug use of heroin and cocaine, the use of cocaine is increasing and is reported to be the preferred substance, and also cannabis and amphetamines has risen in the past few years. Primary heroin users make up the majority of those searching for treatment. (Reitox Portugal, 2002)

Amongst the prison population, communicable diseases (particularly HIV/AIDS and hepatitis) are problematic. According to Fernandes (2003), 14% of Portuguese prisoners are infected with the HIV virus and 396 have AIDS.

It is estimated that there are 100 000² drug users in the country (all drugs included). In 2000/2002, 12 863 patients were receiving substitution treatment (EMCDDA, 2003, p. 50). On 31 December 2002, 15 768 patients were in substitution treatment, of which 10 157 were on methadone and 1 987 were on buprenorphine. The remaining patients received naltrexone. (IDT, 2004)

IDT estimates that between 25 and 42% of the total prison population in 2002 were drug users. 607 prisoners were on substitution treatment in 2002. In four prisons where treatment is managed by the Prison Service directly and not the CAT centre, 293 prisoners were on substitution treatment 253 prisoners, from 40 prisons, were treated with methadone in CAT's centres and 31 prisoners were treated with antagonists through a CAT's centre. (IDT, 2004)

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Dr. Maria Estrela da Graça de Pinho Campinos Poças, Director Health Care Office, Prison Service Administration, Ministry of Justice. A special thanks to Manuela dos Santos Pardal for her support and feedback.

2 Figure given in interview with IDT.

The treatment section (health care in prisons) falls under the jurisdiction of the National Prison Administration, Ministry of Justice, and the CAT centres, Ministry of Health.

1.2 Substitution treatment

Data comes from interviews³ and on-going review of research reports, websites and laws/ regulations.

1.2.1 *Historical and legal background*

Between 1975 and 1980, the phenomenon of drug dependency emerged. Initially, it was seen as an issue related to justice, the Ministry of Justice responded by creating some community centres, and then became a health issue with the Ministry of Health developing additional centres.

In 1990, these centres (belonging to the Ministry of Justice and the Ministry of Health) were integrated into a common service centre: the Service for the Prevention and Treatment of Drug dependence (SPTT) managed by the Ministry of Health. By 2002, across the whole country, there were 53 centres for drug users in the community. SPTT was responsible for the licence and management of these centres as well as for providing standard procedures to private centres.

The SPTT is the national authority on specialised treatments for drug use. Its organisational structure is broken down into Central Services, Regional Offices and Local Centres. The services provided are entirely free and accessible to all drug users who seek treatment. In 2001, as in previous years, the number of treatment units in the SPTT network increased. The treatment programme is tailored to each client's specific problem and the facilities/ services include: Specialised Treatment Centres (45); Consultation Units (16); Detoxification Units (5); Therapeutic Communities (2); Decentralised Consultation Units (3); Day Centres (4). (Reitox Portugal, 2002)

3 Interviews were conducted at the national level with:

- Health Service Director, General Directorate of Prison Services, Ministry of Justice.
- Deputy General Director, General Directorate of Prison Services, Ministry of Justice.
- Vice Director, IDT (Instituto da Droga e da Toxicodependência), Ministry of Health.
- Doctor, AIDS Commission Portugal for the area of 'Prevention of AIDS and Hepatitis in Prisons'.
- Doctor, CAT.
- Staff, CAT Taipas Centre.

After the 2002 general elections, the government stated that drug abuse was seen to be a health problem and so the focus should be on 'minimising the social problem'. The National Strategy and National Action Plan, Horizonte 2004, will continue. (Reitox Portugal, 2002)

Decree 120/2002 (3rd May 2002) ruled that issues surrounding drug demand and the National Institute for Drugs and Drug Addiction (IPDT) should be coordinated by the Ministry of Health. (The IPDT was previously located in the Council of Ministers). Decree 16-A/2002 (31st of May 2002) stated that the IPDT and SPTT should merge into a new agency: The Instituto da Droga e da Toxicodependência (IDT). The IDT was then created through the Government Decree n° 269-A/2002 (29 November 2002).

The IDT, created in 2002, manages the 45 CAT centres which are located in every province of the country. A CAT centre team is made up of a minimum of one GP or psychiatrist, a social worker, a social psychologist, an occupational therapist, and nurses. The largest of the CATs provide methadone treatment (Vice Director, IDT).

IDT is about treatment, prevention, harm reduction and reinsertion. It was reported that the number of CAT centres is adequate. However, better liaison with all health services is needed, especially due to infectious due to drug use. (Vice Director, IDT)

The Action Plan, Horizonte 2004, underlines the need for harm reduction programmes to be available for all drug users in prison. These programmes are managed by the General Directorate of Prisons (Ministry of Justice) in close co-operation with the IDT and the Institute for Social Rehabilitation. (Reitox Portugal, 2002)

The IDT's mission is to *'guarantee the intrinsic unity of the planning, conception, management, control and evaluation of the diverse phases of prevention, treatment and reinsertion in the domain of drugs and drug addiction, in the perspective of the best efficiency on the co-ordination and execution of the politics and strategies already defined'*. (Government Decree, n°269-A/2002, 29 November)

IDT's services are located:

- At central level: Department of Prevention; Department of Treatment, Harm Reduction and Reinsertion, Department of Planning and General Administration.
- At regional level: regional delegations.

- At local level: the specialised unities.

The IDT's tasks:

- To co-ordinate and conduct the national strategy for the fight against drug addiction;
- To promote, to plan, to coordinate, to manage and to evaluate programmes of prevention, treatment, harm reduction and social reinsertion, through community work, alone and in collaboration with public and private entities that work in this area;
- To promote, coordinate, support and evaluate public and private initiatives in the domain of drug prevention;
- To support The Commission for Drug Dissuasion, created by law 30/2000, 29 November 2000;
- To create, treat and spread information about drugs;
- To support the EMCDDA;
- To evaluate political policy and strategy on drugs and drug addiction;
- To support research;
- To support the training of personnel;
- To study legal measures;
- To give permission to private units of treatment;
- To collaborate with the general Directorate of Health to guarantee the continuity of care to users of IDT services.

(Government Decree n°269-A/2002, 29 November 2000)

In order to pursue these tasks the IDT is mandated to create liaisons with labour associations, universities, services of the Ministry of Health, Ministry of Social Security and Labour and also with public and private units that work on prevention and treatment. (Government Decree n°269-A/2002, 29 November 2000)

Because of the large number of individuals convicted for a drug-related crime, (approximately 3 930, 42%, of the total prison population by the end of 2001), the Drug Use Decriminalisation Law (n° 30/2000 of 29 November)⁴ was implemented and Commissions for the Dissuasion of Drug Use (CDTs) were created. Many drug users are referred to and assessed by these

4 On the definition of the penal regime applicable to the consumption of drugs and psychotropic substances, and on the social and health protection of people that use those substances without medical prescription.

Commissions (Reitox Portugal, 2002), with the result that some of them are sent for treatment or to therapeutic communities.

The national strategy⁵ states that substitution treatment should only be used as a last resource, when other treatments have not been successful or for the prevention of infectious diseases. It also states that substitution is not seen as a life-long treatment but rather as a means to find physical, psychological, social and family equilibrium and allow for further attempts to join drug free programmes.

In 2002, 91% of the 4 835 decisions made by the 18 CDTs were suspensions, as the consumers were not considered drug dependents, 25% were acceptances for treatment; 6% involved punishments, 5% were repeated incidences. The majority of them involved males aged 16-34 (IDT, 2004).

A protocol (Protocolo entre os Ministérios da Justiça e da Saúde, signed on 21 of March 1997) implements the liaison between the health system and the prison system in relation to substitution treatment. Doctors or psychologists of CAT go to the prison to deliver methadone or prisoners are taken to the CAT where they receive methadone and psychotherapy.

At the time of the field visit, prison reform was underway, resulting in a new 'Framework Law' establishing action to be taken for the next 10 years. Moreover, a new 'Law of Sentence Execution' was to be produced, drawing up a new model of health care in prison, including the Ministry of Justice's request for health care in prison to be provided by the Ministry of Health.

Substitution treatment in prison formed part of the political agenda; there were discussions on whether the number of prisoners on substitution treatment was appropriate or excessive, the type of treatment (pharmaceutical versus non-pharmaceutical treatment) to be provided and the need for stricter criteria governing access to substitution treatment (Director Health Care Office and Deputy General Director, Directorate General of Prison Services, Ministry of Justice).

5 A resolution of the Council of Ministers of the National Assembly, approved in May 1999, and published in the Official Journal of 26 of May 1999: Resolução do Conselho de Ministros n° 46/99.

In the community

Methadone has been offered in Portugal since the late 1970s. It was first delivered in a CAT centre in Porto, where it was offered in a powder solution which is drinkable once it is mixed with water. (GP, CAT centre and vice director, IDT) At the time, methadone was the only therapeutic response offered to drug users and was highly criticised by all clinicians. (GP, CAT centre)

In other locations, CAT centres started to offer methadone to tourists on methadone treatment and those on holiday in Portugal. The centres then started to offer methadone to problematic Portuguese patients and, eventually, it was provided to a larger sample of patients, numbering around 1000 patients on methadone in 1995. (GP, CAT centre)

Since the outset of methadone provision, the Ministry of Health has retained total control; any hospital or prison wishing to provide methadone treatment must make a request to the Ministry of Health. The Ministry of Health developed a protocol with the 'Association of Pharmacies' where (i) methadone is to be administered in pharmacy under a CAT prescription (the patient goes directly to the pharmacy to get methadone, instead of going every day to the CAT centre), and (ii) the Association of Pharmacies has developed a syrup to mix, stabilise and guarantee the quality of the medicine. (GP, CAT centre)

At the outset, methadone was industrially produced by military laboratories whereas, today, it is bought through international tenders. The powder is then sent to the military laboratory where it is prepared. The military distributes the methadone throughout the country and in all the CAT centres. This has increased the availability of methadone in the country. In 2002 around 13 000 patients in the Portuguese community were on methadone. The average dose is 60 mg; there is no maximal dose. The dose tends to be higher for patients on HIV/AIDS and/or tuberculosis treatments. (GP, CAT centre)

Today, methadone and buprenorphine are used for substitution treatment. Only CATs can prescribe methadone whereas buprenorphine can be prescribed by private doctors and CATs. Usually, the patient's family or friend is involved in the treatment to 'ensure' the uptake. LAAM was prescribed in CATs previously but this stopped in 2002 further to the National Medical Agency's decision. (Reitox Portugal, 2002)

Each patient on methadone is tested weekly for heroin, cocaine and methadone. If tested positive 3 times for illegal drugs, he is expelled from the methadone programme. (Social worker, CAT centre)

The Ministry of Health does not control buprenorphine which results in the situation where any GP has the right to prescribe it. Methadone is provided totally free for all patients, buprenorphine is not. Patients must buy buprenorphine at the pharmacy. Even if the treatment is partly reimbursed, it remains expensive. *'Buprenorphine is used more often in the CAT centres in the North part of Portugal. It all depends on the doctor's approach.'* (Health Service Director, General Directorate of Prison Services) The costs of methadone treatment are comprised of the number of staff and specialised centres involved. (GP, CAT centre)

In 2001, 12 863 patients of the SPTT were in substitution treatment (this does not include patients who take the substance at home): 3 576 were new admissions. The majority of clients on methadone received their treatment in a CAT. Health centres, pharmacies, NGOs and others also dispense methadone. Of those in treatment, 9 664 took methadone, 42 LAAM and 527 buprenorphine. (Reitox Portugal, 2002)

Substitution treatment is provided either according to a high or low threshold. The first aims at minimizing health risks and harm related to drug use by offering a broad treatment, including psycho-social therapy, and by trying to attain progressive detoxification and abstinence. The low threshold aims at street users not involved in treatment and tries to reduce harm due to drug use, as well as 'attracting' the user into a health care approach. (Reitox Portugal, 2002)

Methadone was detected in 5% of drug-related deaths in the community, mostly associated with alcohol and/or opiates, with a greater incidence among women. (Reitox Portugal, 2002)

Buprenorphine may be more appropriate for stable and balanced individuals (e.g. those who have a job), as the provision allows for greater autonomy from institutions. Whereas, methadone may be appropriate for more problematic, disorganised drug users and may be a means to bring them in to seek medical support as it provides stability. Patients who have the will and strength to stop the treatment may do so. As substitution treatment perpetuates a certain kind of 'dependency', to a substance and institution, alternatives to substitution treatment may be offered. Hence, substitution treatment

may be viewed as a first step, although other options and treatments with no opiates – such as therapeutic units – are needed. (GP, CAT centre) '*Substitution treatment is seen as a 'transitory' moment, but then other options must be offered.*' (Health Service Director, General Directorate of Prison Services)

1.2.2 Substitution treatment in prison

It was reported that substitution treatment first became available in prison around 1999.

Because substitution treatment is provided in prison with the support of a CAT centre (either directly, the CAT provides the treatment, or indirectly through liaison and continuation of care), the provision of substitution treatment in prisons follows the guidelines and system of substitution treatment in the community.

Substitution treatment in prison is available either in co-operation with a CAT centre or through the prison, the situation in 3 prisons in 2001 (Reitox Portugal, 2002). Usually, prisoners go to the CAT centre for the provision of methadone and to receive psychological support.

A GP reported that the prisons of Tires, Lisbon, and Oporto are the best examples of practice in Portugal, mainly because trained nurses (Ministry of Health) and experienced doctors are in charge of providing treatment to drug users. In the other prisons, protocols define the possible types of collaboration: drug users either go out to a CAT centre to get treatment, which gives them access to the whole range of services (psycho-social care) or a doctor from the CAT visits the prison to treat the prisoner.

Prisoners who receive substitution treatment are (i) drug users who continue methadone treatment started before incarceration in a CAT centre; (ii) drug users going through withdrawal: the prisoner is sent to a CAT centre for evaluation; if appropriate, the prisoner will start treatment; or (iii) drug users who started using while in prison and are motivated to stop using and have asked for support and substitution therapy. If accepted, the prisoner is sent to a CAT centre for evaluation (Vice Director, IDT).

At the time of the visit, all prisons had to collect methadone from a CAT centre, where they are given the appropriate doses for the number of patients, except for the three prisons, Tires, Porto and Lisbon, who manage the quantity and distribution of methadone themselves (Vice Director, IDT).

Upon request, the CAT centre confirms whether a given prisoner has undertaken methadone treatment and what dose they were prescribed. It was reported that the prisons are not reluctant to continue methadone treatment started in CAT centres. However, it may be more difficult for prisoners who wish to initiate the treatment in prison (Social worker, CAT Taipas centre).

The prison and the Ministry of Justice respect the CAT centre's decision. In most prisons, prisoners are sent to a CAT centre for medical consultation; the substitution treatment is then brought to the prison. If the prison doctor disagrees with the treatment provided by the CAT centre, but the prisoner has the right to have it, then a nurse will supervise that prisoner's treatment (Health Service Director, General Directorate of Prison Services). In prison, nurses deliver methadone to prisoners. This is not always the case, when there is a lack of staff, methadone may be delivered by guards (Vice director, IDT).

It was reported that the Prison Administration (and the prison) receives little or no feedback from CAT centres. *'The prison only helps to deliver the methadone but a better links, and cooperation should exist.'* (Health Service Director, General Directorate of Prison Services).

Although methadone and buprenorphine are both available in prison, only methadone is free. Prisoners who wish to receive buprenorphine need to pay for the treatment themselves. Often, it is the prisoner's family who pays for it (interviews with prisoners and professionals).

Substitution treatment takes place on a detoxification or maintenance basis. It can be initiated in prison but, largely, is a continuation of community treatment initiated prior to incarceration. Substitution treatment in prison varies widely from one prison to the other, depending on the CAT centre and/or prison doctors in charge of the treatment. It also varies for one prisoner to the other, as their personal path and individual needs are taken into consideration (interviews conducted with professionals).

A GP reported that, although substitution treatment is allowed in all prisons, in practice it is not offered everywhere. Out of 59 prisons, approximately 33 prisons offer treatment. Another GP at a CAT centre stated: *'At the level of ideas and principles, discussions are progressive and positive towards health treatment in prisons. However, practically nothing happens or very little development has taken place. It was possible to offer treatments similar to those offered out of prison, but practically it never took place ... Prisons*

could be used as a therapeutic centre, but for this more psychologists and doctors, staff who are properly trained, are needed'.

Psychosocial support and staff training

Ideally, psychosocial support should be provided to patients in substitution treatment. However, there is an obvious shortage of psycho-social staff in prison, as is illustrated in the two examples that follow.

Staff working in CAT centres are specialised in drug issues. Training is ongoing. Several courses for CAT health staff (and other services like private Therapeutic Communities) have been organised. *'CAT centre staff are all specialised on drug issues. It is their personal choice to work in this field. They have no specific university training but they get trained on the job; some do a specialisation in drugs after medical school.'* (Vice Director, IDT)

All guards receive 4 months training and are tested on health, infectious diseases and drugs issues. It is important that they have enough knowledge to be able to identify symptoms (Health Service Director, General Directorate of Prison Services).

1.3 Prison Population

As illustrated in Table 1, there is a high percentage of female detainees in Portugal (8.1%) and a general problem of overcrowding with the capacity of prisons being used at 121.8%.

Table 19 Data on the prison situation in Portugal (Source: King's College London, International Centre for Prison Studies, Prison Brief for Portugal)

Country	PORTUGAL
Ministry responsible	Ministry of Justice
Prison administration	General Directorate of Prisons (Direcção-Geral dos Serviços Prisionais)
Contact address	Travessa da Cruz do Torel, No. 1, 1150-122 LISBON Codex, Portugal
Telephone / fax / website	tel: +351 21 881 2200 fax: +351 21 885 3653 url: www.dgsp.mj.pt

Head of prison administration (and title)	Luis Miranda Pereira , Director General
Prison population total (including pre-trial detainees / remand prisoners)	14,060 at 1.9.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	134 based on an estimated national population of 10.46 million at September 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	29.2% (1.9.2003)
Female prisoners (percentage of prison population)	8.1% (1.5.2003)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	2.1% (1.9.2002 – under 18, Council of Europe Annual Penal Statistics)
Foreign prisoners (percentage of prison population)	12.0% (1.9.2002)
Number of establishments / institutions	59 (2003 – 20 central prisons, 35 regional prisons, 4 special prisons)
Official capacity of prison system	11,603 (1.5.2003)
Occupancy level (based on official capacity)	121.8% (1.5.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 9,183 (93) 1995 12,343 (124) 1998 14,598 (146) 2001 13,500 (131)

2 The Field visits⁶

Time frame. The field visit took place from 28 of January to 2 February 2004 included.

Location. Visits were conducted in two prisons: **Lisbon Prison** and **Tires Prison**.

2.1 Lisbon Prison⁷

2.1.1 Description of the prison

Lisbon Prison is located in the centre of Lisbon. It is a male, remand and sentenced prison, holding approximately 1 100 prisoners with a capacity for 840. It was reported that 70% of these prisoners have committed a drug-related crime.

The main building is made up of several wings: wing A is the Drugs Free Unit; cells in wings B and C are open all day; wing D holds more difficult cases; wing E only holds remand prisoners (approximately 300 prisoners); wing F holds remand prisoners with more serious cases, such as paedophiles and network criminals (a camera constantly examines each cell) and, finally, there is wing H, where prisoners are allowed to work in and outside of prison, but must sleep in the prison.

The prison has a therapeutic unit, located in a separate building. This unit has a capacity of 45 and houses prisoners between 17 and 32 years old who have applied for admission. No substitution treatment is offered in this unit which

6 *Methodology.* Interviews were conducted with the individuals listed below. An interview with one prisoner from the Drugs Free Unit and a focus group with 5 prisoners were also conducted. The tape-recorder was not used. The researcher conducted all interviews/focus groups on her own, accompanied by a freelance and neutral interpreter. All participants were briefed and told about ethical issues.

7 Data from interviews were those conducted with:

- Director Assistant and Director of the therapeutic unit.
- A guard at the therapeutic unit.
- The Director Assistant of the prison.
- A psychiatrist who also works with methadone patients.
- A psychologist.
- A male nurse.
- A psychiatrist who also works in the Drugs Free Unit.

focuses on discipline, psycho-social and rehabilitation activities, daily education, work and sports.

2.1.2 Goals and practical procedures

At the time of the visit, there were approximately 70 prisoners on methadone (and there is a waiting list) and 10 on buprenorphine (paid for by the prisoner's family).

It was reported that methadone is the main substitution substance provided and can be initiated in prison. This rarely happens with buprenorphine due to the costs incurred. Each prisoner embarking on substitution treatment (methadone and buprenorphine) must sign a contract. This includes a clear statement of the risks of topping up. Urine tests are taken and, if positive, the prisoner is expelled from the treatment (The psychiatrist).

The dosage of methadone varies on individual cases, with on average a dose smaller than 100 mg. The prisoner is not automatically told about the dose of his treatment, but he is informed if he asks. The doctor and prisoner will meet and talk about decreasing the dose, prior to the actual reduction taking place (The psychiatrist).

Many prisoners on a substitution treatment tend to have a dual-diagnosis, such as drug dependence and HIV/Aids, hepatitis or have had tuberculosis. The highest dose of methadone ever provided in this prison was 180mg for a difficult dual-diagnosis case (The psychiatrist).

The psychiatrist did not see discrimination against prisoners on methadone as, she said, they are seen as being cured and not using drugs anymore.

Although there is an estimated relapse rate of 50% with methadone (psychiatrist reported), the medical team reported that substitution treatment offers various key advantages:

- Continuation of treatment initiated outside.
- The reduction of the search, the obsession for drugs and thus a better mental focus of prisoners: drugs no longer are their main mental focus.
- Prisoners' stabilisation in prison.
- Change of attitude in prison.
- Reduction of conflicts, aggression (and thefts) between prisoners and better relation and sociability.
- Reduction of prisoners' debts.

Although the nurse saw no disadvantages of providing substitution treatment in prison, the psychiatrist reported side-effects such as decreased appetite, decreased general health status especially for prisoners with other diseases, such as HIV, hepatitis, etc., the possibility of topping up, the risk of overdose, physical dependence (and thus need for other medicine) and anxiety and insomnia when reducing methadone.

The psychiatrist stated that the best antagonist was naltrexone, as it prevents prisoners from using heroin and guarantees abstinence. But, this substance is expensive and, unless it is paid for by the prisoner's family, it is not offered.

Although the nurse said he saw no differences between methadone and buprenorphine, the psychiatrist stated that there were differences; buprenorphine did not have the side effects of methadone. It was reported that a psychiatrist chose to crush and dissolve the buprenorphine pill in water before giving it to the prisoner, to decrease any risks of misuse and trafficking.

In the morning, a nurse prepares the methadone in individual bottles, tagged with the cell number and each prisoner's name. Accompanied by a guard, the nurse goes to the different wings where prisoners on methadone are asked to queue in the main hall to receive their treatment. The prisoner must drink the methadone in front of the nurse. Previously, all prisoners on methadone were incarcerated in the same wing, which facilitated provision of the treatment. This situation has changed and a prisoner may be incarcerated in any wing (A nurse).

It was reported that, with the current system for the provision of methadone, medical confidentiality is not respected. *'There should be more confidentiality and respect of medical secret but it is almost impossible practically. It is difficult for security reasons to bring all prisoners on methadone outside of the wing.'* (A nurse)

The nurse reported an increased desire among prisoners to reduce methadone intake. However, he thinks that prisoners are often unaware of the risks related to ending methadone treatment too quickly and the risks of relapsing.

Psycho-social support and services offered in prison are limited due to lack of funds. The prison has only one psychologist working 4 days a week. The psychologist reported that substitution treatment offers prisoners stabilisation and the possibility to go to the Drugs Free Unit. However, the patient may develop physical dependence and go through withdrawal. The nurse and the psychologist reported that *'Methadone is not sufficient on its own. It is essen-*

tial to provide psychological support, as well as support from CAT centre when released.'

2.2 Tires Prison⁸

2.2.1 Description of the prison

Tires Prison is located approximately 40 minutes from Lisbon. Various buildings are set next to each other in a green and 'open' environment: the administrative area, wings, the drugs free units and the medical area.

This is a female prison, holding approximately 600 prisoners. By 31 December 2003, there were a total of 153 foreign prisoners (i.e. 21.8%), coming mainly from Latin America (mainly Brazil), Eastern Europe, Palop's countries, and Europe (31). The average age of prisoners is between 30-39 years old, the youngest being 16 and the eldest older than 60 years old (20 prisoners).

There is one remand wing (206 prisoners), 1 sentenced wing (214 prisoners), 1 wing for mothers (35 prisoners) with 3 babies who do not go to crèche, 1 Drugs Free Unit (20 prisoners), 1 creche with about 29 babies located just outside of the prison, 1 kitchen, 1 Administrative Department and 1 open wing (82 prisoners on an open regime). At the time of the visit, 1 wing was used by 80 male prisoners (part of their prison being in construction) (RAV: Regimo Aberto Virado o Interior).

The Deputy Governor provided statistics from the prisons' registered cases. By 31 December 2003, there were:

- 56 prisoners with HIV+
- 2 prisoners with Hepatitis B (vaccination has helped to reduce the incidence)
- 243 prisoners with Hepatitis C
- 128 prisoners with syphilis

8 Data from interviews were those conducted with:

- Deputy Governor
- Psychiatrist
- The nurse who delivers methadone
- A guard

At the time of the visit, there were 67 administrative staff (civil function, such as director, deputy director, psychologist, doctors, educators, admin, etc.), 123 female guards and 100 male guards. There are 2 psychiatrists (1 for general and 1 for drug users), 1 psychologist, 1 psychotherapist, 2 volunteer psychologists (only working in the Drugs Free Unit), nurses and GPs on contracts as well as 3 social workers working only on social reinsertion issues and belonging to a social workers' institution.

2.2.2 *Goals and practical procedures*

It was reported that 45% of female prisoners are drug users upon arrest and 64% have committed a drug-related crime (The Deputy Governor, internal prison statistics).

At the time of the visit, 16 prisoners were on methadone and 2 on naltrexone. Buprenorphine is rarely provided. The psychiatrist reported that the provision of buprenorphine is more difficult and requires extra staff to supervise the intake as the pill, which is of high value to prisoners as it can be sold, must be taken sub-lingually and takes approximately 10 minutes to melt. Methadone was first offered in this prison 6 years ago (1998). Previously, prisoners received antagonists such as naltrexone.

The psychiatrist from the CAT Taipas centre works with the Drugs Free unit and substitution treatment prisoners. He stated that, although the methadone dose tends to be higher outside, the lowest and safe threshold in prison is 30-40 mg. But the dose varies from one individual to the other. Prisoners are told about their dose unless they do not want to know. The Deputy Governor reported that the disadvantage of methadone is that the dose is low or insufficient, resulting in many prisoners topping up. The Deputy Governor stated that there have been occurrences of overdoses for this reason.

The reported advantages of methadone were improvement in health and well-being, stability and the guarantee of the quality of the drug (*'It is a pure drug, not mixed'* Deputy Governor). The psychiatrist added that substitution treatment works for some individuals and improves the individual's social life and psychological stability. However, the treatment may not work for others.

Methadone is distributed in the medical centre by the nurse. In order to respect confidentiality no guards are present. Prisoners drink their metha-

done with water and they often like to drink a glass of water afterwards to alleviate the taste of bitterness.

The psychiatrist explained that those on substitution treatment are tested for heroin, cocaine and methadone. Benzodiazepines and other drugs are not tested; this would require different and more expensive testing materials. Results from the tests are provided within the minute. If tested positive three times, the doctor will meet with the prisoner and, after discussing the reasons behind the topping up, he will evaluate whether the prisoner is motivated to continue the treatment or not. Accordingly, she is removed or kept on the treatment.

The deputy governor reported that, although there is good collaboration with the CAT Taipas centre (where prisoners are sent upon release), there is a lack of staff, especially psychologists, psychiatrists and social workers to develop socialisation, contact work and professional training. The prison only had one psychologist. No medical staff are present over the weekend, nor during the night on weekdays. However, medical support will be provided when needed: doctors are on call to come to the prison (The Deputy Governor).

2.3 The views of prisoners

Interviews were conducted with several prisoners, aged between 28 and 45, with a mean age of 37 years old:

- One male prisoner from the Drugs Free Unit who had finished methadone treatment
- Focus group with 5 male prisoners from different wings: all were on methadone
- Focus group with 9 female prisoners: 6 were on methadone, 2 were on naltrexone (1 had just finished the treatment), and 1 had finished buprenorphine (paid by her family) and was in the Drugs Free Unit.

There were no striking differences between male and female prisoners or among the prisoners in general. All prisoners reported that substitution treatment had helped them to stabilise and improve their health and mental status as well as to reduce or stop illicit drug use. The majority aimed towards stopping their treatment, as they wished to be ‘drug free’, free from the medical institution and care.

The methadone dose raised various issues: prisoners disagreed with the dose being unknown; whether they knew the dose or not, several prisoners felt they did not have the appropriate dose.

Prisoners reported that contracts were viewed positively: they reflected authority and made prisoners aware of what is and is not allowed; what is right and what is wrong. They also stated that they agreed with urine tests, which provides transparency and a minimum of control.

All prisoners claimed that psychological support is lacking, although the psychologist was seen as doing excellent work. Prisoners felt that they were provided with very little or no support, except from the medical consultation and treatment (and rare meetings with the psychologist). Although they acknowledged the lack of psycho-social staff in prison, they stated that the methadone treatment was insufficient on its own. Prisoners in the Drugs Free Unit reported receiving excellent support, including psycho-social support. They stated that the Drugs Free Unit is seen as 'the' privilege section in prison.

The only prisoner on buprenorphine chose that treatment rather than methadone because of the waiting list to get on methadone and because she had support from her family. She reported no side effects with the decrease and treatment. She said that because she (or her family) was paying for the treatment, she was determined to take it properly.

Although female prisoners did not report difficulties with prison guards, male prisoners felt that guards were discriminating against them, seeing methadone as 'just another drug' or using methadone as a means of control or pressure. Male prisoners also complained about the lack of confidentiality.

3 Summing up

Methadone is the main substance provided in prison in Portugal. The CAT centres are external centres, specialising in drug treatment, that play a key role in the provision of substitution treatment in and out of prisons, all over the country.

The prison administration, the medical staff and prisoners stated that methadone has a lot of advantages such as improving the health and psychological state of prisoners as well as the prison environment. However, psychological

support was reported as being largely insufficient, although the existing support was seen as excellent.

Only a few prisoners take buprenorphine; the treatment is expensive and must be personally paid for. Naltrexone was perceived as a 'substitution treatment' and seen as beneficial to those motivated to become drug free.

Prisoners requested more transparency and a clear structure in the provision of substitution treatment with less interference from the prison guards.

The general perception of substitution treatment is that it is a tool to reach better physical and mental health but that it is not an end in itself. On its own, substitution treatment is insufficient to achieve long-term rehabilitation and well-being.

United Kingdom: Scotland¹

The United Kingdom comprises two main Criminal Justice Systems: one is proper to Scotland, and the other covers England/Wales. The management of prisons and health in prison falls under the (Scottish) Home Office for Scotland, and under the (English/Welsh) Home Office for England and Wales.

England/Wales has been going through a restructuring of the provision of health care in prison, transferring its management from the Home Office to the Department of Health (Ministry of Health). This transfer is expected to last for several years.

This country report of the United Kingdom focuses on Scotland. No in-depth study or field visit were conducted in England/Wales, contrarily to Scotland.

1 General data: drug use, substitution treatment and prison population

1.1 Drug use

The most commonly used psychoactive substances are cannabis, followed by amphetamines, LSD, magic mushrooms, ecstasy, temazepan (and other prescribed drugs) and heroin (Reitox U.K., 2002). Cocaine use has recently increased (interviews with staff and prisoners). There was an estimate of 55,800 people misusing opiates or benzodiazepines in Scotland in 2000 (Hay et al, 2001). During the field visit, it was reported that heroin is the most problematic drug used in Scotland, and cocaine use is increasing, with some geographical differences. For instance, in the North part of Scotland (i.e. Aberdeen, Inverness, etc.) crack-cocaine tends to be the main problematic drug.

It is estimated that there are about 56,000 problem drug users in Scotland, almost 23,000 of whom are injecting (in 2002²) It is estimated that approxi-

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Karen Norrie, Addiction Advisor at the Scottish Prison Service, who also provided national, general information.

2 SPS: 'A comparative overview of the use of Narcotics and Drug Treatment Strategies in the Scottish Prison Service'.

mately 77% of the prison population tests positive for illegal substance on admission.³ (Scottish Prison Service, (SPS)⁴.

Approximately 700 prisoners are on a substitution treatment in prison.⁵

The treatment section (health care in prisons) falls under the jurisdiction of the Scottish Prison System, Home Office (equivalent to the Ministry of Justice).

1.2 Substitution treatment

Data comes from interviews⁶ and on-going review of research reports, websites and laws/ regulations.

1.2.1 Historical and legal background

The government policy document ‘Tackling Drugs in Scotland: Action in Partnership’ (2000) is the policy framework used to tackle drug misuse at both national and local levels (SPS).

In the community, methadone is used on a maintenance or detoxification basis. Buprenorphine has recently been licensed in Scotland for substitution

3 The Mandatory Drug Test upon entrance at the prison usually examines the presence of cannabis, benzodiazepines, methamphetamines, LSD, amphetamines, barbiturates, cocaine, temgesic.

4 The term ‘addiction’ is regularly used in Scotland to designate professionals specialised and working on dependence issues, such as ‘addiction worker/ officer’. By addiction, it is understood problems related to alcohol, drugs, all volatile substances and tobacco.

5 The Department of Health for England/Wales reported that in 2004 (a given day) in England/Wales there were approximately 140,000 patients on substitution treatment in the community, and about 57,893 of prisoners on substitution treatment in prison. A new clinical model for substitution treatment has recently been created for England/Wales and the two substances to be used are buprenorphine and methadone.

6 Interviews were conducted at the national level with:

- Addictions Advisor, SPS
- Mental Health Co-ordinator, SPS
- Principal of Psychologists, Psychological Services, SPS
- Addiction Co-ordinators, SPS
- Inclusion Manager, SPS
- Nursing Services Manager, SPS
- Acting Head of Health Care, SPS
- Manager of NEDAC, community centre
- Social worker, LINKS, residential house (focusing on detoxification).

treatment. Diamorphine may be prescribed as a maintenance treatment as an alternative to methadone (although this is rare) (Reitox U.K., 2002). Lofexidine, codeine-based substances and benzodiazepines are used for detoxification. Naltrexone is also offered for patients needing a treatment to remain drug free. (Reitox U.K., 2002)

During the field visit, it was reported that substitution treatment is understood as 'maintenance treatment', which is offered with methadone. Detoxification treatment is provided with methadone on a reduction basis or with other prescribed drugs. Buprenorphine (Subutex®) is allowed in prisons; however, it is practically only offered in the privately run prisons of Scotland.

The Nursing Service Manager of SPS stated that substitution treatment is seen as a medical treatment used to stabilise the individual but not as an end-goal. The stabilisation allows tackling the problem at its roots. SPS staff reported that substitution treatment is positive if it can be administered with all the support the patient requires and needs.

The Acting Head of Health Care of SPS reported that there is a disillusion about substitution treatment due to the lack of staff. Financial means have been deployed for assessment to the expense of staff. This results in community based centres being overwhelmed by needs and requests, and the continuity of care between prison and community being difficult.

1.2.2 Substitution treatment in prison

It was reported that substitution treatment is available in prison since 2003.

During the field visit, the Mental Health Co-ordinator of SPS stated that the major outbreak in 1992-93 of HIV/Aids and hepatitis in prisons played an important role in developing substitution treatment in prison. There was a lot of resistance in and out of prisons regarding the use of methadone as people did not feel comfortable about using it. At first, methadone was about the prison environment (being calmer and more stable) and not about the prisoner's health. Since 1995, health care matters much more than ever before in prisons. Since 1997 SPS puts the individual at the heart.

At the time of the field visit, it was stated that there were 700 prisoners on methadone. It was reported that the number increased from 100 to 700 with no added resources (only 1 addiction nurse in each prison). Buprenorphine is not provided in prisons except for those which are privately run in Scotland.

This is due to a generated misuse of the substance in 1995: the substance was crushed and injected. Currently, resistances focus on the price and time needed for the supervision of the sub-lingual intake.

The basis for the provision of substitution treatment in prison is underlined in the SPS Health Care Standard 10. Substitution treatment is offered in prison as (i) detoxification, (ii) stabilisation, and (iii) maintenance with methadone. Retoxification, lofexedine and naltrexone are also provided on individual basis.

Standard 10 of the SPS Standards for the Healthcare of Prisoners (Substitute and Detoxification Prescribing Guidelines) are applied in all prisons and are complemented – as far as possible - by therapeutic support (individual and group basis).

According to the SPS Health Care Standard 10:

- ‘If a prisoner has been on a treatment programme in the community, then they should be offered the opportunity of continuing this in prison.
- The prisoner should enter into an agreed contract prior to the initiation of a substitute/detoxification prescribing programme, a copy of which should be shared with the prisoner. An example of such a contract is given at Appendix 1.
- A detoxification programme will be made available to prisoners only following appropriate assessment.
- All drugs prescribed as part of a substitute/detoxification programme must be issued on a supervised, individual dose basis, within a safe and secure environment.
- Initiation of a Methadone prescription in prison should only occur when a full and comprehensive assessment identifies clear risk factors appropriate to the initiation of a Methadone script, where Methadone prescribing is part of a full and comprehensive treatment programme involving support and counselling. Example of such high risk situations would be pregnancy, or high risk of transmission of a blood borne viral infection (e.g. an individual who is known to be HIV or Hepatitis C positive). Initiation of Methadone must only be done in collaboration with the prison's addiction team, together with the prisoner's General Practitioner or relevant Community Drug Problem Service, as appropriate.
- Appropriate urine testing should accompany substitute/detoxification prescribing.

- While substitute/detoxification prescribing has an important part in helping prisoners deal with the problems of drug abuse they may have, it should in all cases be accompanied by the appropriate support, as outlined in SPS' Drug Strategy.'

(Source: the SPS Health Care Standard 10, SPS)

The SPS Health Care Standard 10 recommends the continuation of methadone (when the treatment was initiated in the community) taking into consideration the following:

- 'Urine should be tested prior to the prescribing of Methadone. Urinalysis should reveal the presence of Methadone.
- If urinalysis reveals the presence of any illegal or illicit drugs, or any medicines which have not been previously prescribed, appropriate assessment must take place prior to Methadone being continued. The decision to prescribe Methadone, however, remains with the Medical Officer.
- Clinical examination will include noting signs of recent injection sites. A body chart should be completed for future reference so that new sites may be positively identified. This information will inform the on-going assessment process.
- Written, usually facsimile, communication will be made with the community prescriber to confirm the dosage, compliance and, if necessary, willingness to continue prescription on liberation.
- The community prescriber's plans will be taken into account in planning a substitute prescribing programme in prison, e.g. the intention that Methadone be prescribed on a maintenance or reduction basis.
- If the appropriate assessment, examination, communication with community agencies and urinalysis are satisfactory, then Methadone may be prescribed.
- Methadone should be administered on a supervised daily dose basis.
- Urinalysis should be undertaken weekly, as a minimum, throughout the period of Methadone prescription, and the result recorded in the Health Care Record.
- If subsequent urinalysis is found to contain illicit substances, assessment must take place involving the Medical and Nursing staff, together with the addictions team, to determine whether Methadone should be continued or not, subject to the contract that the prisoner has signed.

- Prior to liberation, contact must be resumed with the community prescriber to confirm throughcare arrangements and the continuation of the Methadone prescription.’

The SPS Health Care Standard 10 recommends for pregnant women: ‘... *in order to avoid foetal harm, serious consideration is given to the continuance of Methadone prescribing in those women committed to prison who are being prescribed Methadone in the community.*’

(Source: the SPS Health Care Standard 10, SPS)

There is a contract to be signed by the prisoner engaging in a substitution and detoxification treatment.

Copy of a contract (Scottish Prison Service) (Source: SPS)

<p>SUBSTITUTE/DETOXIFICATION PRESCRIBING CONTRACT (to be filed in the Health Care Record)</p> <p>HM:</p> <p>Prisoner's Name: SPIN No:</p>	
<p>I agree to take my medicines in a supervised fashion, as prescribed.</p> <p>I agree not to misuse illicit or prescribed drugs while on a substitute/detoxification prescription.</p> <p>I agree to provide supervised urine samples, as requested.</p> <p>I understand that failure to adhere to any of the above will lead to my substitute/detoxification script being withdrawn.</p> <p>I understand that inappropriate behaviour towards health care and addictions staff involved in my treatment may result in my treatment being stopped.</p> <p>I understand that clinical prescribing may be reviewed and stopped if I do not participate in non-clinical support programmes.</p>	
<p>Signed: Date:</p> <p>Witnessed by: Date:</p>	

Detoxification prescribing is offered to problematic drug users and to individuals with (or likely to have) withdrawal symptoms during their first night in custody. The SPS Health Care Standard 10 recommends continuing assessment and multi-disciplinary support while on a detoxification programme.

Although methadone is used for detoxification, it is common to use other prescribed drugs such as lofexidine, dihydrocodeine continus, diazepam and zolpidem. The recommended prescription regime is the following:

a) Lofexidine and diazepam together

Lofexidine should be prescribed as follows:

- 3 tabs twice daily for 1 day;
- 6 tabs twice daily for 8 days;
- 4 tabs twice daily for 1 day;
- 3 tabs twice daily for 1 day;
- 2 tabs twice daily for 1 day; and
- then stop.

Diazepam should be prescribed as follows:

- 30 mgs once daily for 3 days;
- 20 mgs once daily for 6 days;
- 10 mgs once daily for 3 days; and
- then stop.

b) Dihydrocodeine continus, diazepam and zolpidem together

Dihydrocodeine Continus should be prescribed as follows:

- 120 mgs twice daily for 3 days (Days 1-3);
- 90 mgs twice daily for 3 days (Days 4-6);
- 60 mgs twice daily for 3 days (Days 7-9);
- 60 mgs once daily for 3 days (Days 10-12); and
- then stop.

Diazepam should be prescribed as follows:

- 30 mgs twice daily for 3 days (Days 1-3);
- 20 mgs twice daily for 3 days (Days 4-6);
- 15 mgs twice daily for 3 days (Days 7-9);
- 10 mgs twice daily for 3 days (Days 10-12);
- 5 mgs twice daily for 3 days (Days 13-15);
- 5 mgs once daily for 3 days (Days 16-18); and
- then stop.

Zolpidem should be prescribed as follows:

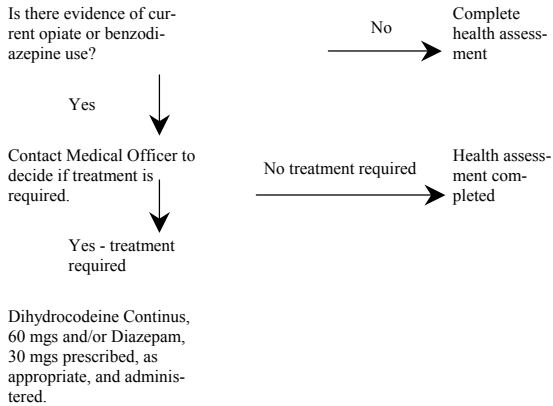
- 10 mgs at night for 6 days only (Days 13-18).

(Source: SPS)

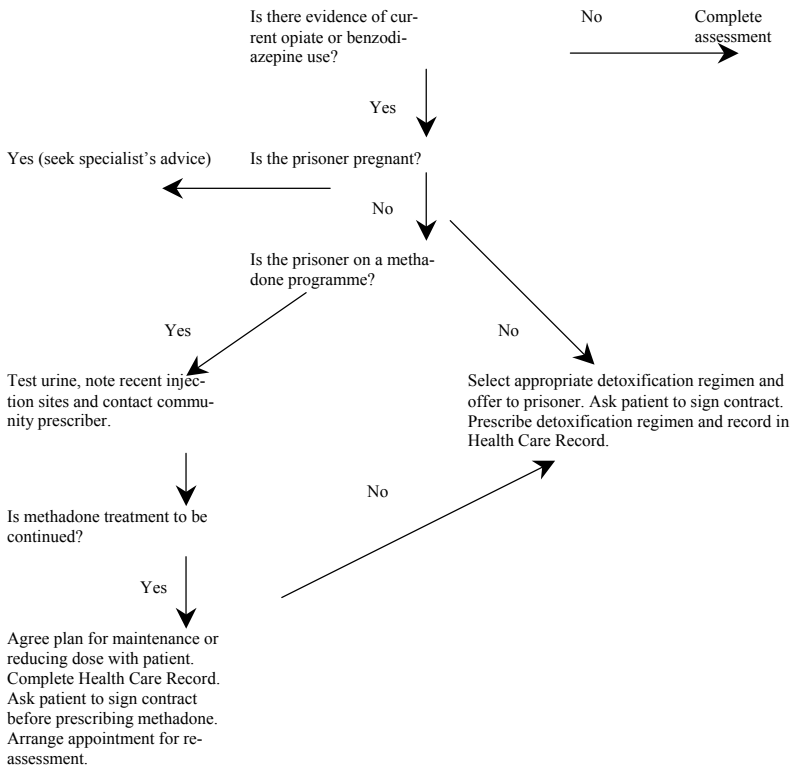
The SPS recommends a treatment pattern as part of its drug strategy.

Table 20 Treatment Algorithm of the SPS Drug Strategy: (Source: SPS) (next page)

RECEPTION NURSING ASSESSMENT



INITIAL MEDICAL ASSESSMENT



The Acting Head of Health Care stated that there are no restrictions on the doses of methadone. There used to be a limit of 60 mg as maximal dose with the original Health Care Standard 10 (1998). The new Health Care Standard 10 (2001) has no dose limit. Upon arrival at the prison the dose of methadone is reassessed. Many GPs are reluctant to continue to prescribe a dose over 100 mg. Usually prisoners receive higher doses in the community and get their dose decreased once in prison.

He further reported that bottles of 500 mg are delivered to prisons. Nurses pour directly from the bottle to the patient's cup and add syrup. The prisoner takes the methadone in front of the nurse and must then immediately drink a cup of water. Guards are involved when methadone is administered, resulting in some confidentiality problems since guards bring prisoners to the nurse area. Medically (and ideally) guards should not know about what treatment prisoners get. Confidentiality is an issue but not a problem as such. Prison officers should be regarded as part of the medical team since these officers stay on and look after prisoners in the evening and tend to be those on the spot when something happens.

Within the Prison Service methadone treatment is prescribed by a GP. Psychiatrists who work in prisons deal with severe mental health issues, not with substitution treatment or addictions. Addictions nurses have been specifically trained on drugs issues to offer service and support in prisons.

Addiction team and psychosocial support

The Principal of Psychologists at SPS reported that 45 psychologists from SPS cover the 15 public prisons in Scotland, which means there is a lack of staff. Psychologists focus on offending behaviour and the reduction of re-offending and risk reports. Every prison has one psychologist trained in CBT (Cognitive Behavioural Therapy), which is not specific for addiction but for all types of prisoners. Although psychologists have a role to play with addictions, they do not get involved in substitution treatment and rather deal with psychological impact of drug use, anger management, etc. 'Addiction' is not psychologists' main focus as many other people work in this area.

'Addiction services' are provided, increasing the number of people in prison accessing such services (to over 6,500 in 2003). The implementation of new contracted 'addiction services', who provide casework and transitional care

post- release support, as well as SPS staff⁷ and other partners carrying work on dependence, have been recently introduced in the Scottish prisons and have played a major role in increasing the number of prisoners consulting ‘addiction services’.⁸ (SPS)

1.3 Prison Population

Table 21 *Data on the prison situation in Scotland (Source: King’s College London, International Centre for Prison Studies, Prison Brief for Scotland).*

Country	United Kingdom: SCOTLAND
Ministry responsible	Scottish Executive
Prison administration	Scottish Prison Service
Contact address	Calton House, 5 Redheughs Rigg, GB-Edinburgh EH12 9HW
Telephone / fax / website	tel: +44 131 244 8522 fax: +44 131 244 8738 url: www.sps.gov.uk
Head of prison administration (and title)	Tony Cameron, Chief Executive
Prison population total (including pre-trial detainees / remand prisoners)	6,803 at 20.2.2004 (national prison administration)
Prison population rate (per 100,000 of national population)	133 based on an estimated national population of 5.1 million at February 2004 (from Office for National Statistics figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	16.2% (20.2.2004)

7 SPS staff such as the inclusion manager and workers, inclusion being about addictions, social care, learning skills and employment.

8 During the field visit, it was reported by the Addiction Advisor that all prisoners are offered an addiction assessment upon arrival at the prison and are then referred to Cranstoun Drug Services (CDS) workers who conduct a CAT (care and throughcare). The assessment focuses on 5 domains: health, work, financial issues, housing and education. CDS provides one-to-one motivation work, shares information on social, health and psychological issues of prisoners, and works with centres located in the community. Before release, CDS liaises with transitional care team.

Female prisoners (percentage of prison population)	4.6% (20.2.2004)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	2.8% (1.9.2002 – under 18, Council of Europe Annual Penal Statistics)
Foreign prisoners (percentage of prison population)	1.2% (1.9.2002)
Number of establishments / institutions	16 (2004)
Official capacity of prison system	6,135 (20.2.2004)
Occupancy level (based on official capacity)	110.9% (20.2.2004)
Recent prison population trend (year, prison population total, prison population rate)	1992 5,357 (104) 1995 5,657 (110) 1998 6,082 (119) 2001 6,172 (122)

In 2003, there were 62,000 to 67,000 prisoners for a capacity of 6,500. (Scottish Prison Service)

2 The Field visits⁹

Time frame. The field visit took place from 9 to 12 December 2003 included.

Location. Visits were conducted in two prisons: **HMP Shotts** and **HMP Cornton Vale**.



Map of Scotland

⁹ *Methodology.* Interviews were conducted with the individuals listed below. Three focus groups were also conducted with prisoners. The tape-recorder was used with two focus groups. The researcher conducted all interviews/focus groups on her own. All participants were briefed and told about ethical issues.

2.1 HMP Shotts¹⁰

2.1.1 *Description of the prison*

HMP Shotts is located approximately 30 minutes drive southwest of Edinburgh. It is a maximum-security prison for male adults who have a sentence of over 4 years.

At the time of the field visit, there were 516 prisoners (the actual prison capacity, the deputy governor stated). 160 out of the 516 prisoners are lifers (i.e. on a life sentence).

It was reported that usually, prisoners first go to a local prison and are then transferred according to their sentence. Prisoners are transferred to a less secure prison before being released, unless they fail to meet the criteria for transfer and are kept at HMP Shotts until the end of their sentence when they are released straight into the community.

2.1.2 *Goals and practical procedures*

At the time of the field visit, the prison counted 60 prisoners on methadone, of which 4 were doing a one month detoxification programme on methadone (the Health Centre Manager stated). The Clinical Manager stated that there is a lack of follow-up for methadone detoxification programme once the programme is finished, which limits its success.

The medical team follows protocols for the provision of substitution treatment. It was stated that in the prison:

- (i) methadone is offered as long-term detoxification (over 1 year) with the goal of reducing, or as a short-term detoxification over 33 days,¹¹

10 Data from interviews come from those conducted with:

- Deputy Governor
 - Health Centre Manager
 - Clinical Manager
 - Head of Activities
 - Inclusions Manager
 - Senior Addiction Worker
 - Addiction Co-ordinator
 - Addiction Officers
 - Addiction Administrator
 - A guard
- Service Manager Cranstoun Drug Services.

- (ii) prescribed medication, such as lofexidine, dihydrocodeine¹² continus, diazepam, zolpidem, are provided for short detoxification¹³,
- (iii) naltrexone is provided for short to long term detoxification and abstinence,
- (iv) methadone is offered within a retoxification programme for ‘to be released’ prisoners, approximately 12 weeks prior to release, who present health risks (such as relapsing or overdoses), on the condition that the treatment can be continued in the community. The Clinical Manager stated that with retoxification prisoners feel they have better changes to get over their drug habits. Retoxification is used to reduce death rate upon release as well as prisoners’ anxiety, which tends to be high on release. Addiction officers opposed to retoxification believe providing only a medical treatment is not the solution and other aspects must also be treated.

The Health Centre Manager stated that it is important to be able to offer a range of different approaches to meet individual needs.

It was reported that the methadone programme is successful and is individually based. Among other things, methadone has permitted drug-using prisoner to re-establish communication and a relationship with their families, and has boosted their self-esteem.

The Health Centre Manager stated that the methadone is ‘risky’ if the prisoner tops up, although topping up may be due to insufficient doses. Professionals may question the purpose of providing methadone: does methadone maintain the dependence or is it really treating it? Whatever the answer, if any, the advantages with methadone is that prisoners feel they receive proper treatment as ‘equivalent’ to that offered in the community. The contract

11 The Clinical Manager said that *‘if the prisoner used drugs for a long time, methadone is better taken over a long time. If some prisoners are always going to be using drugs, especially those who are dual-diagnosis, it is probably better to have them on methadone rather than on IV heroin’*.

12 Dehydrocodeine is an opiate based pain killer and is usually given for pain. It does not tackle the addiction itself and is not licensed for detoxification, as stated by the Health Centre Manager.

13 The Clinical Manager stated that DF (dehydrocodeine and valium) is not often used but is with prisoners coming off methadone quickly or to prevent withdrawals. Lofexidine is offered as a detoxification over 12 days. Sleeping tablets are also provided when prisoner is off lofexidine.

underlines the risks methadone presents and is about prisoners and practitioners' safety.

The Clinical Manager stated that the prison counts two GPs: one for drug issues and the other for somatic health issues. At the time of the field visit, the former had been working at the prison for 3 months, occupying a post in prison for the first time. Although he prescribes the medical treatment, he works with the whole team and after discussion/ meeting, decides on the treatment.

The doctor decides on the dose – which is on average 50 to 60 mg and less than that offered in the community – and programme and discusses his/her decision with the addiction and medical team and the addiction team. The latter has access to the assessment file (conducted by the caseworkers) but not to the medical file. The number of new entrant prisoners who started methadone in the community has increased. The prison staff reported that waiting lists for methadone treatment within the prison are long and frustrating for them. They are a consequence of a lack of staff resources and a success of methadone programme in the community.

The prison must respect quotas for the number of prisoners on a methadone programme in order to assure deliverance of proper support and supervision. The prison staff stated that at present there is nothing they can do to alter this situation.

The clinical manager stated that the provision of methadone takes place under the supervision of one competent member of staff (an Addiction worker) and a nurse. 7 to 8 prisoners can be brought at once to the medical centre for methadone treatment. Providing there are 60 prisoners on such treatment, this provision requires time every day.

Prisoners on methadone who test positive on MDT, will get a yellow 'warning' card on the first occurrence. On the second positive MDT, the prisoner is expelled from the methadone programme, even though the medical team tries to discuss and understand the triggers to this drug use.

Other medication, such as lofexidine (as mentioned here above), is prescribed for detoxification, although prisoners' preferred medication is methadone. Naltrexone, offered indefinitely after 2 weeks of being drugs free (supported by 2 drugs tests), is abstinence-oriented. It is not very popular amongst prisoners, but at the time of the field visit, 4 prisoners were on a

naltrexone treatment. The Health Centre Manager said that '*naltrexone is a real test to see whether prisoners are really motivated to stop using drugs*'.

Psychosocial support and staff training

The Addiction team offers a therapeutic approach and provide motivational skills, explaining how to reach progress and better-well being, building prisoners' self-esteem, trying to change labels of 'drug users', etc. They have received training on drugs: (i) STRADA certificate, (ii) training on counselling, (iii) training on HIV-AIDS, harm reduction, tolerance, motivational interview, training trainers, bereavement, etc. These officers have also learned from prisoners themselves.

Addiction officers reported that it was difficult to see prisoners on a one-to-one basis because of the lack of free spaces, sometimes having to see a prisoner in the hall (which is prevents confidentiality) or in his cell (which is unsafe) with one foot holding the door open.

Prison staff reported that support for one another is lacking. They stated that relying on peer-support was insufficient, contrarily to the counselling supervision they previously received. Nurses were satisfied with the support and training they receive as they are entitled to clinical governance, i.e. support and supervision from nurses, psychologists and doctors.

Prison staff claimed that training on substitution treatment, methadone and detoxification has been minimal. Further training has not been provided although officers have asked for it.

The Clinical Manager reported that there is no support or supervision offered to Addiction officers, even though it is needed and this must be acknowledged at the managerial level.

The physical and mental health team and the Addiction officers are meant to work together. The former treats anxiety, depression, chronic and dual-diagnosis; whereas, the latter works specifically on addictions (drugs and alcohol). Both teams occupy the same area in the prison, which – it was reported – strengthens the links and teamwork and facilitates exchange of information as both teams work towards reaching the same goal.

2.2 HMP Cornton Vale¹⁴

2.2.1 *Description of the prison*

HMP Cornton Vale is located nearby Stirling (approximately one hour drive northwest of Edinburgh). This is a female prison, holding at the time of the field visit approximately 240 prisoners, on remand and sentenced, aged 16 to 70. This is the only prison in Scotland only for female prisoners. Three male prisons have wings or accommodation lots for female prisoners.

The Deputy Governor reported that on MDT most of these women (95%) are tested positive. 75% of them inject. The first drug used tends to be heroin, followed by cannabis; crack-cocaine is used but to a lesser extent and benzo-diazepines, especially Valium®. She further stated that 80% of these female prisoners had been sexually abused. Most of them have experienced very little or no recognition and awards, and very basic education and lack basic skills, such as cooking, parental skills, etc.

2.2.2 *Goals and practical procedures*

At the time of the field visit, there were 40 prisoners on methadone on an average dose of 50-60 mg, usually initiated at 10mg, with a maximum dose of 120 mg. Generally, a lower 'initial' dose is provided in prison than outside with a gradual increase. The GP in charge of substitution treatment stated that there was no medical evidence to go beyond this limit.

Methadone is provided in a liquid lotion and arrives at the prison already prepared.

14 Data come from interviews conducted with:

- Deputy Governor and Head of Opportunity & Social Inclusion
- Head of Health Care Unit
- Supervisor and head of nurses (Clinical Manager)
- Doctor (GP)
- Addiction Nurse
- Social worker and senior practitioner
- Team Leader, Cranstoun Drug Services
- Case workers, Cranstoun Drug Services.

The GP stated that methadone is provided:

- (i) As a continuity of a treatment offered in the community.
- (ii) As initiated in prison if there is a follow-up in the community upon release (the doctor must contact various services in the community to assure continuation once released).
- (iii) As detoxification especially if the prisoner keeps on using drugs (detoxification with methadone is avoided for those injecting heroin).
- (iv) As retoxification prior to release, although prisoners tend to stay in the community for a short time coming back to prison quickly.

Other types of medicine are also provided, such as DHC and valium for heroin users for 12 days, diazepam for cocaine users (18 days programme), naltrexone. Although buprenorphine is available, the GP said that there were no 'candidates' for it. Buprenorphine is safer than methadone as fatal overdose is rare. However, the prediction, he stated, is that an increase demand in the community will generate a higher demand in prison.

The Addiction nurse is in charge of any new prisoner with drug issues and who wants to address them, as well as to assess the prisoner's needs, to look at how she wants to approach and tackle the issue. He works closely with the Addiction Team and they share information.

Even though the GP prescribes the methadone, the Addiction Nurse reports to the doctor on whether methadone is a suitable treatment for the individual according to the assessment. The assessment and case of the prisoner is discussed between the GP and the nurse. The Addiction nurse reported that HMP Cornton Vale was based on an individual approach compared to other prisons. Medical is seen as a medical treatment but the prisoner's understanding of methadone needs to be evaluated, as well as her willingness to look at psychological issues and engage with the Addiction team. He further stated that the challenge of methadone treatment is not about the lack of resources but rather is situated on an operational issue. The high increase of drug users on methadone in the community means there is an increase of prisoners on methadone in prison.

The Addiction nurse stated that retoxification has decreased the number of deaths and recidivism on release. He says that '*it is difficult to change the behaviour. It is more realistic to change the risks*'.

It was reported that at night, there no longer is a night nurse. Although the nurse stays at the prison until midnight, there are first-aid trained staff and a night duty manager in charge during the night. The doctor can also be called if necessary. Prisoners tend to arrive at the prison in the evening. The nurse conducts the MDT and medical assessment, also covering drug issues. Medicine is provided, if needed, according to the doctor's general advice. If no medicine is provided to the prisoner, she is more likely to commit suicide. Therefore, the medical team prefers to give some medicine, even in the GP's absence. On the first morning at the prison, the prisoner visits the GP. The GP stated that he feels he can cover (and do a good job) with the whole 250 prisoners.

The Head of Health Care Unit stated that methadone offers a means to 'put the prisoner back together' as she arrives at the prison in a 'shocking state'. Very little can be done for a prisoner who is in prison for less than 6 months. However, access to health service in prison is available to all drug-using prisoners, often contrarily to outside. The disadvantage of methadone is increased pressure from some prisoners asking those on methadone to do drug dealing with the medicine they receive. This is especially the case with methadone where a tampon is placed in their mouth (i.e. called 'spitting methadone'). Some of these prisoners are vulnerable people, whereas others are drug dealers.

A social worker stated that substitution treatment is seen as fulfilling individual needs. Most prisoners have a problematic drug-use and have committed a drug-related crime. Upon arrival at the prison prisoners ask for medicine to help with withdrawal symptoms. Methadone has a bad press and many prisoners have heard about difficult withdrawal effects from it. However, if they tend to ask for methadone to continue the programme started in the community or to start a new treatment in prison. Prisoners often want to stay clean even though it is difficult and often unrealistic. Prisoners tend to ask for retoxification with methadone. Some also ask for naltrexone but it is uncertain whether they are really ready to use it safely, as, the social worker stated, it is usually very difficult for women to abstain from drugs.

A social worker claimed that

- Substitution treatment is too focused on medical protocols, and thus tends to put all prisoners in the 'same basket'. It does not cover social and individual needs.

- Concerns have been expressed regarding some prisoners being ‘encouraged’ to have positive drug tests to be able to receive methadone treatment.
- The Health Care Centre (1 Addiction Nurse and 1 Addiction doctor) is well under-resourced.
- There is a need for more work on a one-to-one basis.
- Although prisoners are encouraged to engage in different programmes, resources (availability and time) are lacking.

The Deputy Governor stated that although substitution (medical) treatment helps, it is important and needed to tackle the root, the source of drug use. Social issues, such as parental, education, self-esteem, environment these female prisoners were brought up in need to be tackled.

Psychosocial support and staff training

Psychosocial support to prisoners are provided like at HMP Shotts, through the Addiction teams and caseworkers (Cranstoun Drug Services).

The staff did not express any complaints about a lack of support or training. They felt well trained on substitution treatment and ‘addiction’ issues.

2.3 The views of prisoners

Interviews were conducted with several prisoners:

- One focus group with 5 female prisoners (age 29 to 32, mean: 32) – HMP Cornton Vale
- One focus group with 5 male prisoners – HMP Shotts
- One focus group with 4 male prisoners (age 25 to 32, mean: 29) – HMP Shotts

There were no striking differences between male and female prisoners or among the prisoners in general. Most prisoners mentioned methadone when talking about substitution treatment; buprenorphine was said not to be offered much in prison.

All prisoners said that the situation in prison (health care and other support) is a lot better today than it was 4-5 years ago. All feel proper medical treatment was provided at the prison. However, prisoners reported there were long waiting lists to get on a substitution treatment and to see a doctor. Equivalence of care between the community and prison was said to be lacking in the type of and access to substitution treatment.

Access to substitution treatment

'I have been waiting for methadone for the past 11 months. I've been on a waiting list.'

'You have to be off it. You got to want to be rid of it yourself. They have to let me detox when I want to, not f... 10 months later when they decide I can.'

'We tell them we need help, and they put us on a waiting list for several months, which means that our problems are getting worse. We should be getting the help, not the waiting.'

'There are 500 in this jail, and there are 300 prisoners who have a drug habit, who should get the help they need. Instead, they are on a waiting list.'

'I think it's just a numbers game. It's just my opinion, if there's 50 guys on it, it doesn't matter if somebody next door to you is dying because he's using too much drugs, someone else has to come off it before he can get on it.'

'One needs to keep on pushing and asking for medical treatment. Asking just once is not enough in prison.'

'It's hard to see the doctor, but it is easy to see the nurses. It is also difficult to see specialists (such as dentists ...).'

'I went to a doctor outside, and said to this doctor, 'I've got a heroin problem. I need help. I need methadone.' He'd say 'Give me a urine sample'. If the urine sample is positive, I'd start me on methadone. In here [prison], I wait a lot of months, and I don't get help. There's the waiting list for methadone. I mean, methadone isn't everybody's thing, maybe some guys want Subutex®, that was an offer in a private prison, but it's not offered in many other prisons.'

Prisoners felt there was a lack of resources to provide methadone treatment.

'Only 25% of the guys are on methadone, and they're so reluctant to go over 25%. I don't know why, maybe they can't afford it. (...) They are short staffed. We have to get it [methadone] at half 8 in the morning because they've not got the staff. They take us to the hall to get it.'

'See, the drug workers, the addiction team, every one of them says the same thing: 'Oh, if I could get you on methadone, I'd put you on methadone. If I had the resources, I'd have put you on it months ago.' But they just don't get the resources. Their hands are tied.'

Although methadone is feared by some prisoners and doctors, prisoners also stated that methadone stabilises the person and allows him/her to get his/her life sorted and to go on with life.

'I am actually scared of methadone because I did an overdose with methadone once. I will not top up anymore because of my previous experience. Apart from this fear, I feel that I am fine with methadone and that the treatment suits my needs.'

'Some doctors prefer to stop methadone in order to save lives and avoid overdose and to give more stability.'

Methadone is mainly provided as a detoxification treatment, short term, or as a retoxification treatment (prior to release) on a long-term maintenance treatment. Some prisoners felt that methadone should also be provided on a long-term basis.

'They avoid the long term, because some guys don't want to be on it long term. That's good. (...) They'll retox you, that's the only way you can maintain, they'll put you on it and reduce you.'

'They give you retoxification a month before you get out. That stabilises you if you're using drugs, so you don't over do it.'

'I've got to go to retox for three months before I get out. They'll hold me up with methadone for the last three months so as I got a habit when I get out. I don't agree with it because I'll never kick smack without it, but I'm going to do it.'

'Methadone is not for short term. Methadone's long term.'

Prisoners stated they felt unease with the lack of confidentiality regarding treatment, although they said it did not cause a big problem to them.

'I overheard nurses talking about the case of such and such person in front of prisoners. There is no private or confidentiality in prison.'

'It shouldn't be broadcasted. It happens that they yell 'it's time for your methadone' in front of 140 people. It should be the same as in the health centre. (...) It doesn't help, but it's not a problem here, really.'

It was clear to prisoners that if they fail the mandatory drug test (MDT), they are removed from methadone treatment.

'I've been on a detox before and got kicked off it, for failing my drug test. (...) That's an agreement, you sign a piece of paper saying that if you fail a drug test while you're on it, you'll be taken off it. So I failed that drug test.'

'Previously I was tested positive on MDT. I was removed of any treatment and did not sleep for 36 nights. This time I have been in prison for 4 weeks. I received methadone on my first day. I was tested positive for heroin and methadone on MDT upon arrival at the prison because I had just started methadone treatment when I was arrested. Once in prison I was immediately put on methadone treatment.'

3 Summing up

Methadone is the main substance of substitution treatment provided in prison in Scotland. Although under SPS Health Care Standard 10 (1998), methadone was mainly offered on a detoxification basis or maintenance basis for those who started the treatment prior to incarceration, this trend has changed since SPS Health Care Standard 10 (2001) with an increase in the provision of methadone maintenance treatment.

Other medication, such as lofexidine, dihydrocodeine continus, diazepam, zolpidem, and naltrexone, is used in prison for detoxification. Retoxification is also offered to prisoners approximately 12 weeks prior to release as a harm reduction measure and to decrease the number of overdoses and relapses on release. Prisoners' feelings on 'retoxification' were mixed, not clearly satisfied about this option.

Upon entry to prison, drug testing is compulsory for all new entrants and various assessments (medical, social, psychological and specifically on drug use) are conducted. Specialised staff (addiction workers and caseworkers) provide rehabilitation programmes, care and throughcare to drug-using prisoners. Addiction workers and nurses are key actors in the treatment of drug-using officers and as assistant to the GP, who often has very little time for each prisoner and has a more limited knowledge of each prisoner (compared to Addiction Officers or caseworkers).

Even though there is structure and staff (from the SPS and from external organisations) in prison for drug-using prisoners, staff reported that too much time is spent on administrative activities and on assessments (often duplicated), and that there is a lack of resources, especially facing prisoners' high demand for substitution treatment due to the 'success' of the treatment in the

community. This results in prisoners being put on a waiting list for substitution treatment.

Prisoners on a waiting list stated they were not satisfied with the whole health service offered in prison. They expressed a certain 'disliking' of the Addiction staff, as they do not accept the long waiting list and procedure. However, when global therapeutic structure was offered, prisoners expressed satisfaction towards the functioning of the prison system and substitution treatment. Female prisoners tended to be satisfied, whereas men tended to be unpleased as most of them said they had been on a waiting list for substitution treatment for months.

Slovenia¹

1 General data: drug use, substitution treatment and prison population

1.1 Drug use

Although, according to doctors' reports, alcohol is a bigger problem than any other drug, the most commonly used psychoactive substances are cannabis, sedatives, ecstasy, alcohol, benzos, LSD, cocaine, heroin and amphetamines. (Lovrecic, 2004)

The number of drug users in Slovenia is estimated to be 15-18 500 people, of which approximately 6000 are intravenous drug users. (Reitox Slovenia, 2002)

In 2003, the number of drug users on methadone substitution treatment was approximately 1800 (The Newsletter of the International Harm Reduction Development Program of the Open Society Institute, 2003, p. 15). On 31 January 2004, there were 1927 patients. (Head of the Centre for Treatment of Drug Addiction, Slovenia)

In 2002, the number of drug users in prisons was estimated at 13% of the total prison population (N=703 out of 5219 prisoners)² (Government Adviser, Head of the Treatment Department at the Prison Administration) The majority were connected with heroin³ (Hren et al, 2004) At the time of the visit, the number of drug users on substitution treatment was 222. (Government adviser, head of the treatment department at the Prison Administration)

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Joze Hren, from The Government Office for Drugs, who, with Borut Bah (Stigma Association), also provided national, general information and support with the finalisation of this country report.

2 Statistics provided by the National Prison Administration.

3 A study reported that the majority of prisoners who had committed a drug-related offence were mainly connected to heroin. Other drugs (cocaine, stimulants, hallucinogens, cannabis) were less connected or were topped up with heroin. (Hren et al, 2004)

According to Lovrecic (2004), the national prevalence of:

- HIV/AIDS is less than 5% in the general population and, among drug users, less than 1 per million with HIV and 0.5 per million with AIDS.
- TB is 21.3 per 100,000 population (N=423).
- 23.5% of injecting drug users are being treated for Hepatitis C.

The treatment section (health care in prisons) is part of the responsibilities of the National Prison Administration (Ministry of Justice).

1.2 Substitution treatment

Data comes from an on-going review of research reports, websites and laws/regulations, as well as from interviews conducted during the field visit⁴.

1.2.1 Historical and legal background

The Ministry of Health is responsible for the planning and implementation of health care and substitution treatment. In 1994, national guidelines for methadone treatment were adopted by the Health Council. These guidelines, updated in 2000, provide recommendations for the identification of drug use, diagnostic methods, harm reduction strategy, methadone maintenance programmes⁵, and therapy offered in centres and hospitals. First established in

4 Interviews conducted at the national level with:

- The Director General of the Prison Service.
- National Prison Administration, Ministry of Justice.
- Communication and International Affairs, National Prison Administration, Ministry of Justice.
- Advisor to the Government, in charge of the health-treatment group working in prisons, National Prison Administration, Ministry of Justice.
- The Head of Psychologists, National Prison Administration, Ministry of Justice.
- The Head of Pedagogues, National Prison Administration, Ministry of Justice.
- A psychiatrist, The National Centre for Treatment of Drug Addiction.
- The psychiatrist and M.D. Head, The National Centre for Treatment of Drug Addiction.
- Advisor to the Minister, Ministry of Social and Labour Affairs.
- The Counsellor to the Director, Government of the Office for Drugs.
- Social workers at the Centre for Social work, Ljubljana.
- Social worker, Skala (NGO), Youth Street Education.
- Social worker, Areal (NGO).
- Social workers, Association for Harm Reduction Stigma.
- A priest.

5 The National Drug Policy includes methadone maintenance programme as a fundamental drug treatment and harm reduction programme.

1995, there are now 18 regional Centres for the Prevention and Treatment of Drug Addictions and 2 out-patient clinics that offer substitution treatment among their services. These centres are closely connected to prisons. The number of people seeking assistance has increased since the creation of these centres (Kastelic and Kostnapfel Rihtar, 2003).

In May 2004, buprenorphine was registered as Subutex® tablets 0,4mg, 2mg and 8 mg. The launch was planned for the 2nd National conference on Addiction, organised by the Sound of Reflection Foundation, in Slovenia, June 2004.

Methadone treatment is offered as:

- short-term detoxification (decrease of the dose within one month),
- long-term detoxification (decrease of the dose over more than one month),
- short-term maintenance (same dose prescribed for up to 6 months),
- long-term maintenance (same dose prescribed for over 6 months).

(Kastelic and Kostnapfel Rihtar, 2003)

'Methadone maintenance programme is successful, when it includes the whole treatment and is supported by medicine, counselling and administration, when it takes into consideration the patient's individual needs, assure enough stable and trained staff and considers appropriate methadone doses.' (Kastelic and Kostnapfel Rihtar, 2003, p. 13-14)

Specialised professionals reported that substitution treatment in Slovenia is not a controversial issue and is seen as a medical treatment. Generally, it is well accepted, although some professionals favour abstinence to substitution treatment.

It was reported that public opinion on methadone is divided; 50% see methadone as supporting the drugs users' use, allowing them not to tackle their habit and personal issues. The other 50% see it as a medical treatment, although 'detoxification' from methadone may be problematic. Finally, an NGO reported that distribution of methadone doses for the weekend on Fridays is likely to generate a black market.

It is believed that buprenorphine is less addictive than methadone and is thus easier to detox from; it has a lower risk of overdose and is easier to prescribe. However, buprenorphine is expensive and may be less effective among long-term drug users. As for methadone, a psychiatrist observed that, although there is theoretically no maximum dose, doses tend to be inadequately low.

1.2.2 *Substitution treatment in prison*

'Hospitalisation and imprisonment are not reasons for dropping out of the methadone program.' (Kastelic and Kostnapfel Rihtar, 2003, p. 13)

Methadone is the substitution treatment offered in all the prisons. It has been available since 1995 and is prescribed by specialist doctors from the Network of Centres for the Prevention and Treatment of Drug Addiction. Buprenorphine has been integrated in Slovenian programmes very recently (2004) and is not yet offered in prison, although the National Prison Administration and the National Treatment Centre reported that it was only a question of time before prisoners are prescribed buprenorphine.

Substitution treatment is provided according to "Eurometwork" Methadone guidelines and Slovene Methadone guidelines. Nurses collect the treatment, prescribed by doctors, at pharmacists.

It was reported that the philosophy of methadone treatment in prison is detoxification (gradual reduction) as prison is seen as an appropriate place to abstain from drugs. Maintenance treatment is also offered but with exceptions. Prisoners either continue the treatment they received prior to incarceration or, in a recent development, may have treatment initiated in prison. Patients on this treatment have regular urine tests. (Government Adviser, Head of the Treatment Department at the Prison Administration) When transferred to another prison or released, prisoners on substitution treatment can continue their treatment according to the doctor's advice.

A patient must fulfil conditions⁶ to be included in a methadone program. The whole team of experts (such a team exists within each prison), which includes a psychiatrist, nurse, social worker, psychologist and therapist from

6 Conditions are: having a repetitive use of opiates, physical dependence to opiates, previous detoxification attempts, the willingness for methadone treatment, agreed and signed consent for methadone treatment, minimum age of 16, health insurance (the Government pays for all Slovene citizens and all prisoners have the right to health insurance like any citizen), a family doctor and residence in the same region as where the Centre is located. Although prisoners used to be insured, due to a contract between the Ministry of Justice and the National Health Insurance Company, currently the Ministry of Justice covers all health services costs for prisoners directly. A negotiation is currently taking place to have all health services for prisoners covered by the National Health Insurance, as applies to all citizens.

the prison, must agree to the treatment (Kastelic and Kostnapfel Rihtar, 2003).

Substitution treatment in prison is financed by The Prison Administration. In 2002, the costs for methadone treatment (only for the medication methadone) in prison amounted to 15,000€ approximately (Government Office for Drugs).

Psychosocial support and staff training

A range of psycho-social treatments should be offered to patients on substitution treatment (Kastelic and Kostnapfel Rihtar, 2003).

Although medical staff are trained on substitution treatment through the Centres for the Prevention and Treatment of Drug Addiction, prison staff do not receive specific training. Nevertheless, several workshops and information training were organised with the prisoners and staff, such as workshops with prisoners on harm reduction, training for prison staff on addiction treatment in prison and workshops on methadone maintenance programme with staff. Moreover, international conferences in Slovenia, including work with prisoners, were organised by the Sound of Reflection Foundation: Heroin Addiction in Europe (1997), International Society of Addiction Medicine and WHO Symposium on Substitution Treatment (2000), Harm Reduction Conference (2002), Adriatic Conference (2003), and two national conferences on addiction (1999 and 2004).

As part of the public health network, all prisons are closely connected to the Centres for Prevention and Treatment of Drug Addiction. Continuous coordination and cooperation take place between prison staff and community health professionals.

During imprisonment, prisoners are offered treatment within the public health network facilities. Drug free units have been opened in most prisons. Detoxification is offered along with individual counselling and group work.

It was reported that, once a prisoner shows psychosomatic stability, s/he is prepared for integration into psychosocial programmes dependent on his/her willingness to engage in such programmes, which are provided by pedagogues, psychologists and social workers (Government Adviser, Head of the Treatment Department at the Prison Administration).

1.2 Prison Population

Table 22 *Data on the prison situation in Slovenia (Source: King's College London, International Centre for Prison Studies, Prison Brief for Slovenia)*

Country	SLOVENIA
Ministry responsible	Ministry of Justice
Prison administration	National Prison Administration
Contact address	1000 LJUBLJANA, Tivolska 50, Slovenia
Telephone / fax / website	Tel: +386 1 478 5270 Fax: +386 1 478 5470
Head of prison administration (and title)	Dusan Valentincic, Director General
Prison population total (including pre-trial detainees / remand prisoners)	1,099 at 1.9.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	55 Based on an estimated national population of 2.0 million, September 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	23.8% (1.9.2003)
Female prisoners (percentage of prison population)	3.6% (1.9.2003)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	1.0% (1.9.2002 - under 18)
Foreign prisoners (percentage of prison population)	15.3% (1.9.2002)
Number of establishments / institutions	7 (2002 - 6 prisons, 1 correctional home for juveniles. The 6 prisons have facilities in 13 different locations.)
Official capacity of prison system	1,067 (1.9.2003)
Occupancy level (based on official capacity)	103.0% (1.9.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992: 836 (42) 1995: 825 (41) 1998: 756 (38) 2001: 1,148 (58)

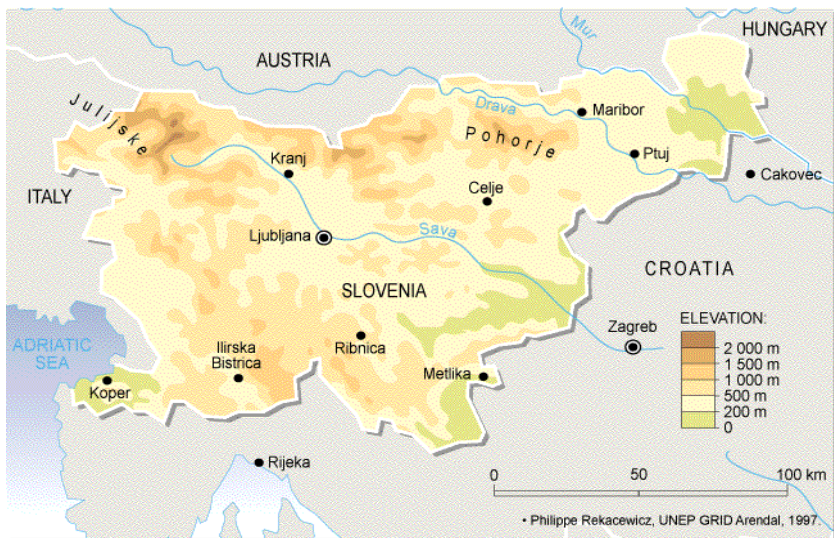
Slovenia has approximately 1000 prisoners in a total population of less than 2 million. Although Slovenia only has 6 prisons, they are located in 13 different locations. It was reported that the prisons are overcrowded; not in the sense of a lack of physical space for prisoners (Slovenia usually adheres successfully to the Council of Europe, CPT measures about detention) but regarding the number of staff per number of prisoners.

2 The field visits⁷

Time frame: The field visit took place from 22 to 30 September 2003.

Location: Visits were conducted in two prisons: Ljubljana Prison and Dob Prison.

Map of Slovenia



⁷ *Methodology:* Interviews were conducted with the individuals listed below as well as focus groups (tape-recorded with consent) with the prisoners. The researcher conducted all interviews/ focus groups accompanied by a freelance and neutral interpreter in both prisons. All participants were briefed and told about ethical issues.

2.1 Ljubljana Prison⁸

2.1.1 *Description of the prison*

Ljubljana Prison has 4 departments located in different areas of the country. The department visited is located in the capital Ljubljana. Initially, it was built to be a hospital but has been used as a prison since 1964. It has a capacity of 128 but held 223 prisoners at the time of the visit. Prisoners are either on remand (95) or have a sentence shorter than 18 months (118).

The prison has 105 staff, of which 70 are security guards and 12 are treatment staff (doctor, psychologists, social workers, pedagogue, psychiatrists).

At the time of the visit, the medical department reported having no registered cases of HIV, hepatitis A, B, C or tuberculosis but had reported 44 cases of self-harm and 2 suicides (one hanging and one overdose).

2.1.2 *Goals and practical procedures*

At the time of the visit 22 prisoners, aged 21 to 40 (average age 28), were receiving methadone. On average, the starting dose was 50 mg (the lowest being 25 and the highest 205). 12 prisoners were maintained on the same dose (for 1 year to 15 days) but it is unknown whether or not these prisoners had been on a detox programme at some point. The others' doses were decreased. The length of treatment varied from several years to several months. At the time of the research visit, data was only available for prisoners on a methadone treatment.

It was reported that, in this prison, substitution treatment is provided as a continued treatment, offered to the individual prior to incarceration; the initiation of substitution treatment is very exceptional. The team (a nurse, medical doctor, psychiatrist, pedagogue and possibly others, such as a psychologist and social worker) reviews each case individually and collectively decides whether the treatment is appropriate.

8 Data from interviews were those conducted with:

- The governor of the prison.
- The nurse.
- The doctor.
- The expert group (9 people: the head of guards, 2 social workers, 2 pedagogues, a psychologist, the chief of the group, 1 social pedagogue, a professor).
- The Head of Guards.
- Two police agents at the Police Detention, located at the base floor of the prison.

It was reported that nurses prepare the methadone treatment and label each bottle with the prisoner's name. The bottle is delivered by a guard, at the same time as other medication, but the prisoner drinks it in front of a guard and a nurse or prisoners can take the treatment in the medical area in front of a nurse. A nurse stated that she thought it was appropriate for a guard to know who gets methadone. *'There is a difference between alcoholics who try to hide their dependence and drug users who don't hide their dependence and tell everyone they take methadone. If any prisoner wants confidentiality, then he can get it by going to the medical area to get the methadone – guards would not know about the treatment he gets.'*

Guards reported that methadone provision is routine and is provided along with other medical treatment. Although it gives them an extra task, it does not bring any extra new stress.

It was reported that methadone brings stability, less difficulties and less abuse of other substances. Staff training and good control of methadone have diminished any fear of overdoses. However, according to prisoners' reports, it may be difficult to get off methadone completely. Moreover, the medical team observed that methadone may allow prisoners not to face or fight their dependence and that improvement of medical care in this prison would be limited as long as there is a staff shortage.

The expert team reported fear of overdoses with methadone. They stated that, although methadone reduces drugs traffic, a new black market traffic is created and may also put pressure on prisoners having treatment to smuggle methadone. *'You can't expect prisoners not to know about who takes methadone, as several prisoners share the same room.'* However, prisoners are more stable, can work and do not anymore think obsessively about getting drugs. The expert team is in charge of prisoners' programme (work, free activities, education, psycho-therapy and links with outside) but reported finding it difficult to keep up with the workload for the number of staff available.

2.2 Dob Prison⁹

2.2.1 *Description of the prison*

Dob Prison was built in the late 1950s and opened in 1963. It has 2 departments (located nearby in Dob) and is the largest prison in Slovenia with a capacity of 289 prisoners. At the time of the visit it held 364 prisoners. The department visited, located in the countryside, has a capacity of 233 and holds only prisoners with a sentence longer than 18 months.

The prison has 6 sections (4 closed sections, 1 open-dislocated and 1 semi-open), an intimate visits room and a Drugs Free Unit. Although, in Slovenia, 7 m square is allocated per prisoner in one cell or 9 m square per prisoner in cells that have more beds, overcrowding and staff shortage (especially expert, specialised staff) were reported as being problematic.

The prison has 222 staff, of which 110 are security guards. Dob Prison is the only prison in Slovenia that has a doctor paid by the Ministry of Justice (not contracted out).

At the time of the visit, the medical department reported having no registered cases of HIV, hepatitis A or tuberculosis but had 57 cases of hepatitis B, 17 cases of hepatitis C, 20 cases of self-harm and 1 case of suicide.

2.2.2 *Goals and practical procedures*

At the time of the visit, 12 prisoners, aged 25 to 46 (average age 29), were receiving methadone treatment. The starting doses varied from 30 to 80 mg (the highest being for prisoners on a treatment before incarceration). 9 out of 12 were on a decreasing dose. A maintenance dose was offered to 3 prisoners who had been on a detox programme first, the dose was then increased again and, at the time of the visit, was maintained at the same level. Data was only available for prisoners on a methadone treatment.

Every weekday morning, Methadone is provided in the medical centre where labelled bottles have been prepared. Guards deliver it over the weekend. It was reported that this is not problematic – there is no unnecessary spread of

9 Data that comes from interviews were those conducted with:

- The governor.
- The doctor (GP) and nurse.
- The expert team (5 people: addiction therapist, psychotherapist, pedagogues).
- The Head of Guards.

information – but links with other services (guards) are needed especially as there is a shortage of staff (Medical team).

In order to minimise the risks of methadone traffic and misuse (and thus risks of overdose), a guard reported the importance of ensuring that prisoners swallow methadone. Guards are entitled to ask for urine test for suspicious prisoners.

The medical team reported that methadone can be a good prevention against infections as prisoners' drug use is identified, although prisoners tend to conceal their use for too long and are already infected when they go for a consultation. However, it was reported that methadone is seen by some prisoners who have ran out of money as a free drug to replace illicit drug use and not as a means to reduce or abstain from using. It was stated that not all prisoners are willing to consent to the urine test.

If tested positive (on opiates, cocaine and/or THC), methadone may be removed (usually, it is only removed after the third positive test). In such cases, prisoners have threatened to harm themselves. However, a doctor from the Centre for Treatment of Drug Addiction reported that this only occurs when doctors do not work according to the national methadone guidelines. The main purpose of urine tests is to examine whether or not prisoners top up methadone. The majority of doctors in prisons are not employed by the Prison Services and are not responsible for prisoners' privileges scale. Prison governors and administration regard any drug use in prison as leading to the prisoner's reduction or discharge of privileges. In Dob prison, it was reported that prisoners on methadone who tested positive for the third time may lose some of their privileges and/or be removed from the methadone programme. Prisoners doing well on the methadone programme and/or finishing the programme are likely to be entitled to stay in the Drugs Free Unit, which prisoners reported as a privileged area, as it was more spacious and calm.

However, prisoners take the treatment more seriously when signing the statement and the medical staff perceive urine tests to be useful and necessary. The medical team believe that too many tests are done on prisoners in treatment at present and not enough random tests are conducted throughout the whole prison. The expert team agreed with the current policy. The medical staff also reported that the shortage of staff impedes the ability of a nurse and psychiatrist to concentrate on 'addiction' issues.

One nurse reported receiving training once a year as she belongs to the 'Association of nurses' who provide seminars and lists of courses. The nurse stated that there could be more training, but there is a lack of staff.

There are not many cases of overdoses. In the last 10 years they have had one case, 2 years ago.

The expert team reported that, when discussing a prisoner's methadone treatment, the expert team is consulted by the psychiatrist as the doctor needs to be informed of the individual's behaviour and attitude. If methadone maintenance is suggested, agreement from the whole expert team is needed. If methadone is provided too quickly then prisoners want to keep the same dose (maintenance) '*which is no life*' – these prisoners are rather passive and cannot take an active part in the prison, especially if they have received a high dose for a long time.

Although medical staff feel well trained on substitution treatment, prison staff would welcome more training and information on drugs.

2.3 Views of prisoners

Two focus groups were conducted with:

- 5 male prisoners aged 24 to 31
- 7 male prisoners in their thirties

Prisoners who took part in the research started using drugs at the age of 14-16 and reported having used heroin (smoked and by injection), cocaine, marijuana, LSD, ecstasy, speed, party drugs, benzos and alcohol.

Prisoners reported methadone being offered in prison but only on the basis of a team decision. They underlined individual differences in relation to the success of the treatment:

'I went into detox in December last year and the doctor prescribed some pills, like a sedative and some other stuff. Methadone was not approved for me. The psychiatrist said, yes to methadone for me, the GP, the medical doctor said yes, but the team of experts said no.'

'After a long period of methadone, it's harder to get off, but if you have it for six months, it's easier. But some prefer to keep the doses, and take it long term.'

Illicit drugs and methadone circulate on the black market in prison:

'I tried heroin when I came in here [prison]. Outside, I did mostly party drugs and speed. Speed became a very important part of my life. Gradually, I took it regularly, every day. It gave me a feeling of being more confident in the business of trafficking, I felt more confident on speed. I came here, to this prison. That was then, such a shock, a big change from the life outside, and I felt emptiness, suddenly. I felt this psychological pressure, and that's why I started heroin when it was offered.'

'I took methadone on the black market in here but fell asleep, standing up in the toilet. I don't want to do methadone again.'

'When I came, I was having cramps and withdraw. I was forced to get myself methadone from the black market. The psychiatrist said I looked ok and I was all right. The psychiatrist had me waiting two weeks. Normally you wait for one month.'

Prisoners reported valuing the Drug Free Unit and wanting to be there, with or without a substitution treatment. However, they stated that places are limited and sometimes given 'wrongly' to child molesters and not drug users:

'I was clean for a month, failed the urine test, was clean for another month, failed the urine test. Over and over again, I tried to explain that I couldn't remain clean in that section and asked to be transferred to the drug free section, but no, no. They just let me stay there in that non-drug free section, until the time when I started to inject. Up to this time I had never injected, but then I started. Because they had nothing else to offer to me. Then they offered me detox. I had a month of detox, and after a month, they transferred me to the drug free unit.'

'Sometimes people who'd like to come on the Drug Free Unit, can't because there are no vacancies because other prisoners are transferred there for their protection, like child abusers/sex abusers. The staff knows that those criminals are safe there, and they're not there because of drugs. The only violence is against them. No one likes them. In the drug free unit, it should be a little more rearranged.'

3 Summing up

The tendency in prison is to offer methadone treatment on a detoxification basis (with gradual dose decrease). Although prison staff show reluctance and resistance to offer methadone maintenance treatment, it is allowed and, increasingly as doctors try to work out an individual approach, it is offered. Buprenorphine was integrated in May 2004 and is expected to be offered in prison in autumn 2004.

The decision to offer substitution treatment is taken within a team: the doctor, the prisoner and the expert team (present in each prison). Prisoners wished for an individual approach and treatment, welcomed substitution treatment contact, but wished to stop associating the treatment with punitive measures.

So far, substitution treatment has been a successful harm reduction and public health intervention, offered with the cooperation and supervision of the Centre for Treatment of Drug Addiction.

Spain¹

1 General data: drug use, substitution treatment and prison population

1.1 Drug use

Cannabis is the most frequently used psychoactive substance in Spain. Heroin use and opiate use by intravenous have decreased. Significant increases in cocaine-related problems have occurred in the last ten years. There has been an increase of the use of ecstasy and amphetamines for recreational use, but some users have needed health treatment. Drug users are mainly poly-drug users, with a general tendency to mix alcohol, tobacco and cannabis with other substances. (Reitox Spain, 2002)

44,255 admissions for opiate (around 68%) or cocaine (around 19%) treatment for a total of 44,255 admissions were recorded for 2001 (Reitox Spain, 2002). *'Those reported in 2001 for consuming or holding drugs in accordance with the Organic Law 1/1992, of February 21, for the protection of the civic security were 112,270.'* (Reitox Spain, 2002, p. 31)

In the community, 78,806 people were on a substitution treatment in 2001/2002. (EMCDDA, 2003)

In prison, during 2001, on a given day, 21,642 prisoners (19,474 men) of 69 prisons (with a prisoner population of 57,365) were on a methadone treatment (prevalence-day of approximately 22%) (Reitox Spain, 2002).

1 The field visit, conducted by Laetitia Hennebel, was facilitated by Graciela Silvosa Rodriguez, Head of the Prison Programme Services, the National Drugs Plan on Drugs (Delegacion del Gobierno para el Plan Nacional sobre Drogas). Special thanks to her and Julian Sanz Sanz, Head of Drug Treatment Services, Ministry of Interior, for their support.

1.2 Substitution treatment

Data comes from an on-going review of research reports, websites and laws/regulations, as well as from interviews conducted during the field visit².

1.2.1 Historical and legal background

The Spanish Constitution of 6 December 1978 and the General Health law of 14/86, of 25 April, were the first important documents establishing measures to take regarding health issues.

The implementation of substitution treatment in Spain has been rather smooth. Substitution treatments are regulated in the Royal Decree 75/1990, of January 19, amended by the Royal Decree of 5/1996, of January 15.

Substitution treatment has been offered, among other things, as a reaction to the HIV/Aids epidemic. Since the second half of the eighties, HIV/Aids infections are one of the major health problems associated with the use of drugs in Spain. The National Drug Strategy (2000-2008) sets forward the 'new' National Plan on Drugs, and preventive measures.

Methadone is the main substance used in substitution treatment. Buprenorphine was introduced in Spain in 2002 – first to be tested in Madrid – for '*drug users who cannot take methadone*'. (Reitox Spain, 2002)

1.2.2 Substitution treatment in prison

All prisons in Spain offer initiation of methadone, methadone maintenance treatment, and detoxification with methadone. Brief and progressive detoxification may also be offered with opiates and benzodiazepines.

Substitution treatment in prison has been developed as part of the harm reduction strategy since 1992, and was extended to all prisons in 1998. Substitution treatment has proven highly efficient and effective in preventing HIV infections. (Reitox Spain, 2002) It is reported that approximately 16% of prisoners are infected by AIDS and 46% by hepatitis C (Reitox Spain, 2002).

2 Interviews were conducted at the national level with:
– The Head of the Prison Programme Services, the National Drugs Plan on Drugs.
– The Head of Drug Treatment Services, Ministry of Interior.
– Social workers, NGO-based in the community.

Articles of the Spanish Constitution of 6 December 1978 underline the equivalence of health care between the community and the prison. The General Health law of 14/86, of 25 April, further states prisoners' rights to access health services similar to those offered in the community.

The circular 5/95 from the directorate general of prison services on the global drugs policy 5/95 establishes that within the framework established by the National Drugs Plan (Plan Nacional sobre Drogas), in coordination with other sectors of public administration or other organisations and institutions, such as the Municipal and Regional Drugs Plans (Planes Autonómicos y Municipales sobre Drogas) and Non-Governmental Organisations and Entities, prisons will run specialised drug dependency programmes for prisoners who voluntarily request them, consisting of prevention, harm and risk reduction, methadone treatment, breaking the cycle of drug dependency and social reintegration.

Health care in prison is under the management of the Ministry of Interior (Directorate General of Prison Services).

Substitution treatment is offered in prison as part of 'interventions' for drug-using prisoners. The objectives are:

- To reduce of deaths due to overdose.
- To control and reduction of physical health harm.
- To control or reduction of infections like HIV.
- To reduce of delinquent activity and recidivism.
- To improve social and labour adaptability.
- To modify drug use.
- To provide a mean to remain abstinent for several periods.
- To improve and facilitate rehabilitation and reintegration into social life.

(Ministerio del Interior, 2001)

Methadone is offered as:

- a treatment with methadone (methadone treatment), or
- a treatment of detoxification with methadone.

These two types of treatment are not exclusive. A prisoner may go from one to the other, according to the biopsychosocial situation of the drug user. To reach efficacy, the biopsychosocial focus needs to be part of a drug user's treatment. Methadone programmes must include health interventions, psychosocial interventions (with group and individual therapeutic sessions) and

throughcare (or preparation for release and rehabilitation). (Ministerio del Interior, 2001)

The Ministerio del Interior (2001) reported that methadone treatment is the most effective intervention for the number of drug using prisoners it attracts, and for individual and group benefits it brings. Moreover, it facilitates the reduction of drug use, reduces the intravenous use of drugs, improves physical and mental health, as well as hygiene and health habits. It reduces antisocial activities, delinquent activity and recidivism (and return to prison). Quality of life, socio-labour situation (the social integration) is generally improved.

The Ministerio del Interior (2001) stated that in order to reach all these advantages and benefits, methadone treatment cannot be limited to the sole prescription and distribution of the substance. Methadone must be delivered within a global therapeutic approach, taking into account individual differences and needs, and including psychological and social interventions. A sole distribution of methadone is a harm reduction measure, contrary to a methadone treatment that includes psychosocial activities and preparation for release (and, if needed, continuation of the treatment on release in a community centre) and is thus a rehabilitation treatment.

Detoxification treatment with methadone is offered to drug-using prisoners who wish to abstain from drugs and according to their health, personal, social, penal and penitentiary conditions. (The Ministerio del Interior, 2001)

In 2001, (31 December), 7,531 prisoners (around 7% of total prison population) went through detoxification programme. 21,642 (around 21%) went through methadone treatment (maintenance). (The Ministerio del Interior, 2001)

The Minister of Interior (2001) stated that the variety of treatment options and the plurality of therapeutic strategies are determining criteria for the successful treatment of drug users. This diversity also increases the number of drug-using prisoners consulting and engaging in treatment in prison.

It was reported that methadone treatment is delivered differently from one prison to another. (Sanz Sanz, 2000)

In 1999, on 31 December, out of the 6,589 prisoners on methadone treatment, 19% were on a dose less than 40 mg per day, 47% on a dose between 40 and 80 mg, and 34% on a dose higher than 80 mg per day. (Sanz Sanz, 2000)

1.3 Prison Population

Table 23 *Data on the prison situation in Spain (Source: King's College London, International Centre for Prison Studies, Prison Brief for Spain)*

Country	SPAIN
Ministry responsible	Ministry of the Interior
Prison administration	General Directorate of Prison Administration
Contact address	Calle Alcalá 38-40, E-28014 MADRID, Spain
Telephone / fax / website	tel: +34 91 335 48 81 fax: +34 91 335 40 64 url: www.mir.es/instpeni
Head of prison administration (and title)	Angel Yuste Castillejos , Director General
Prison population total (including pre-trial detainees / remand prisoners)	57,365 at 20.2.2004 (national prison administration website)
Prison population rate (per 100,000 of national population)	140 based on an estimated national population of 40.98 million at February 2004 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	22.4% (20.2.2004)
Female prisoners (percentage of prison population)	7.8% (20.2.2004)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.3% (31.12.2000 – under 18, Council of Europe Annual Penal Statistics)
Foreign prisoners (percentage of prison population)	25.4% (1.9.2002)
Number of establishments / institutions	85 (2001)
Official capacity of prison system	45,320 (1.9.2002)
Occupancy level (based on official capacity)	112.5% (1.9.2002)
Recent prison population trend (year, prison population total, prison population rate)	1992 35,246 (90) 1995 40,157 (102) 1998 44,763 (114) 2001 46,962 (117)

The Ministry of Interior reported that there were approximately 45,000 prisoners in a total of 66 prisons in 2002 (this excludes the Catalonia region). It is estimated that 77% of prisoners have used drugs prior to incarceration. (Ministry of Interior) 46% of them have used heroine and/or cocaine, although they often have also used other substances (Ministerio del Interior, 2001)

Although the Penal and Penitentiary Law is the same for the whole country, Catalonia is the only autonomous community in the country that has competence for the management of prisons in the Catalonia region, i.e. the Government of Catalonia can regulate and make decisions about the management of its prisons. There are, in 2004, approximately 7,800 prisoners in a total of 11 prisons in the Catalonia region. Around 50 to 70% of them have used drugs prior to incarceration. (Treatment Section and Rehabilitation Services)

2 The field visits³

Time frame: The field visit took place from 14 to 16 July 2003.

Location: Visits were conducted in two prisons: Madrid I and Madrid IV Navalcarnero.



Map of Spain

- 3 **Methodology:** Interviews were conducted with the individuals listed below as well as focus groups with prisoners. One focus group was tape-recorded. The researcher conducted all interviews/ focus groups on her own. All participants were briefed and told about ethical issues.

2.1 The Prison Madrid I⁴

2.1.1 Description of the prison

The Prison Madrid I is located in the surroundings of Madrid. It is a female prison. Madrid II (male prison) is located opposite the female prison in a deserted area in the middle of the countryside.

At the time of the visit, there were approximately 350 prisoners for 102 cells. Around 75% of the prisoners have used drugs.

2.1.2 Goals and practical procedures

At the time of the visit, there were 92 female prisoners on a methadone treatment. The treatment was initiated in prison for 26 of them, continued from another prison for 62 of them, and continued from a community centre for 4 of them.

At prison entrance, prisoners get a medical evaluation. Blood tests are offered upon entry to the prison, and most prisoners comply with it. Most of the prisoners come from another prison. The demand for psychotropics is high. If they are drug users, methadone is offered. If the prisoner says she has been on a methadone treatment, after verification of the information, the treatment is continued. Over weekends, the medical staff may give a small methadone dose if they estimate that the prisoner is going through withdrawal due to a lack of methadone.

Methadone is offered as maintenance treatment or detoxification treatment. The treatment team comprises 3 social workers, 4 psychologists, 5 educators and 2 lawyers, and the team meets once a week to discuss individual cases. Psychosocial support is provided to prisoners as part of the treatment.

Prisoners are called and brought to the medical centre where they drink the methadone syrup in front of the nurse; afterwards, they are asked to say something, proving they have swallowed the substance.

Methadone doses varied from 5 to 205 mg. 10 were on a dose less than 40 mg, 39 on a dose of 40-80 mg, and 43 on a dose higher than 80 mg. The

4 Data from interviews were those conducted with:

- Guard
- Doctor
- Psychologist
- Social worker

medical staff reported no difficulties or pressure from prisoners regarding the doses.

Most of the women, even if on high doses, said they were stabilised thanks to methadone. Several women had a methadone treatment prior to pregnancy and continued successfully during the pregnancy. The dose was often reduced during pregnancy, but increased again after the birth.

Buprenorphine can be prescribed, not as a programme but as a treatment like a benzodiazepine or other prescribed drugs. However, the medical team said that it was rarely prescribed.

Overall, the provision of methadone treatment was said to go smoothly and to satisfy prisoners' needs. Medical staff and prison staff were all content with the treatment and benefits it brings to the prisoners and the prison setting.

Psychosocial support and training

It was reported that psychosocial support and therapeutic approach is offered to prisoners on methadone. The psychologist's office is always open and prisoners are encouraged to 'walk in' whenever they need to. Access to professionals is easy and available on an ongoing basis. The structure of the prison is friendly, located in the countryside, and prisoners are free to circulate in the setting. This increases a 'friendly' environment that promotes rehabilitation.

Medical team reported that training on drug issues and substitution treatment are quite complete and sufficient.

2.2 Madrid IV Navalcarnero Prison

2.2.1 *Description of the prison*⁵

The prison of Madrid IV Navalcarnero is located in the surroundings of Madrid. The prison was built in 1993. The structure allows for all sorts of activities, such as education, work, training, sports (including a swimming pool), to be offered to prisoners. Cells are on a single or double occupancy.

The prison is a remand prison for male prisoners.

At the time of the visit, the governor reported that the prison has approximately 1 000 prisoners, for a capacity of 1 200. The staff are ‘funcionarios’ from the Ministry of Interior. The prison counts approximately 460 staff. The medical team comprises 8 doctors, 10 nurses and 18 clinical assistants.

2.2.2 *Goals and practical procedures*

It was reported that there was reluctance to start methadone treatment, especially due to a fear of high workload. Guards perceived the treatment as ‘just another drug’ and thus associated medical staff to the image of drug traffic. Training and information facilitated development of the treatment. Furthermore, substitution treatment was introduced in prison as ‘an order’ to implement the practise in prison from the Ministry in charge at the time.

Methadone started in the prison in 1999. At first only one designated doctor with the support of one nurse provided methadone treatment. This was later opened to all doctors of the prison.

Methadone is offered as a maintenance treatment or detoxification treatment. In general, the methadone programme was started in the community or in another prison and is continued at this prison. The majority of prisoners are on a maintenance treatment. Detoxification is less frequent and not encouraged as prison life is difficult, a nurse reported.

5 Data from interviews were those conducted with:

- The governor of the prison
- A doctor
- Nurses
- Psychologist
- Guards

Methadone is provided in a syrup form. Buprenorphine is not offered in prison. A nurse stated the pill form is problematic and not ideal in prison as the supervision of the intake is difficult.

Methadone is prepared outside of the prison by a Pharmaceutical Centre. Methadone is distributed to prisoners on a daily basis, and at the same time. Prisoners are called to visit the medical centre for the treatment.

It was reported that confidentiality about methadone treatment cannot be entirely respected in prison. Guards are involved in the treatment indirectly (by bringing prisoners to the health centre, etc.). The medical team stated that the cooperation and relations with the guards were positive.

Nurses reported that sometimes prisoners put pressure on the doctor (not the nurse) to get higher doses.

Prisoners are aware of the doses they receive, which are individually based. There is no maximal dose. The dose provided at entrance of prison is carefully examined in order to decrease risks of fatal overdose; usually the starting dose is 15-20 mg. Overdoses usually occur due to methadone being topped up, and is rare for prisoners included in a methadone programme. The nurse reported that in general, prisoners on a dose that is higher than 80 mg remain in treatment, whereas those on a dose less than 80 mg, if they remain in treatment, they tend to top up. She further stated that some prisoners take 20-30 mg of methadone to continue using drugs but avoid any withdrawal symptoms.

It was reported that some families put pressure on drug-using prisoners to abstain completely from drugs, including methadone. However, only a minority of prisoners on methadone decrease the dose towards a 'drug free' status. Decrease of the dose goes by 1 or 5 mg, depending on the individual.

It was reported that methadone has reduced the number of overdoses and infections. Prisoners' quality of life has improved. Conflicts within the prison (especially, between prisoners) and aggressive behaviour have decreased. Methadone allows prisoners to think about something other than 'getting drugs'.

Psychosocial support and staff training

It was reported that psychosocial support is lacking in the prison, mainly due to the number of prisoners and lack of staff. Some professionals said that

prisoners often lack motivation to engage in therapeutic work. Social workers from external NGOs do provide work and support in prison but the needs are still higher than the offer.

2.3 Views of prisoners

Interviews were conducted with several prisoners:

- One focus group with 8 female prisoners – Prison Madrid I
- One focus group with 6 male prisoners – Prison Madrid IV Navalcarnero

Female prisoners tended to talk all at once, resulting in the loss of a lot of information. The male focus group was dominated by one talkative prisoner.

There were some differences between male and female prisoners, mainly due to the whole prison environment. Women were satisfied with the treatment and psychosocial support, whereas men complained about not receiving enough or any psychosocial support and ‘being put on methadone’ to generate peace and tranquillity within the prison.

Methadone was seen as a positive measure.

‘I’ve gone back to work thanks to methadone. My life is much better now.’

Providing methadone at the same time was also requested.

‘I come from a prison where they gave me methadone at 9.00 am every day – and that for 1 year. In here, they don’t respect it and give it to you at different times.’

The main complaints were from male prisoners who wanted higher doses, but at the same time some wanted to reduce and wanted a closer relation with the medical staff. They felt methadone was used to keep them quiet and their individual needs were not respected.

‘I wanted to reduce my methadone but the doctor refused because she said that the risks that I topped up or use illicit drugs were too important. I want the medical staff to take individual needs more into account. I am not everyone, I have my needs, and I want to reduce, but with time.’

3 Summing up

Methadone is provided in all the prisons of Spain, and is the only substance offered as maintenance treatment for drug-using prisoners, or 'long-term' detoxification. Like in most countries, there was reluctance at first to provide methadone treatment in prison, although it was implemented as a ministerial health measure. The reluctance was due to the status of the medicine and the implication of providing the treatment in prison.

Psychosocial support is seen as an important factor for the success of the treatment. However, during the visit, it was reported that psychosocial support was insufficient. Male prisoners also wanted more psychosocial and individual support. Female prisoners were generally satisfied about their treatment and support provided.

Methadone was not talked about as a problematic or difficult to manage treatment. It was well integrated in the whole drug-using treatment approach.

Sweden¹

1 General data: drug use, substitution treatment and prison population

1.1 Number of drug users (EMCDDA data)

According to MOB (Mobiliserings Mot Narkotika²) figures (2004) the number of problematic drug users is about 28-30,000 of which approximately half of them (12 200) are supposed to be opiate users. Amphetamine use is the predominant pattern for problematic drug use in Sweden. According to the respondents, the number of drug users in prisons amounts to 60%, which is an increase of 10% compared to the situation 6-7 years ago. Different views have been given as to the amount of illegal drugs in prisons. Prison doctors and ex-inmates from a NGO stated that there were drugs in prison (cannabis, benzodiazepine, Subutex®, anabolsteroids, cocaine) but that heroin was not widespread. The most frequently abused drugs were amphetamine, benzodiazepine and dexepopozephin³. According to other views, the amount of drugs used in prison is not that widespread, at least not as much as is conveyed in the media.

After more or less neglecting the drug problem during the 90's the government initiated a survey and a report was published about the extent of the drug problem in 2001. A parallel report was published within the criminal justice system. After that MOB was installed with funding of about 350 million SEK of which 100 million was directed to the prison system⁴. The whole launch (2002-2004) is scientifically evaluated.

1 The field visit, conducted by Heino Stöver, was facilitated by Åke Farbring, Swedish Prison and Probation Administration, Programme Inspector, who also provided general information and support with the finalisation of this country report.

2 The bureau that was installed to handle the government funding to reduce drug use.

3 Dating back to a Stockholm based examination of used drugs in the criminal justice system.

4 used for ASI-reports, finding drug users in remand prisons and elsewhere, Motivational Interviewing (a semi structured programme), and cognitive based programmes aiming at reducing drug use.

1.2 Substitution treatment

1.2.1 *Historical and legal background*

Since 1999, methadone and buprenorphine have been registered and authorised agents in substitution treatment. According to an interviewee, there are about 800 patients receiving methadone in Sweden (more or less distributed over the cities of Stockholm, Uppsala and Lund). Subutex® is prescribed to approximately 1,000 drug users. There are different policies and practices applied, with gaps from South to North and from West to East, with ambivalent responses on the part of doctors. On the one hand an increasing resistance can be noticed to prescribe substitution drugs, and on the other hand doctors are interested to give this patient group evidence based treatment (i.e. substitution medication). In 1967, methadone was launched in Sweden (Uppsala) (see Farrell et al., 2000, p. 13) but only in the first structured and scientifically evaluated programmes did not appear until the 80s. The methadone services have been restricted in terms of high-threshold programmes which are only provided in four specialist centres throughout Sweden, GPs are not allowed to prescribe methadone⁵, only buprenorphine (“Subutex®”).

New regulations are coming up in August 2004 (they will begin to work at the 1st of January 2005), stating that heroin users who want substitution treatment should be offered that, and this is regarded a major change in policy, probably leading to a big increase in the number of patients receiving treatment!

A specific “treatment philosophy”, corresponding to deviant behaviour, is deeply rooted as a cultural concept in the Swedish society. Subsequently, both drug policy and practice are basically treatment-oriented which means that the efforts of drug services and politicians focus on supporting drug users to abstain from drugs. Thus, substitution treatment is seen as an intervention which is only indirectly trying to achieve this goal. This is despite encouraging research results on methadone maintenance programmes from Swedish scientists into the preventive effects of methadone on HIV infection (Gunne, 1987), treatment characteristics and retention rates of methadone programmes (Gunne & Gronbladh, 1981; Gunne, Gronbladh & Ohlund, 2002) and the impact of methadone treatment for heroin mortality (Gronbladh, Ohlund & Gunne, 1990).

5 Although methadone is supposed to be used as a painkiller.

Encouraging results from a recent Swedish study on buprenorphine may lead to an intensified discussion about substitution treatment. In a double-blind, randomised controlled trial, Kakko et al. (2003) found a high retention rate (75%) of the buprenorphine-treated group⁶ after one year compared to a placebo group who only received psychosocial treatment (0%). Kakko et al. come to the conclusion that buprenorphine and psychosocial care “is safe and highly efficacious, and should be added to the treatment options available for individuals who are dependent on heroin” (p. 662). The term substitution drug is not used, medication assisted treatment is preferred which clearly indicates that any substitution drug is used as a medication:

“So I think the kind of treatment, Subutex® or methadone, is very, very important for the patients if you do it the right way. And in Sweden we don’t like to say ‘substitution treatment’ because we don’t think it’s a substitute for the drugs. But we say, it’s a medication assisted treatment because we use those medicines like a medication, not like drugs. The way they can use for example Subutex® as a drug is not the way we take it.” (Doctor)

1.2.1 Substitution treatment in prisons

Substitution maintenance treatment in prisons is not available in Swedish prisons. In a few cases, a short-term detoxification treatment is carried out (see prison visit). The Swedish Criminal Justice system is mainly focuses on rehabilitation of inmates by means of different programmes for education and behaviour change. Käll reported that, in 2000, about 35% of all identified incarcerated drug users received drug treatment. Random mandatory drugs testing of urine is performed in all Swedish prisons. A refusal or positive test gives a 5-day extension of the stay in prison, up to a maximum of 45 days. Neither methadone or buprenorphine maintenance programmes are provided in prison. Heroin detoxification is usually done by prescribing clonidin, in severe cases supplemented with dextropropoxiphen. Consequently, no initiation of substitution treatment in prisons is offered.

Interviews with inmates supported the view of Käll (2001), that changes in these policies and practices are currently being discussed and that ongoing maintenance treatment may be continued during a short sentence and prisoners may be permitted to apply for and start maintenance treatment shortly be-

6 16 mg buprenorphine daily, which blocks 80-90% of opioid receptors.

fore release. Whereas methadone can only be prescribed by doctors in specialist centres, buprenorphine can be suspended by GPs.

The policy of substitution treatment is to provide a drug free prison atmosphere and environment that makes substitution treatment dispensable:

“In prisons it has been still more controversial and the reason for substitution treatment is the craving for the drugs so that you shall not continue to take it. And our aim with the drug policies in prisons is, that there should be no drugs in prisons, so it will be not necessary to do anything for the craving because the supply of drugs should be zero ... Supply and request gives the abuse. Of course, every one knows that the prisons, not even in Sweden, are not completely free of drugs, but the situation is not as bad as it is told in the papers. Examinations show that there are about ten prisons, I think, where they have daily problems with drugs. But the majority of prisons, they have problems with drugs now and then. So it isn't as bad as it says in the media.” (Senior medical advisor)

The Swedish approach towards the provision of substitution treatment in prisons is outlined by the senior medical advisor. The key aspects are that buprenorphine is judged as being superior to other agents and that doctors are allowed to use it in the process of initiation of a substitution treatment before release, to avoid overdoses, and it is assumed that there is contact with a prescribing clinic outside.

“... so it is much more difficult to get drugs in prison than outside. Outside there is a completely free market in spite of the polices and the customs work ... But we are now in the beginning of a discussion in the Swedish prison system whether we shall or not shall have programmatic substitution. That would be with buprenorphine, not with methadone. And we are having a continuing discussion about an experiment in some wards to see how it works out. But that is a programmatic thing of work. But in the health service in prisons doctors are operating on their own responsibility. And I know of cases, where buprenorphine is used as a detoxifying agent, where we as a matter of fact recommend it in our pharmacological recommendations to our prison doctors. That, if abstinence troubles or they repeat, they should prefer buprenorphine to dextropropoxiphin-programmes. Dextropropoxiphin, that is an artificial opioid which is used as an analgetic which is prescribed in quite large amounts in the society. But because of it's similarity to morphine it is acting in the same way in the receptors, in the brain. So, therefore it is

used. But it is very hazardous to your liver and your health, especially if you are a heavy user of alcohol or your liver is stressed anyway. So buprenorphine is less risky. If they are in a situation where they consider dextropropoxiphin we recommend them to use buprenorphine only in the detoxifying situation. In the substitution situation, our recommendation is that our doctors should not introduce substitution treatment. If the patient is well known in officially legitimated policlinic and they want to take the responsibility of introducing substitution therapy before release so as to avoid relapses. The first hour of the release is the most dangerous hour in an addict's life, because he is detoxified. And the first hour is when it is decided whether he will fall back or not, I think. So if they are willing to take the responsibility of their own patient and continue responsibility after the release we can accept that they introduce such a substitution-treatment sometime before releasing the prisoners ... And we also recommend that they have a small discussion with me before they do so. So we can have some control over the situation and also reach this certified policlinic."

In single cases, a continued prescription can be organised as well as the uptake of substitution treatment shortly before release (two weeks), which is illustrated in two examples by the senior medical advisor.

"... I have two good examples: that's from the XY prison in the southern east coast, a nurse who is interested in drug abuse. And he first contacted me. That was one patient who should do time in XX prison. And he already had a very good contact with a very highly respected addiction centre in ZZ. And so they called me and asked if it should be allowed to continue the substitution therapy while in jail and this was only two months. So I told them that clinic has a good reputation and if you can manage the prison social system, so that there will be no leak for the Subutex® for abuse, cause you can use one pill, you can divide it into ten to make misuse of it, because dose response. And he described exactly how he would do it. The patient would come to the nurse and sit there, the pill should be trashed and melted in mouth. The patient staying there for at least ten minutes and then show his mouth again and then go back and take care of no pills himself ... they managed that very well and before release they went to the addiction-centre in ZZ, the contact freshened up, he was released and I heard some days ago that it was still going very well for that patient."

"And another case had contact with ZY in Stockholm. So, about two weeks before release the nurse and this Patient went from ZW to ZY policlinic. And

he had a consultation with the doctor in the ZY, he decides about the dose and so on, he went back to jail with this ordination, it was carried out in the jail and the patient was released some weeks ago and we had time at the ZY clinic the day after release. It ought to be the same day but sometimes that can't be."

As substitution agent buprenorphine is preferred by the senior medical advisor:

"But I think buprenorphine is ok. I don't think it's necessary to work with different treatments that are acting in the same way for the cellular membrane. At least, similar enough to make the purpose available of the treatment. Methadone was introduced in '68, and was so controversial that it wasn't a thing even to discuss in prison. I have been involved in some discussion concerning this exclusion criterion. Now, I don't think it's necessary anymore because buprenorphine exists. There are not such regulations around the buprenorphine. Our doctors could prescribe it as they want to, as an abstinence pill and they can take it as substitution in those few cases where it can happen. And it's easy to handle – a pill that melts under your tongue as compared to liquids or methadone pills which are easy to hand out and so on. So there are reasons to prefer the buprenorphine. One thing that is not so good is that it's very expensive. Methadone is very cheap"

1.3 Prison Population

Table 24 Data on the prison situation in Sweden. Source: King's College London, International Centre for Prison Studies, Prison Brief for Sweden)

Country	SWEDEN
Ministry responsible	Ministry of Justice
Prison administration	Swedish Prison and Probation Administration (Kriminalvårdsstyrelsen)
Contact address	Slottsgatan 78, S-60180 Norrköping, Sweden
Telephone / fax / website	tel: +46 11 496 3000 fax: +46 11 496 3420 or 3802 url: www.kvv.se
Head of prison administration (and title)	(Mrs.) Lena Häll Eriksson Director General

Prison population total (including pre-trial detainees / remand prisoners)	6 755 at 1.10.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	75 based on an estimated national popula- tion of 8.96 million at September 2003 (from Council of Europe figures)
Pre-trial detainees / remand prisoners (percentage of prison population)	20.7% (1.10.2003)
Female prisoners (percentage of prison population)	5.4% (1.10.2003)
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.2% (1.10.2003 – under 18)
Foreign prisoners (percentage of prison population)	27.2% (1.10.2002, of sentenced prisoners only)
Number of establishments / institu- tions	84 (April 2004 – including 30 remand prisons)
Official capacity of prison system	6 317 (1.10.2003)
Occupancy level (based on official capacity)	106.9% (1.10.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 5 431 (63) 1995 5 767 (65) 1998 5 290 (60) 2001 6 089 (68)

2 The field visits

2.1 Prison Österåker

2.1.1 Description of the prison

The Österåker prison is situated about 30 kilometres north of Stockholm and was originally built, in 1969, for 200 prisoners – a figure that has now reduced to 146. In 1976, a therapeutic unit was installed on one of the wards for drug users, it was outlined as a therapeutic community within the prison system and the theoretical concept was largely based on cognitive behaviour therapy. The ward could host up to 15 prisoners. Despite the success of the

evaluated programmes in terms of reduced recidivism (see Farbring, 2000), the programmes have been reduced due to budget constraints (which also includes a reduction of time that NGOs come into prison supporting prisoners). The prison still has a treatment ward, where motivational interviewing, discussion and contact with other drug treatment services and family is provided. According to the people in charge, this approach is successful in supporting prisoners to abstain from drugs.

2.1.2 Goals and practical procedures of detoxification treatment

As in all Swedish prisons, substitution maintenance treatment is not available. The prison doctor only prescribes Subutex® (4 mg, 2 times a day) from time to time to drug dependent prisoners on admission. One of the reasons for the discontinuation of community-based substitution treatment is that committing criminal offences is one reason to be expelled from the programme. And, if a drug user comes to prison this proves his/her inability to abstain from drugs and criminal behaviour. Another reason is that the exchange of medication among inmates should be avoided, and finally inmates are often moved from one prison to another, and it is difficult to followed up treatment everywhere. This would require the same prescription policy from doctors all over Sweden:

“For the Subutex it’s quite good within the dependency ward but we have some private doctors, who don’t follow this and don’t care about the patients either, they just abuse the drug and it doesn’t help.” (Doctor)

The detoxification process is described by a doctor:

“... We give 4 mg twice a day and then we decrease the dosage after the third day; they get it in six or seven days.”

One debate with drug using inmates is the issue of benzodiazepines, as a nurse states:

“... but when they come, these people that want Benzos, there is a struggle, but there are not very many.”

Everyday life in prison is perceived to be less complicated for drug using prisoners when compared to life outside, and reduces problems and temptations of continuous drug use. Coercive treatment 6 six months⁷ is legally

7 A study published on the effects of 6 month coercive treatment was not very positive .

possible and is seen as an valuable contribution to the experience for being off of drugs for a while:

“I think the problem is that most of the people here have a problem to keep limit. And if you are in prison, life is much easier, not so complicated. So it’s easier to keep those limits, it’s not so complex as outside ... They are usually functioning better in prison. And you have no money to buy drugs. We have this law for drug-addicts that we can force them into treatment for 6 months. Then they are in the treatment houses, they are forced to be there. They can keep free from drugs during this period.” (Doctor)

Much effort is spent in the prison on the support of abstaining from drug use and on assistance on the process of release. The work of the medical service is explained by the doctor:

“... we have limited possibilities. What we do: just a motivational interview and we try to arrange that they can manage to get away from the drugs. Sometimes it’s enough that we just discuss and they come back and we follow up it. Sometimes we have to contact the staff to maybe arrange some other placement. Or something like that. But we mostly do just arrange the connection between the prison and the dependency ward when they are released. Most of the inmates use drugs less in the prison than outside. And a lot of abusers manage to get away from the drugs when they are in prison. But they don’t manage afterwards. So we try to motivate them to try to continue the treatment afterwards. And we use a lot of antidepressants because we see a lot of depression and anxiety when they get drug-free. And the treatment results are very good. But the problem is just to follow up after the release.”

One big issue is the prescription of benzodiazepines and the gap between western and eastern Sweden which improved after discussions and lectures on the dangerousness of constant prescribing⁸:

“... big difference. You will hear it from XX, we have a unique follow up for the medications within the prison system. So every doctor can see his own prescriptions over six month periods. They check it for all the prisons, all the remand prisons, and then they calculate the statistics for the remand prisons separate because its another need, and for the maximum security prisons and for the open prisons. So you can see while your prescription is above the

8 See Kriminalvårdsstyrelsen. Planeringsenheten (2003): Läkemedelsstatistik 2003 Första Halvåret, Stockholm (www.kvv.se).

medium or below and we can see it for Benzodiazepines or opiate tranquilizer, for the neuroleptics, the psychiatric medication, so you can see all the groups. Its very good, because we had an enormous difference on the east coast in benzodiazepine prescription. And it's getting better now, just as a result that you can see what you do.... 40 times more⁹. And now its about 20 times ... “ (Prison doctor)

When it comes to the criteria of introducing substitution treatment in the prison setting, the following prerequisites are needed:

“You need those special wards, where the staff must be educated for this treatment, they have to manage to give the medication the right way, all this you need to manage the Subutex®.

And then we need to choose the right persons as patients. If you get a wrong person, they can disturb the whole group. So how you choose them must go on very well, too ...”

Discussions about the introduction of substitution treatment with Subutex® centre around release preparation:

“... So I think from the beginning we can do it so they maybe get Subutex® during the last 3 months or 6 months or something like that before they are released. And then they can continue.” (Doctor)

One of the practical problems would be to supervise the intake:

“It takes a little bit of time to give it and supervise the medication.”

The need for a infrastructure in the community, to allow the continuity of substitution treatment, is another prerequisite for introducing it in the prison setting:

“... it must be discussed before. We can't give treatment ... which can't be continued. We have to discuss it with the dependency ward in the community ... The patients just move, when they are back in the community. When they get it for example in ZZ and then decide to move to Stockholm.” (Nurse)

There are practical constraints in terms of personnel needed to supervise the intake. Although the staff do not oppose the provision, the intake has to be ensured by nurses:

“In daytime the nurses are not distributing, it's the staff. It doesn't work very well, because you have to supervise all the medication here. And the staff

9 West coast.

don't do it really. So its impossible to leave the Subutex® for the staff. It must be the nurse." (Doctor)

2.1.3 *The view of prisoners*

The focus group was attended by two prisoners who had several years of experience in substitution treatment programmes in the community.

Prisoners are very experienced and are also aware of the different effects of substitution agents

"... with Subutex® you can't sleep, I have been on Subutex® a couple of times, Methadone is the best for me, because I have been on heroin for so many years, Subutex® doesn't make it feel like what I am looking for, its like you are drinking whiskey when you are supposed to have ordered wine ..."

The access to substitution treatment is only indirectly possible by staying in an open house and then organising Subutex® treatment:

"Well, as we noticed, it's impossible to get it inside the prison. The only way is, now we have a little opportunity to get 3:30:4 (an open house where you can get a treatment with Subutex® and any kind of treatment) the last couple of months before you get free from prison."

"... and its not just Subutex® but any kind of treatment ... You can't stay at the service centre but you are allowed treatment while you're sentenced ..."

Prisoners are very well aware of the structures and rules regulating substitution treatment:

"To get this programme is like freedom and if you relapse once you are kicked out. So it's a little bit a mess: you get one opportunity to get in this programme and if you fuck it up, you're fucked up at least for 1/2 a year to a year then you can go back to the methadone again in the community. I am speaking of the methadone-programme. The Subutex® you can make a little bit faster with, that's a little easier to get these days in Sweden."

One reason given was the different atmosphere and the exclusion of the drugs topic:

"So I can say, in this prison I was quite good to be free, everybody is quiet, nobody is speaking so much for drugs. That's a big help."

3 Summing up

At present, substitution maintenance treatment is not available in Swedish prisons. Substitution drugs are only used in the detoxification process and in single cases before release. The dominant agent of prescription is buprenorphine, which is easier to access because it can be prescribed by every GP in the community and in the prison as well. The value of it is seen ambivalently. On the one hand, it is viewed as an effective treatment option (for detoxification purposes) with a high and acceptable safety profile. On the other hand, the supervision of intake is seen as very time consuming which is binding time of qualified nurses.

Given encouraging results from Swedish studies into buprenorphine, it seems likely that, in the future, the prescription will be more regulated with regard to indication, monitoring etc. At the moment, there is a heterogeneous prescription policy. On the other hand, the introduction of buprenorphine is being considered as a substitution drug. First, discussions focus around two perspectives (i) the continued prescription of short sentences and (ii) a prescription before release (3 to 6 months). In both cases, close cooperation with community based drug services and clinics/doctors is a prerequisite. As there were only two prisoners in the focus group, they were both in favour of a substitution treatment in prison but also pointed out that they were successfully managing to live without drugs. This new strategy needs staff training, i.e. nurses and establishing sustainable networks with the community services. Homogeneous practice was also noticed regarding the prescription and use of benzodiazepines.

B. Emerging Issues

In the following chapter, findings of the two prisons visited in the 18 countries¹ with additional information on the situation in that respective country are presented. When examples are introduced with the country name following the examples, only the two prisons visited in that country are indicated. The practice and policy is much too heterogenous, even in one country, to claim to have covered the situation completely.

Data also comes from workshops at conferences with experts, such as the “7th European conference on Drug and HIV/Aids services in prison. Prison, drugs and society in the enlarged Europe: looking for the right direction”, where nine experts took part in a workshop on substitution treatment in prison.

1 History and coverage of substitution treatment in prisons

Introduction of substitution treatment in the prison setting

Substitution treatment in prisons can only be understood in the context of the development of this form of therapy in the community. Looking back to the experiences in all countries, substitution treatment was first introduced in the community setting and then transferred to the prison setting. This was a long process. The more this treatment is acknowledged and put into practice on the outside, the shorter the time of import into the prison setting. As table 25 shows, substitution treatment has mostly been introduced in prisons in the nineties, whereas in many countries, methadone has been prescribed in the community already since the end of the seventies/beginning of the eighties. The catalyst dynamics of the spread of HIV/AIDS which counts for an enlargement of substitution treatment in the community cannot be observed in the prison setting, but only indirectly via the increase of prisoners in substitution treatment outside who come in prison. Nevertheless, HIV-positive prisoners in several prisons were the first ones to benefit from the continuity of substitution treatment. As an initialising first indication: *“My experience is that a GP simply does not welcome substitution treatment until the*

1 Except for Sweden and Greece where only one prison was visited, and Austria where three prisons were visited, Luxembourg where no prisons were visited.

moment he gets the first HIV positive patient that is a drug user, and at the moment, the GP changes his generally negative approach to substitution treatment. Then he's very much in favour, ready to study or learn more about addictions or dependences, and at that instant, he/she is ready to prescribe substitution treatment. Information or awareness has to be enhanced." (A contribution from the Prague Conference 2004).

The epidemic of hepatitis has obviously not developed such a shearing load as HIV/AIDS had.

With Eastern European countries included in our study this process was shorter, because many good practice models in Western Europe already exist, which could be used as an example. Good cooperation with agencies in the community before the start of prison-based substitution treatment facilitated this process, as was the case for Poland and Slovenia.

Historically seen and parallel to the situation in the community substitution treatment was first confined to certain vulnerable groups in prisons with the characteristics: HIV-infection, pregnancy, infectious diseases. Eventually, these constraints vanished and this treatment form is now more available to others.

It has been that, generally, the integration of substitution treatment in prison follows the initiative and perseverance of one or two individuals (who often are GPs or psychiatrists).

Table 25 Year of introduction of substitution treatment in the community and in prison²

Country	Availability of methadone in the community since	Introduction of other substitute medications	Substitution treatment introduced in prison
Austria	1987	Buprenorphine (1997) Slow release morphine (1997)	1987
Belgium	1994	Dihydrocodeine Buprenorphine	2000
Czech Republic	1992	Buprenorphine (2001)	2003 (experimental)

2 Elaborated version of Euromethwork – Training Manual, 2002.

Denmark	1970	Buprenorphine (1998)	1983
Finland	1974	Buprenorphine (1997)	1997
France	1973 (experimental) 1996	Buprenorphine (1996)	2001
Germany	1987 (controlled trial)	Dihydrocodeine (1994), Buprenorphine (2000) Heroin (2002, experimental)	1990
Greece	1996		Not introduced
Ireland	1992		1996
Italy	1980	Buprenorphine (1999)	1990
Luxembourg	1989	Dihydrocodeine (1994) Mephenon (1989) Dihydrocodeine (1994) Buprenorphine (2000)	1997
The Netherlands	1970		1972
Poland	1993		2003
Portugal	1979	Buprenorphine	1999
Scotland	2000	Buprenorphine (2000)	2003
Slovenia	1994	Buprenorphine (20004)	1995
Spain	1983	Heroin (2002, experimental)	1992
Sweden	1967	Buprenorphine	Not introduced

The introduction of buprenorphine into the range of substitution drugs was welcomed as a valuable contribution to the diversification of substitution treatment and enlarged the treatment options of substitution treatment. It was now possible to use other drugs apart from methadone to meet the needs and eligibility of patients.

Parallel to its authorization and its introduction in the community, buprenorphine (and other substances) as a substitution drug had also been introduced to the prison medical health care with a time lag of several years in most countries (with the exception of France, where it was used predominantly in the community as well). The reasons for this development are manifold: cost aspects, the different every day practice, lack of regulations of (supervision) of intake etc. But it shows that only with a time lag of several years, patients in prisons benefit from new treatment options in the field of substitution treatment in the community. If the patients could benefit more quickly from new developments outside such as new substitution drugs, and if the health care in prisons were under the Ministry of Health cannot be said with the results of this study, but it seems likely in the field of substitution treatment.

Scope

Substitution treatment in Europe is widespread. Almost 400,000 patients in 16 countries receive substitution treatment. 60% solely in Spain, France and Italy (around 250,000). There are approximately 100 000 patients in France. Looking at the scope of this treatment in prisons, we see a similar allocation in terms of concentration of this treatment in the prison setting in these countries.

In several other countries the coverage rate of this treatment in prisons (according to the number of problematic drug users in prison) is considerably lower (see Table 26: Substitution treatment outside/inside), in others it is poor (see also Michel & Maguet 2003, 34).

In most of the countries studied, the coverage is very patchy. There is not only a high heterogeneity throughout Europe, sometimes in one country, provision differs from region to region (e.g. French and Dutch speaking part in Belgium), from state to state (e.g. Germany), or even from prison to prison, or from doctor to doctor.

Table 26 Substitution treatment among problem drug users in the community and in prisons (18 countries)

Country	Prevalence of problem drug use	Number of clients in Substitution Treatment	Substitution coverage rate (%)	Number of prisoners	Prevalence of problem drug use in prisons	Number of prisoners in Substitution Treatment	Substitution coverage rate
Austria	20-30,000	6,423 (2003)	21-32%	8114 (10-11-2003)	1623 (20%)	531 (28-2-2002)	33%
Belgium	30,000	7 000 (2001/2002)	23%	9,245 (1.3.2004)	4,622 (50%)	224 (2004)	5%
Czech Rep	35-37,500	1,000	2,7-3%	17,429 (16.1.2004)	38.5%	No substitution treatment provided	0%
Denmark	12,752-15,248	5,077 (2003)	33-40%	3,908 (25-11-2003)	547 ¹ (14%)	300	55%
Finland	12,550	240 (170 buprenorphine and 70 methadone)	9-13	3,719 (15.4.2004)	2975 (80%)	45 (2001)	1,5%
France	120 000-180 000	100,000 (2004)	56-83 %	55,382 (1.4.2003)	18,276 (33%)	2,548 (2001)	14%
Germany	80 000-152 000	46 200 (2002) ²	30-58	81 176 (2003)	20 294 (25%)	700	3,5%
Greece	15-22,000	1000 (2003)	5-7%	8,841 (1.12.2003)	27,5% ³	No substitution treatment provided	0%
Ireland	13,735	6 000 (12.2003) ⁴	44%	3,602	1 080 (30% in 2000)	500	46%

- 1 Estimation for all Danish prison, done once a year. The estimation is divided into drug users in general (1316 of all inmates = 38% in 2000; rising from 22% in 1980 to 27% in 1990) and hard drug users.
- 2 National Drug Coordinator of the Government: Annual Report on Drugs and Addiction 2003, p. 76 (Die Drogenbeauftragte der Bundesregierung: Drogen- und Suchtbericht 2003), S. 76.
- 3 Fotiadou et al. 2004.
- 4 According to Brion Sweeney, Consultant Psychiatrist in Substance Misuse (The Drug Treatment Centre Board, Dublin).

Country	Prevalence of problem drug use	Number of clients in Substitution Treatment	Substitution coverage rate (%)	Number of prisoners	Prevalence of problem drug use in prisons	Number of prisoners in Substitution Treatment	Substitution coverage rate
Italy	155,096	86,778 (2001/2002) ⁵	56%	56,761 (1.9.2003)	15,442 (27%)	1,860 (31.12.2003)	12%
Luxemburg	1 900-2 220	864	39-46%	498 (1.9.2003)	191 (43%) ⁶	191	100%
Netherlands	26 000-30 000	17,500	58-67%	16,239	5,358-8,119 (33-50%)	No data	No data
Poland	32 000-60 000	700 (Nov.2003)	1-2%	80 693 (2003)	2662 (3.3%) ⁷	7 (Nov. 2003)	0.3%
Portugal	100,000	15,768 (31.12.2002)	16%	14,060 (1.9.2030)	3,515-5,900 (25-42%)	607 (2002)	10-17%
Scotland	56,000 (2002)	No data		6,803 (20.2.2004)	5,238 ⁸ (77%)	700	14%
Slovenia	15-18,500	1924 (2004)	10-13%	5 219 (2003)	703 (13, 47%)	222	32%
Spain	144,198	78,806 (2001/2002) ⁹	55%	57,365 (20.2.2004)	26,387 (46%) ¹⁰	21,642 (2001)	82%
Sweden	12,200	1800 (2004)	15%	6,755 (1.10.2003)	4053 (60%)	No substitution treatment provided	0%

5 EMCDDA (2003).

6 Comité de Surveillance du Sida Luxembourg, 2003.

7 According to a study carried out by J. Sierosawski⁷ (2003): 3.3% of prisoners confirmed intravenous drug use.

8 77% of arrestees tested positive for illegal drugs in 2002.

9 EMCDDA 2003.

10 Ministerio del Interior (2001).

Nevertheless, the scope has been enlarged when comparing our work to that of others. For instance, Turnbull and McSweeney (1998) who conducted a research on 15 EU-Member States and found that prescribing methadone on a maintenance basis was commonly available only in Austrian, Danish, French, Luxembourg and Spanish prisons and occasionally in German institutions, whereas the prescription of other substitute drugs was available in five countries.

In Greece and Sweden, substitution treatment is not provided in prisons, while there are at least some approaches in the Czech Republic. This is due to different reasons: late introduction of substitution treatment in the community (e.g. Greece 1996), and/or high threshold – substitution programmes in the community (Greece and Sweden), an abstinence-based overall drug policy, limited number of substitution places, limited drug problems or not opiate-related spread of problematic use of drugs in prisons, e.g. amphetamines.

In several countries the coverage of substitution treatment is seen as insufficient and far from ideal by experts, professionals in the field, government and non-government organisations. For instance, although The Netherlands do have a long tradition in substitution treatment, the number of prisoners receiving methadone drops significantly when entering prisons. This has also been criticised by the national health council who elaborated recommendations which were then set into practice by the Ministry of Justice.

A lot of movement has been made in improving substitution treatment in prisons. Much work is spent on regulations, guidelines and improvement of particular treatment modalities.

2 Treatment aspects

Abstinence and/or harm reduction

Although in several countries substitution treatment in prisons has been introduced to a wide and obviously sufficient extent, covering treatment needs of patients. This process is not satisfactory in many other countries. Substitution treatment in the community is most likely to result in a discontinuity of treatment when entering prison. The reasons for this at the prison level and service providers are manifold:

- Basic drug free orientation in prison, which is identical with the purpose of the sentence to support prisoners not to commit any crimes any more

(and drug users are most likely to commit crimes, simply by purchasing their drugs). The culture of abstinence orientation is widespread among staff in many prisons.

- Methadone (or any other substitution drug) is viewed more as a psychoactive than as a therapeutic drug by doctors, health care staff, prison administration, etc.
- Lack of understanding of the phenomenon of dependence as a chronic recidivist disease and the belief that the prison is a drug free setting.
- Limited places (e.g. Germany) for substitution treatment due to adjunction to psycho-social care for the same amount.
- Limited resources for carrying out substitution treatment properly and sufficiently (doctor hours, nurses etc. for instance in Ireland, Scotland, Italy).
- Confinement only to those who are in a community-based substitution programme and a lack of substitution placers after release in the community (Germany, Ireland, Belgium) is responsible for not taking new patients into the treatment..
- Access limited to HIV-positive, pregnant women and suffering from Hepatitis (similar when respective confinements do exist in the community).
- Lack of personnel to supervise (especially buprenorphine, e.g. Sweden, France) the intake and other organisational tasks.
- Lack of knowledge and experience by doctors and nurses to either prescribe at all or limit the substitution to certain drugs (methadone) because it is easier to handle and the risks are lower (overdose).
- Misunderstanding of the potential and quality of methadone, buprenorphine (and other substitution drugs) as means to be used as short-term agents to achieve sustainable abstinence. This accounts also for the situation in the community (see studies of Caplehorn et al.) but allows patients to seek a doctor who acknowledges the value of maintenance treatment.

Also, the prisoners' reasons against a continuation of treatment are formulated that partly cover the arguments above:

- Basic drug free orientation. The wish to be abstinent during the prison sentence. Substitution drugs are seen in this context also as hedonistic, psychoactive drugs (because it is also purchased on the black market from dealers who sell other illegal drugs) and not as drugs as part of a medical treatment for drug dependence.
- Lack of understanding of the nature of substitution treatment. Although many prisoners interviewed admitted relapses immediately after release, resistance against a continuity of prescription was expressed by several inmates, who regarded their prison sentence as their only drug free time. These yo-yo effects were perceived as normal and not as explicitly health damaging.
- Lack of understanding of the nature of drug use and drug dependence. Although in substitution treatment several prisoners wanted to reduce their dosage to zero shortly before release because they wanted to leave the prison 'drug free' either to avoid getting into the dependency of the methadone prescribing clinics outside again or wanting to avoid the drug scene around dispensing clinics. Not knowing, they exposed themselves to enormous risks when relapsing.
- Prisoners want to hide their drug use for several reasons (one is that they fear prejudices and disadvantages for their current sentences as being viewed and treated as a 'drug user' when being in a substitution programme), which would become apparent immediately when entering the medical units on a daily basis¹.

Substitution substances in European Prisons

Methadone is still the predominant substitution drug used in prisons in the 18 countries studied. The diversity of different substitution agents is mirrored in the medical services of the prisons only with a time lag of several years (with regard to buprenorphine). Protocols and practices are oriented more to the institution's needs and requirements rather than each patient's needs and wishes. For instance, the approximately 5 minutes for the supervision of intake of buprenorphine (sublingual) is seen as very time consuming and taking up too much staff time. Instead, methadone is prescribed: methadone

1 Some of these results may also be important for changes in the organization of substitution treatment in the community.

is a cheap substance; it is easy to deliver to the prisoner and the intake can easily be supervised; whereas buprenorphine is expensive and the intake must be supervised, which requires time and staff. The costs associated with the methadone provision are those due to staff and training of staff. This also accounts for retarded morphine where some different views can be noticed between prisons (remand vs. sentenced). In Austria, for instance, there is a policy to substitute these morphines prescribed in the community because it is perceived to have effects too near to the original substance of dependence, and subsequently changed to methadone. In the prison for sentenced prisoners, retarded morphine is seen as a valuable contribution to substitution treatment. Patients are complaining about these changes in their substitution drug and see double standards with regard to what happens in the community. One of the reasons for their complaints is that unlike the situation in the community, they do not have the choice of visiting another doctor other than the one prescribing their preferred means of substitution. Prisoners express their wish to get the choice of what will be prescribed, which in their experience is the most suitable substitution drug for them.

Table 27 Substitution drugs used in Europe¹

Medication	Frequency	Optimal dose recomm.	Route of administration	Brand Names	Overdose Risk	Withdrawal	Notes	Use in prison?
Methadone	Every 24 hr	50-120 mg/ day	Oral (syrup, tablets) Injectable	Metasadin®	+++	++	Optimal dose level dependent on subject: it can be < 50 mg and >120 mg according to individual variability	YES
Buprenorphine	Every 24 or 48 or 72 hrs	8-16 mg/ day	Sublingual	Subutex®	+ (with additional drugs)	+	Start 6-8hrs after the last heroin intake or on appearance of withdrawal symptoms. If patient was previously on meth., meth. has to be tapered until 30 mg/ day and buprenorphine can be administered at 24 hrs of last methadone doses or on appearance of withdrawal symptoms	YES
Diamorphine	2-3 times/ 24 hrs	400-700 mg/ day	Injectable Smokable	NO	+++	++++	Only available in clinical trials	Only in 2 Swiss prisons
Codeine			Oral (syrup, tablets)	DHC® Remedacen®	++	+++	Used only in Germany	no
Levo methadone	Every 24 hr	40-60 mg/ day	Oral (syrup)	Polamidon(®)	+++	+++	Available only in Germany	YES
Prolonged-action morphine	6-10 hrs						Available only in Austria	YES

1 Elaborated version of Verster/Buning 2003, 21.

Replacing one substitution drug with another (e.g. Ireland, Austria, France, see country report) obviously needs to be communicated to the prisoners, who feel that, for instance methadone (or methadone in a different composition) is less effective. Prisoners did not understand the obviously damaging effects of the replaced drug.

In Germany, information on another form of methadone introduced as a cost effective measure, wasn't understood by the prisoners (who have choices outside to either get the pure or the mixed form of methadone). In France, prisoners who were on buprenorphine and were offered to change to methadone because of their misuse of buprenorphine said they were satisfied. This satisfaction is related to the fact that methadone is provided in a highly supervised environment. The prisoner receives support and medical care daily, which is not the case with buprenorphine, which is delivered for up to several days, tapering off to once a week, and lacking contact with the medical team and centre.

Both examples led to dissatisfaction (the psychological component is very important for patients on substitution treatment, especially in a setting with limited choices) and showed that there was only a little information given for patients on the substitution drug. This may have occurred because providers think everything is already known by experienced users, but is not always the case.

Access to substitution treatment

Access to substitution treatment for all prisoners who are in need of it is only given in a few countries (e.g. Spain, Austria). In other countries, access is limited either in general (limited places and resources), to specific vulnerable groups or dependent on various other reasons (as shown above). The other extreme is that there are several states, regions, prisons or prison doctors not offering maintenance at all. Here it is most likely that existing substitution treatments in the community result in a detoxification.

Between several prisons, one consensus is applied that there will be a continuity for those patients being on substitution treatment in the community. But again, this is limited to the time being on substitution treatment before imprisonment (at least four weeks before admission to prison to avoid those patients who, in face of the imprisonment, started a treatment, e.g. prison visited in Germany), or depends on the expected length of imprisonment.

Prisoners interviewed complain about the fact that not all who want to get substitution treatment get it. Although the access is limited to them, and be-

cause of experiences of immediate relapse after release, they want to have the choice of either detoxification or maintenance. This increased demand is due to a broader access and availability of methadone in the community. Prisons often do not have enough staff to deliver the treatment properly and put prisoners on a waiting list. The example in Scotland shows that the change of a different health care strategy in the community (substitution treatment) has not to adequate structures in the prison health care. This gap is more dramatic in face of the severe overcrowding in the prison system, so it demonstrated that these two types of health care, service delivery and often financial structures, clearly fall apart.

Although access may be guaranteed to all prisoners who need a continuous substitution treatment in guidelines and regulations, in practice this looks very different and depends on the factors outlined above, but basically on the doctor's free choice of therapy.

Assessment and the role of the doctor

In most of the prisons visited, the decision about continuation or start of substitution treatment is made by the doctor. In some institutions, it is made within a multi-professional team, which guarantees different views (e.g. Austria, Slovenia). Classical diagnostic instruments (e.g. DSM IV or ICD 10) do play a minor role in diagnosing patient's status of dependence. However, the key element for assessment is the doctor or nurse's expertise and experience with substitution treatment. Networking competencies and specialisation (e.g. in Scotland: 'addiction nurse', who works in close cooperation with the GP/psychiatrist, received additional training and has become an expert on substitution treatment). Although the GP/psychiatrists prescribe, the nurses generally spend more time with the prisoner and are more apt to evaluate whether the prisoner's treatment is adequate. Many other aspects include contributing to the assessment of the patient's need for a substitution treatment (e.g. medical examination, drug history, previous treatments in the community or in remand prison, patient's expressed needs). Nevertheless, the central and responsible role in substitution treatment is in the hands of the prescribing doctor, who is given the leeway within the therapeutic freedom to more or less engage in substitution treatment.

The engagement of the doctor depends on his or her workload, the hours paid by the Ministry of Justice or health to start or continue substitution therapy. In some sites, there has not been given additional personnel (nurses) or resources by claiming an increase of pharmaco-therapy, so that the engage-

ment as such or the number of patients in substitution treatment remained restricted.

We found some good examples of team structures as basis for the substitution treatment, for instance in Austria, The Netherlands (e.g. “PMO: Psycho-medisch overleg”, psychological-medical consultation), Slovenia, Scotland, such a team structure including social worker, nurses, doctor and psychologist meeting on a regular basis has been very well established.

Also, certain job-profiles with specialisation in certain health care areas (like ‘addiction nurse’ in Scotland) has to be seen as valuable step towards more professionalism.

While in the beginning of substitution treatment the role of the doctor is central, the ongoing everyday provision is done by the nurses or medical officers. So the nurse becomes crucial, because he or she is seeing the patient more often than any other person involved and can see the patient in different situations. Regarding the crucial role of the nurses, it was said in several interviews that they should be offered more vocational training to be able to cope with new challenges and to be connected with prison services and experiences of outside institutions. There is also often a lack of nurses, like there is of doctors and other psycho-social staff.

In some countries prison officers with a special course in health care or drug issues are employed in the health unit (called ‘medics’, e.g. Ireland, who are currently replaced by registered nurses, ‘addiction worker’ in Scotland). Although in many respects these officers fulfil an important task, which is also very cost-effective, it is problematic from the viewpoint of patients. Prisoners interviewed trusted (registered) nurses more, who are seen as not having more distance to the prison system. This was not so much the case in Scotland, where prison officers received a job promotion and, because of personal interest, got training to do a different type of work.

Continuity of Care

Success of opioid substitution maintenance therapy depends to a large extent on a timely entry into treatment, longer duration and continuity of treatment, and adequate dosages (see part I). Several countries (for instance, Spain, Austria, Denmark, France, Portugal) continue substitution treatment started in the community more or less as a routine. Proof and diagnosis of the prisoner’s dependence status, apart from a quick check with treatment agencies

in the community, are done on a routine basis, so prisoners do not have to struggle for a continuation. In other countries structures do exist, such as official guidelines (e.g. Germany), agreements (Ireland) that recommend a continuity of therapy which is either not realized in all regions/prisons, or in all cases where it is needed. The coverage remains patchy and unsatisfying in terms of limited access for the patients.

In several prisons studied, good cooperation links have been established with other institutions outside as part of an intended throughcare after release (e.g. to prescribing clinics in Denmark, or with individual doctors in Germany providing assistance for patients in finding doctors before release).

Duration and Limitation of substitution maintenance treatment

In some countries substitution treatment is explicitly limited formally within written guidelines (e.g. The Netherlands, Belgium). The time limits are foreseen for a period of time of 6 (e.g. Italy, The Netherlands, without counting the remand prison time) to 12 months. In other countries such time limits are informally applied but not subject of official guidelines or regulations, rather but everyday practice (e.g. Germany). Some countries, like Spain and Austria do not hold any time limit and rather offer the substitution treatment on an individual basis. In Spain, maintenance is common practise.

Although these time limits do not affect the majority of (ex) drug using-prisoners because they mostly serve shorter sentences, it may become problematic for some patients. The reasons for the limitation are seen in the drug free setting prison which is aiming at and which does not require such a drug – oriented treatment when a prisoner is serving longer sentence. In the first place it is assumed that prison drug treatment facilities should be successful in supporting individual prisoners into abstinence. But moreover, substitution treatment is also seen as a cost factor and an additional organisational task (to bring the prisoner to the medical unit or hand out the substance in the cell(on the ward)). In a pragmatic way substitution treatment is also often seen as a way to bear the prison environment, as prisoners are more stable and detoxification does not occur through the cold turkey method anymore, which is a painful experience for prisoners but (although differently) also for staff. Another reason is, like in France, to use substitution treatment as a way to attract the prisoner to the health unit and to stabilise him/her, and then to provide care and support through therapies (group and individual) and eventually reach well-being, stability, no substitution treatment and absti-

nence. Some doctors feel they are 'drug providers' or 'drug dealers' curing nothing, only prescribing.

In The Netherlands for example substitution treatment is not automatically cut, when the length of the sentence exceeds 6 months. If the patient opposes this restriction, then a second opinion is integrated in the decision making process.

But these prescribing restrictions are in process and are subject of reviewing the substitution treatment modalities (recently the Dutch Ministry of Justice, lifted the time span from 3 to 6 months).

Reduction schemes

When it comes to a detoxification treatment the heterogeneity found for the distribution and quality of substitution treatment as such can also be found regarding reduction schemes throughout Europe. The reductions steps vary considerably not only between countries and states but from prison to prison in one state (e.g. Germany, see country report).

Being on a dosage of 50 mg means a detoxification period of 35 days (10 mg less per week) in Men's prison Hanover or in 20 days (5 mg less every second day, the same scheme found in the Amsterdam prison visited) in another prison (Women's prison Vechta) in the same state of Germany. Apart from this example we found reduction schemes between 7 days and four weeks (for a 40-50 mg dosage).

Although these schemes are not seen as completely static (periods may be prolonged according to individual needs in some countries) they give basic orientation and is a result of the experiences of patients (may be different women and men who may prefer either the faster or slower reduction scheme). The most important element of the reduction scheme is that it responds to the patient's needs. Reduction schemes that are provided to all patients equally are likely to fail and/or to result in relapse as individual needs are not taken into consideration.

There have been many criticisms of the reduction schemes by prisoners in the interviews, which point at the static scheme as such and the speed of reduction steps. According to them the reduction schemes are not sufficiently reflecting individual needs and abilities. The practice is often perceived as inflexible and not adopted to the wish of the inmate/patient. This applies especially to those drug users who are dependent for twenty or more years and for whom methadone became a sort of basic therapy for many years. Inmates express their wish to be more involved in the decision making proc-

ess and to be asked about the steps of reduction. The plea is for leaving the decision to the inmates, whether or not and if, in which steps they want to reduce their methadone. Clear explanations provided by the doctor and dialogue with the prisoner are key elements in the success of the treatment.

Apart from perceiving the detoxification procedure as too rigid, it has been criticized that medical time was not offering enough space to negotiate. This has been analysed as a lack and difference to the provision of methadone in the community.

Detoxification and/or maintenance treatment?

As said above the decisions either to detoxification a patient or to continue (or even start the substitution treatment) in prisons depend on several factors: lack of resources, personnel, which results in a limitation of the places (e.g. Germany), poor knowledge, depending on the development of substitution treatment in the community (e.g. Ireland) no supporting regulations/guidelines, opposing substitution policy for the prison setting (Greece) or restrictive substitution policy outside in the communities (e.g. Sweden).

Apart from these institution-related reasons, a constant factor seems to be that the wishes of drug using prisoners/patients have been expressed to have free choice for either of these options (see country reports in Ireland, Germany, The Netherlands). This is what they experience mostly on the outside, especially with the growing facilities in the communities, and are facing in prison apart from other restrictions also the complete dependency from the decision of the doctor in charge of the team. This leads to disagreement and dissatisfaction.

A lot of interviewed prisoners (Belgium, Spain, France) said they wanted to detoxification but the doctor did not want them to. Actually, often, once stabilised, the prisoner wishes to detoxification quickly and be completely drug free, wishing to have no more contact with drugs, doctors, to hear or talk about dependence and problems related to drugs, wishing to start a new life and be ready and 'clean' for release. The doctor and nurses sometimes are opposed when s/he feels the prisoner is going too fast. Relapse and/or overdose are likely to happen, especially when detoxification occurs too fast. Here, the satisfaction is from prisoners who wish to detoxification and the doctor who is opposed to a quick (too fast) detoxification. Again this leads to disagreement, dissatisfaction and misunderstanding. One key element is that the doctor explains clearly to the patient the advantages and disadvantages of

a quick and long detoxification, if an individualized approach is taken (this is not possible in standardized forms of detoxification treatments of 15 days for all prisoners).

Initiation of substitution treatment in prisons

Initiation of substitution treatment remains a marginal offer. It is either done immediately on admission (despite having no registered previous treatment in clinics or individual GPs, e.g. Germany) or in a period of time before release (e.g. Scotland). The pragmatic reason for the rare initiation on admission lies in the fact that usually the demand already for those being in registered substitution treatment before imprisonment is higher than the places available in prison.

To start substitution treatment before release is meant to be a sort of “immunisation”, to avoid immediate relapse and overdose after release, which constitutes a major problem in several countries. There are still remaining problems in several countries with respect to the continuation of treatment for prisoners to be released. In many prisons the goal of ST is detoxification in order to make sure that the prisoner is detoxed when released, because the continuity of substitution treatment is difficult or problematic to continue on release. Overdoses on release in most of the countries are problematic and have resulted in a change of attitude: it is advised to maintain the prisoner on a small, stable dose until released, to avoid (or decrease the risks of) overdose on release (e.g. Belgium). Overdoses on release and suicides in prison have been key elements in England/Wales to integrate substitution treatment in prison and propose a proper structure for such treatment (still being ‘constructed’ in England/Wales via the Department of Health). Scotland offers ‘retoxification’ to vulnerable prisoners prior (approximately 3 months) to release in order to avoid overdose or relapse. England/Wales also wish to offer retoxification.

Good cooperation with community services is necessary in order to provide retoxification or maintenance beyond release.

No substitution treatment in prison

The role of psycho-social care

Psycho-social care is seen as an additional and necessary part of treatment to support the medical part of the substitution treatment in prison. The benefits

of substitution treatments depend on the dose but also on the medico-psychosocial-educative measures provided to the patient. The aspect of psychosocial support associated to substitution treatment is constantly underlined for the success of the treatment. However, such a support is rarely provided. Only a few consistent psycho-social programmes could be identified that are accompanying the provision of substitution drugs (e.g. women's prison in Vechta, Germany). But apart from that, there are several structures within the prison that try to combine all efforts (counselling as well additional treatment services) made to support prisoners. Furthermore, prisoners welcome outside community-based agencies offering assistance.

In some countries the professional psycho-social care is a mandatory requirement of substitution treatment (e.g. Germany) in others it is facultative (Austria, France) in many other countries such a formal intervention offer is not known or applied (e.g. Ireland, The Netherlands). Although psychosocial support or any other personal assistance is acknowledged in many prisons visited, it is also lacking in many institutions. Many prisoners interviewed have been demanding more time to speak to social workers, psychologists (e.g. Austria). Community-based offers in prison are lacking in many of the institutions visited.

In the interviews with prisoners, it turned out to be that self help groups are often perceived as ambivalent. On the one hand, they guarantee an exchange of experience and valuable information. On the other hand, the confidentiality of the personal input given is doubted, so that it may occur that some of the information is taken out of the group and misused.

When looking at all the countries that were visited, dissatisfaction and complaints (mainly from prisoners, but also from staff) about substitution treatment were NOT on the substance itself, but focused on the support or lack of support associated with the provision of the substance. Some prisoners complained about only receiving the substance, and seeing no psychologist or social worker to talk to (Belgium, Spain). Some prisoners felt they were not receiving any care or support, but rather a drug that they could misuse (e.g. France). Some of these prisoners were much more content on a methadone treatment as they could not misuse it because they had to go to the medical centre every day, and thus integrated a medical framework. Staff questioned the success or purpose of substitution treatment if psycho-social support was not provided (e.g. Portugal and France).

Dosage

The average dosage we asked for in the prisons visited varied considerably (from 30-70 with individual doses far more than 70 and less than 30). Apart from the individual case-oriented prescriptions certain policies and philosophies regarding dosage become obvious. On the one hand, there is the opinion that relatively low dosages are sufficient (in contrast to the outside, see Interview with Jan Palmer) in the prison setting for two reasons (i) the in prison mostly thoroughly applied supervision of intake guarantees a 100% of intake and (ii) the amount of other drugs taken is substantially reduced compared to the situation outside. On the other hand, we found average dosages in prisons of 60 mg (Germany) and much more (up to 120 mg Denmark, Spain – this also reflects different cultures in the community). This has been criticized also by prisoners and NGO workers as ‘cosmetics’ or unnecessary to stop the craving. As there is no such a thing as average dosage, dosage questions should be left up to the doctor-patient-relationship and should be adjusted to individual needs. Though there should be space and time to negotiate the needs of the patients to either reduce or increase dosage (e.g. Austria).

In most places the prisoner knows the dosage. In others, he is not told unless he asks (e.g. Portugal). In France, the maximal dose of buprenorphine is controlled by the pharmacist, and can overrule the doctor’s prescription if it is over the pharmacist’s limit. In many countries, it is advised not to go above a set maximal dose, although the doctor is allowed to go over it. Some doctors prefer to stick to the advise (e.g. Scotland).

It is also reported that prisoners try to achieve an amount as high as possible in the beginning of their sentence to calm their fears, being cut off from the possibility to increase dosages the same as outside and the fear of going through pain and withdrawal) but are attempting themselves after a while to reduce these amounts, of down to zero. Sometimes these processes are viewed by the doctors themselves as too quick and probably associated with additional risks (e.g. overdose after release or during home leave).

Several experts said that one should not talk about and aim at low or high dose but rather about adequate dose. The most adequate dose is the one that is amicably negotiated between the doctor and the patient.

Supervision of intake

The supervision of intake (of methadone either in liquid or tablets) is organised in different ways, done either by nurses or guards, depending on how and where the substitution drug is dispensed: either within the medical unit or on the cells/wards. This is to ensure that the substance is swallowed. In most cases, control is carried out by letting patients talk afterwards.

Although methadone is the main substance provided in prisons, buprenorphine is also increasingly provided. Two examples indicate the differences in supervision and control policy and practice:

In the Czech Republic, each prisoner on buprenorphine is on a short-term detoxification treatment. Each prisoner is called to the medical centre where the doctor, assisted by a nurse, provides the pill. The prisoner must stay in the medical centre for approximately 10 minutes, or as long as it takes to dissolve the pill sub-lingual. The provision is controlled and the intake is done as recommended.

In France, the provision of buprenorphine is a lot different. Usually, the prisoner is asked to go to the medical centre every day for one week, where he receives the pill, is told about substitution treatment and gets in contact with the psycho-social team. Sometimes, this supervision only lasts a few days, and buprenorphine is prescribed and provided like any other substance (like for instance a sleeping pill), that is provided by the nurse who visits the different cells. The prisoner is normally allowed to make the request to go to the medical centre to get his medicine and have none delivered to his cell by a nurse.

After the first week of buprenorphine provision, usually the pill is delivered by the nurse to the prisoner in his cell as described here above.

The medical staff often states that this method of delivery takes place (i) to increase the prisoner's responsibility in himself, (ii) for practical reasons: delivering every day to each prisoner under substitution treatment would require time and resources that are lacking, and (iii) to free the prisoner from the dependence and obligation to visit the medical centre every day.

Unfortunately, this delivery has resulted in misuse and traffic of buprenorphine pills in the French prisons, echoing the situation outside. Prisoners tend to stock the pills, sell them and/ or misuse them. Usually, when misusing, the prisoner crushes the pill until it becomes powder and then sniffs it or injects it, resulting in getting a kick. This results in buprenorphine being associated to the 'white powder' and to drugs to get high. The delivery of

methadone in the French prisons, however, is very different and is extremely controlled and supervised. Prisoners must go to the medical centre every single day to receive their treatment. Traffic and misuse is thus highly minimised and inexistent.

One particularity must be noticed to the supervision of intake of buprenorphine. For instance, in several prisons the buprenorphine tablets have been crushed by the doctors themselves in order to make sure that all the amount has been taken (this form of intake is not adequate and may lead to not fulfilling its purpose), to reduce the risks of traffic and misuse, and to reduce the time of supervision (e.g. Sweden and Portugal).

Prisoners have said that a supervision of intake protects those being in substitution treatment from other prisoners who wish to participate from the substitution drug. This pressure put on inmates can be avoided by a well organised supervision of intake.

Urine controls

The value and consequences of medically ordered urine controls varied substantially between the sites visited. In some countries, very few urine controls are taken (e.g. Denmark¹, comparably to the practice in the community). It is thought that the use of (additional) intoxicants will be noticed by the medical staff and the guards. In other countries (e.g. in one prison Ireland) a positive urine test (e.g. cannabis) may lead to consequences for the substitution treatment itself (reduction of dosage). Also it has to be noticed that different standards are applied (i) from prison to prison in one city (e.g. Dublin, Ireland) regarding for instance the toleration of cannabis and (ii) from community services in comparison with prison-based substitution treatment. In Scotland cannabis is not tested for, as there is no treatment for cannabis use. Whereas in one prison the doctor is reducing the methadone dosage for some time, it is completely tolerated within the medical context in another. This is different when it comes to prison-control related urine tests, which may lead in both cases to consequences in terms of loss of home-leave for some time or other privileges.

1 At the time of the country visit in June 2003, meanwhile another policy seems to be applied (personal communication with Alette Reventlow).

Whereas the sanctions regarding urine tests in general, and cannabis use varies considerably throughout Europe, and depends on an individual doctor's view, there is a growing consensus about the negative effects of benzodiazepines within substitution treatment. The permanent consumption of benzodiazepines leads in several cases to an exclusion from the substitution treatment. So the range of sanctions regarding positive urine tests varies from toleration to exclusion from substitution treatment.

Co-prescription of benzodiazepines and other drugs

In those countries with a longer history of opioid use dating back to the late 60's (e.g. The Netherlands, Austria, Germany) the use particularly of benzodiazepines is widespread among drug users, mostly to bridge the gap between the lack of availability of the preferred opiate (merely heroin) use. The using patterns often constitute an additional dependence with severe syndromes and problems in detoxification.

With a time lag of several years the use of benzodiazepines is entering the prison system and constitutes a major health problem. Whereas there is a growing consensus about the dangerousness of these drugs taken chronically among doctors and health workers, this hasn't lead to a complete ban of prescribing them on a steady basis. In many prisons, interviewed prisoners were dependent on benzodiazepines before admission to prison (e.g. The Netherlands, Germany, Austria, Denmark). One of the debates with doctors and nurses is the continuity of prescription of these drugs in prison, which is not done in the prisons visited. In some countries more arguing is going on about benzodiazepines than about substitution drugs. In others we saw evidence that the lessons about benzodiazepines were understood by prisoners and led to an awareness of the harmful consequences of chronic use of benzodiazepines (e.g. Ireland). Although there is a growing demand from prisoners, only very little mostly in remand prisons is prescribed. When it comes to sentenced prisons, a detoxification of these substances is organised in different steps, depending on how long the use has taken place.

Information to patients

The information to the patient about substitution treatment and drugs in general and on particular rules, agreements, expectations is lacking in many studied prisons. It could be observed that prisoners didn't understand the

goals pursued with the substitution treatment, nor the specific drug nor the specific treatment setting applied (rules, exclusion criteria etc.).

The informed consent often has not been undersigned when it comes to additional information that has to be acquired from other persons and institutions.

This leads to the fact that treatment modalities are either not completely understood, and/or are not transparent and seem arbitrary (buprenorphine intake is 'sub-lingual' which requires education/ information). The lack of adequate information is not contributing to a motivation to play an adequate role in the treatment process.

Prisoners acknowledge positive developments (Ireland, Germany) as many of them have experienced insufficient regimes of substitution treatment in previous sentences.

Guidelines, recommendations, regulations

As listed below, several countries developed guidelines and regulations, protocols of how best to proceed with new inmates with regard to either detoxification or maintenance treatment. These documents provide every practitioner with either the legal basis of substitution treatment and/or with clear guidance and detailed protocols of how to cope with individual cases and problems.

Confidentiality of treatment provision

Confidentiality is an important part of the substitution treatment as it assures the prisoner that other inmates and staff are not aware of his or her treatment. The fear is that if somebody knows about the drug dependence, it will lead to consequences for the actual sentence in terms of disadvantages (e.g. access to work, qualification, jobs), prejudices, loss of privileges or simply by the negative attitude of staff and other prisoners. The patients moreover fear pressure from other inmates, who wish to participate from the substitution treatment in terms of smuggling substitution drugs out.

Although it is hard to reach anonymity and confidentiality within the prison context, attempts have been made in many sites to organise the suspension of substitution drugs in a way that protects prisoner. Either the prisoners on substitution treatment are all put together in a wing (Portugal), or substitution drugs are delivered with other medicines. But also, we found examples where prisoner were complaining about the way substitution drugs are given

out (e.g. by shouting over the ward or by indicating substitution treatment on the nameplate at the door (e.g. prison in Vienna, Austria; Portugal).

It must be taken into consideration that good results and success of treatment and supervision of prisoners have taken place in prisons where the different staff (psychologist, doctor, social worker, nurse, guard) take part in meetings and know about the treatment. Follow-up of prisoners is easier. Guards are often the only one present in the prison over night and weekend and it was reported that being informed (sometimes largely, just being informed that prisoner x takes various medication) has been useful. It also seems that when guards are completely shut out of the psycho-socio-medical support, barriers are built between the different professionals and sometimes prejudices and misunderstandings about the prisoner and drug use are stronger. Hence, it seems that basic cooperation and information and training of prison staff, including guards, is needed to ensure positive or better attitudes of staff towards drug users.

Substitution treatment as a reward for a good behaviour?

Prisoners interviewed often regarded substitution treatment as a kind of reward for good behaviour and not as part of a 'normal' treatment within a variety of medical and psycho-social treatment options of drug treatment. This understanding may of course have consequences for criticism within the doctor-patient-relationship or in the formulation of critics concerning the substitution treatment with the nurse.

And in this sense misbehaviour within serving the sentence clearly leads to an exclusion from a medical treatment. It is this combination in practice that may reveal a close co-operation between the control and the care part of the sentence.

Prescription before home leave/release

This depends on the organization of substitution treatment in the community and either results in giving the amount needed for the respective day(s) to the prisoner (e.g. Denmark) or to co-operate with other doctors/pharmacies on the basis of a particular letter (e.g. Germany). When it is given to the prisoner, it also reflects trust and stabilization already achieved not to sell it etc.

Training

Whereas in countries where a particular vocational training is needed to engage in substitution treatment (in ‘addiction medicine’ e.g. Germany), this necessary for prison doctors as well. Where this is applied or planned (e.g. The Netherlands), at least a baseline information is given to the GPs working in prison and the prison doctors. In several countries specific training for prescribing doctors is not specifically required. Additional training makes sense because the need for the changing treatment demands is expressed by many of those interviewed.

Specific training on drugs and substitution treatment is clearly missing. Most professionals said they were learning on the field. Although this along with support from colleagues seemed to work fine and allowed them to do their job well, they still welcomed further specialisation and/or information. Some professionals have reported that some trainings and/or seminars focus on drugs and drug treatment as applied to the community environment, and lack information and advice for those working in prison.

In some prisons officers are trained to become specialised on drugs, such as Scotland, or like in Italy where the staff of the Ministry of health is specialised in drug issues and works in prisons.

Also for health care staff, refresher courses are needed as new developments are coming up (e.g. ‘new’ substitution drugs like buprenorphine). For instance in some prisons buprenorphine has not been introduced, although authorized, simply because the knowledge on how to measure the switch from methadone to buprenorphine (if needed), or of how to supervise the intake is lacking.

Finally, guards need to be trained in the nature of dependence and drug use and health care interventions, particular substitution treatment.

A structural question is whether to employ nurses instead of officers with a short vocational training of several weeks, or to employ officers instead of nurses for the delivery of substitution treatment.

Lack of evaluations

Almost in all countries visited, we identified a lack of evaluation of the substitution treatment, taking the needs of the patients into consideration and also the views of the service providers. Also, it seems as if the consciousness of looking at the topic often stops at the gate (that means the point of release is taken at a sort of ‘natural barrier’ – more holistic perspectives need to be taken).

C. The need to treat women separately in substitution treatment

The issue of gender specific treatment needs has yet to be raised within the context of substitution treatment. Imprisoned female drug users often show severe and risky patterns of use within the context of multiple major health issues (physical and psychological) which require special attention within the delivery of health care (Zurhold and Rebernig 2004). Jan Palmer (Nurse and consultant on Substance Misuse HMPS Women's Team, England) was one of the first to raise this issue in “Clinical Management and Treatment of Substance Misuse for Women in Prison” (see References).

HS: You gained your experience of clinical management of opioid addiction in the prison centre here?

P: I began on secondment from the NHS to the prison service in January 1997 and then I led the development of the first detoxification unit in the prison service in England.

HS: What was the name of it?

P: Holloway in London, the women’s prison.

HS: This was the first detox unit in England and Wales?

P: Yes. I didn’t know that at the time. When I was doing it I didn’t know it was the only one. That’s how I began working with substitution treatment for women in prison.

HS: How did you analyse the need for this treatment and what were the main obstacles to introducing it?

P: I didn’t identify the need. The prison service directorate of health care, as it was then, funded the setting up of the unit. So the prison service must have seen the need. I purely came along and lead that development. I wasn’t involved in the original planning, the prison service identified the need.

HS: ...the design?

P: No, not the design. In fact it was very difficult. The prison service and my NHS trust got together to plan what the provision might be like. But neither of them had any experience of delivering that care in prison. So when I came

along and began to do the work it began to look very different to the way that they had planned it. So that was quite an interesting experience, because I had then to convince senior people in both the prison service and my own trust, that it was right to move things in a different direction, to the original plans. I had no previous experience in prison work. I was just working with what I was finding. So that was a very interesting time to begin to try and change the culture in a prison.

HS: Why was it only in 1997 that the first detox came up in the prison while in the community maintenance must have been present for many years?

P: That's right. I have no idea because I wasn't around in the prison system before that. But even in 1997 it was a detox unit. In the early stages, we were not allowed to do any maintenance. Everyone was detoxed. It didn't matter how much they have been using, or for how long, apart from pregnant women and we didn't pick them up to start with. So it was only a detox unit in the beginning.

HS: The detox steps, the reduction scheme, was it initially set up as it is described in your handbook¹?

P: No, it was much less than is in the handbook. In dosage and duration. Much shorter. The level was probably similar, I can't remember how much shorter. What we have got in the handbook is a very basic 10 day opiate reduction regime. But our minimum now is 14 days. And we will detox anybody who is coming off methadone over a minimum of 21 days or more.

When they come in, if they are on methadone, there is a 21 day withdrawal regime. We have a minimum of 14 days for everybody coming off street drugs, but a minimum of 21 days if they are coming off methadone. If they are positive to methadone, they need a slower withdrawal regime, because methadone is a much longer acting drug. We have basic fixed regimes, but there is also a blank sheet so that you can do anything else as well. So the baseline is really to make you act to ensure that everybody gets the safe minimum, and then we would do anything else on top of that, increased reduction or maintenance or whatever is needed. We would expand the

1 Jan Palmer (2003): *Clinical Management and Treatment of Substance Misuse for Women in Prison*. Central and North West London NHS, Mental Health NHS Trust, Substance Misuse Service, London, England.

regime upwards, so that you could have somebody detox over six weeks, or longer, and, of course, we now do maintenance.

HS: The minimum is 21 days when having been on methadone prior to arrest?

P: It should be, and fourteen if it's just heroin. But they are only minimums, we would encourage people to offer longer if it is needed. We have lots of locum doctors and inexperienced staff in prison at the present time and at least by having these minimum set standards, you can be sure that everybody is safe. When you have more experienced staff you can offer more individualised care and try to have care plans for each person. We do that to a varying degree, not as much as we would like, we don't have the resources yet. But we do now have maintenance as well.

HS: So, is there any strategy to inform prisoners of the risks of reduced or zero tolerance in their body with occasional drug use in prison and after release?

P: I mean, all the harm minimisation information is given out, very much in the CARAT's team, and we give information on the clinical side as well to all people at risk of overdose. But my personal view is that it is of little value, because addiction is so powerful, and in prison they may be completely abstemious as there are no drugs that they are allowed to use, so when they leave it's like Christmas. It's very unrealistic to expect them to go out and to take nothing, and I think that overwhelms them when they leave prison. They are blind to the risks, even though they know what they are. We know with addiction that, cognitively, people don't see the harm. The alcoholic continues drinking, even when they know it's killing them, they don't seem to register the risks. And I think the same thing happens with opiate overdose, they know it as well as we do. When they are offered injectable heroin, the desire is too great.

HS: So wouldn't it be the best strategy to propose and promote maintenance, for short term prisoners?

P: Yes, we do promote that. The problem we have is that most of our community services haven't got the ability to pick people up when they leave prison. They might be on maintenance in prison, and we could keep them on that to preserve their opiate tolerance, but there is often nobody in the community to continue the prescription. So we have a big gap at the moment.

HS: It's a very important point. What do you do with them, having them on the maintenance knowing that there is no continued prescription afterwards?

P: At the moment our criteria for maintenance is that if you are in treatment before you come in, and you can go back to your previous prescriber, or if you are pregnant then we offer treatment. When they come in we check with the prescriber that they are on prescription and we ask the prescriber: will you take her back? If they say yes then we give them maintenance. If they say no, we might still maintain them for a while, and see if we could find another prescriber. If we can't, then the patient has to choose: do they want to come off, maybe slowly, or do they want to continue maintenance to protect their opiate tolerance, and upon release return to using as they did before.

HS: Is it up to the doctor and the teams discuss the pro's and con's of the maintenance programme with the inmates?

P: Yes. I'd be lying if I said that we were that sophisticated in all our prisons. We are not; we are in some, not in others. Although we have a network of provision all over England's prisons, it's still in varying stages of development. So one prison would be very good at one thing and one would be very good at another. We have the same standards and assessments and the same approaches to treatment in all the women's prisons. But those who have had better investment, who have had more money, are better established. Though everybody understands that we are moving in the same direction, we are all at different levels at the moment.

HS: How many women's prisons are there in England and Wales?

P: There aren't any in Wales. They go to Gloucester. There are 17 now.

HS: What do you think of the coverage and the scope of this design you have developed, the different options people can take, either to detox or not, and the communication with the outside agencies? In how many of the 17 prisons this is done satisfactorily?

P: The bulk of all our work is done in our local prisons, the remand prison, and there are only seven of them. The other ten are training prisons. So the work I just described started off at the remand prisons, then, when people are sentenced, and if they are on maintenance, they can be transferred to the other ten. The other ten prisons will just continue the treatment and they manage the maintenance or very slow reduction, if people want to do that.

Our remand prisons are local prisons because they take everyone from the local courts. Our training prisons are where people are training and working, whilst they serve their sentence. They are either getting an education or working.

HS: But the scheme you just worked out is for individualised care, at least for the pharmacotherapy?

P: Not at the moment. It will be, and the principles are there and the idea is there and some of it is done. But it depends on the number of staff and how long the service has existed. Some of them are very new. One only opened in September last year, and one in December, so they are still in their infancy. They are very limited in what they can do, they haven't got the staff, they haven't got experience; they are just getting used to treating huge numbers of admissions every day. They might get 20 admissions into the detox unit per night, and you have got to stabilise and treat all of them. And tomorrow you get another ten, and the day after another fifteen and so on. Over the space of 3 days you have got 50 new patients to process. So, to some extent, prisons will always have some tendency towards a standardised regime, at least to begin with, because otherwise how do you safely process huge numbers of people. Once you get a bit further on you can individualise the care a bit more. That is the way we are planning and progressing with the services.

HS: So the continuity of the care depends very much on the capacity and the resources and the willingness of the community services, it's closely linked together?

P: Yes.

HS: Are you involved in discussions about expanding places and capacities outside for methadone treatment?

P: Not really. I mean, I did a presentation at a UK national drug treatment conference recently, and one of the things that I talked about was the difficulty in getting prescribers to continue treatment for people who are leaving prison. So I had a wide audience of GPs and specialist drug services.

HS: It takes time?

P: Yes. Well I have always been saying the same thing, so they knew it already, but they haven't got the money to provide the necessary additional services.

HS: Can you give a little bit of detail on the procedures, with regard to Buprenorphine. You mentioned that it's taken sublingually under supervision, how long does it take, what is your scheme with it, you got ten minutes, or so?

P: Well we are only using a very small amount of buprenorphine at the moment, as we have just launched it a month ago as our second line of prescribing. Our main substitution in the women's prisons has always been methadone. We have extensive use of methadone. We are now beginning to give buprenorphine as well, it will be given under supervised conditions, (as is methadone) its given sublingually and the patient will be observed until its gone. There is a whole procedure, I'll send you the buprenorphine protocol. I think the need to supervise it and the length of the dissolving process will limit its use, its so time consuming and it is much more expensive than methadone and it isn't superior clinically.

HS: It is not?

P: No, but it will be very useful for women who are reluctant to take methadone.

HS: Only for some target groups like pregnant women?

P: No, we wouldn't use it for pregnant women, no.

HS: Because I was told that the withdrawal process should be safer for the baby?

P: Well, that's debatable, if you mean the literature. Buprenorphine given in a low dosage doesn't give you 24-hour-cover, whereas methadone does, so there must be a risk of the baby going into withdrawal. It is not licensed for use in pregnancy. We wouldn't recommend it at the moment. If you use low dose methadone as we do in the prison, the neonatal abstinence syndrome in babies is very minimal, if at all. If we only give 30 mg of methadone, we get very, very minimal withdrawal and by the time women deliver we hope they are on less. You can also breast feed on methadone, but not with Buprenorphine.

HS: That's an important issue?

P: Well it is, because babies are delivered in custody and they go to a mother-baby-unit, the mothers can stay on their methadone and breast-feed,

which protects her from relapse when she is released. She can have indefinite methadone maintenance if she has a baby in custody.

HS: This is an important thing about buprenorphine in relation to methadone?

P: At the moment, yes. This research I am doing for my masters is around the outcomes of pregnancy on doses of methadone at levels of less than 50mg in prison. From observation we know that the obstetric outcomes are very good. But there's nothing published to demonstrate that. So I am doing this research to evaluate the efficacy of the care that these women receive in prison.

HS: Regarding the dosage of methadone, do you think there is a certain dosage, 50 or 60 mg has been set by Australian researchers, that is more likely to be successful in certain outcomes than low-dose-methadone programmes.

P: Our experience of – I mean we must have detoxed in excess of 15-20 thousand women, that's a large amount of women. Our experience almost exclusively is, that because people's supply of drugs is interrupted – when they get arrested, (they usually spend time in police custody) therefore their last use was often three days ago, they already have a drop in their level of use. When they get to us, the important thing appears to be the length of time you are prepared to prescribe for, rather than the dose you go up to. And without exception, once they are stable, they will always want to come down and we find 30mg averagely in prison is fine. We'll go up to forty for those using street drugs who need it.

It gets very complicated if you talk about someone who has been in treatment with a high dose, supervised consumption of 30/40mgs is unlikely to be sufficient, but it is still unsafe to give the whole amount that their community prescriber confirms is their once daily dose. This is a particular problem in pregnancy. And we are currently trying a combination of giving half the previous prescription, topped up with dose titration until a comfortable level is reached. In prison that appears to be fine because people aren't exposed to the same level of drug-use as they were in the community.

Most women using street drugs are stabilised and quite comfortable at 30 mgs or, occasionally, up to 40 mgs. But 30 mgs is our average. They are generally stabilised on 30 mg.

HS: Is it that, in prison, vulnerability is reduced, the tempo is lower, the circumstances are much safer and the day-night rhythms regular?

P: Well, they say they are fine on that sort of amount in prison. They then say they can't manage on that in the community: "I am on 30 mg here but I need 90 mg when I am out" is a typical report. But that's fine because we send them back to their prescribing agency, and that agency knows they are stable on 30 mg so they can start to increase again gradually to a level that meets their need in the community. So I would not say for one minute that lower doses would work in the community, but it works in prison, therefore we don't (usually) need to give more. The other difference in prison is that there is 100% supervised consumption. We know that they take it all. When they get a script of 80 mgs in the community, they may sell 30 mg, so they take only 50 mgs. Which is probably another reason that they stabilise out on the level of Methadone that I have described. So it is low dose in prison, but it is 100% supervised consumption. Most of them are simultaneously withdrawing from Benzodiazepines, so we are also prescribing diazepam at the same time. Again we have to be cautious with these reduction regimes, which are usually over a period of seven to ten weeks.

HS: How did you organise the way patients are informed about the way you are treating them with pharmaceuticals?

P: There is an information sheet that we give them. We give them an information sheet about the opiate detox, the maintenance regimes, and the alcohol detox, there are several.

HS: What is the interaction between methadone maintenance treatment and the HAART – or even Interferon treatment?

P: Very few of our women are on interferon because they are not abstinent from drugs and the policy in many areas is that they won't treat them when they are still actively using drugs or alcohol. They usually require them to be abstinent for six months. So very few get this treatment.

For antiretroviral treatment they get the same. What we have had to do in the past – when we were reducing a lady's methadone (at her own request) and her consultant wrote and asked if we could put her methadone dose back up because he thought her antiretrovirals would make the methadone less effective – is that we did, we got her level of Methadone up again. But it's no problem to have the antiretrovirals and methadone together.

HS: Is the dosage increased slightly?

P: Well, that's the only time we had to do that, but we would be willing to do so if a consultant says that the effect of the antiretroviral treatment is less effective, we would put the dosage up as needed.

HS: Yesterday we spoke of using urine control as drug tests, could you just repeat your experience in the way of handling it?

P: We have several different systems in England, one of them is mandatory drug testing which is a prison service provision aimed at detecting illicit drug use. We then have voluntary drug testing which, again, is a prison service initiative, but it's voluntary, and a therapeutic type of support to help people remain off drugs whilst in prison. Then for us, in healthcare, we have clinical urine testing. We test people on arrival and during their maintenance programmes, that's clinical, it is medically confidential. We don't disclose that to the prison for disciplinary purposes.

HS: Do you have information from the test results of the prison service?

P: Yes, we could have. We don't use it often. But ours is medically confidential. We have to have a positive urine test for opiates/methadone before prescribing takes place. I mean, occasionally somebody might have a negative result, as they have been in police custody for a while, but if you can see evidence of withdrawal, we would still prescribe. The urine testing is very much part of our assessment and in the "blue handbook" you will find a lot of information about semi-quantitative urine testing. We had a machine on site which was capable of doing this, it gives you levels of drugs present at admission. Temporarily, we are without that, but we are trying to get those machines into all the big local prisons so that we have an idea of the level that they have in their urine when they come in. It gives a better idea of expected tolerance to opiates, and the level of benzodiazepine needed.

HS: What are the consequences of additional topping up, let's say benzos or Cannabis?

P: We don't retest the Cannabis clinically (except for pregnant women) as we don't prescribe against a cannabis positive result. The prison service wants to know about the cannabis in terms of Mandatory Drug Testing (MDT) and Voluntary Drug Testing (VDT). We would re-test for cannabis in pregnant women because we want to know about their ability to be drug-free when caring for their baby. But otherwise we do a base-line of six

substances upon admission. At present the dip 'n read tests are in common use but they don't give levels.

We are not yet that advanced in managing relapse, because most women on maintenance are very appreciative of receiving this treatment, so they don't use on top. As we do more maintenance it may well become a problem. We recently had a situation where someone was using on top and, from a policy point of view, we are bit uncertain how to proceed with these situations. I think our approach (at the moment) is, if they use on top we are likely to suggest that they reduce the methadone, at least temporarily, and maybe put it back up if they are otherwise abstinent. We certainly won't push the level of methadone up and up. I think the difficulty that we will have in the prison system is that if we increase people's doses, due to their using on top, this will be an invitation for a lot of illicit use – we would lose credibility within the prisons. So our main approach at the moment is to say that if you do use on top, we have to reduce your methadone. We might reduce it by ten milligrams and review it in a week. If somebody really needs a high dose we might consider changing them across, to Subutex®, but we are not very clear about this the moment. That's something we are currently feeling our way with.

HS: Is heroin also prescribed?

P: No, only methadone and subutex.

HS: And not retarded morphine?

P: I've never even heard of them.

HS: In Austria, I have been in the prisons, they prescribe it on a wide scale.

P: There is a lot of use of the DF118 (Dihydrocodeine) in the male prisons. It is now almost withdrawn in women's prisons. We now have subutex as a second line, as we should always have a choice. DF118 is not effective, it is very highly misused, it's short-acting, it's not an appropriate opiate substitute and not licensed for that treatment. The other drug that's used in the male estate is Lofexidine.

HS: Please describe that, this is something new.

P: It's not as effective as methadone or Subutex®, and is really considered more in the symptomatic treatment range. It was designed, for the community, for less severely dependent users. It's not really terribly effective for

severely dependent individuals. And we almost never use it for women, we have a problem with hypotension in our client group of young, underweight women, as it has a tendency to reduce their low blood pressure further. We don't use it often because most of our women have very low (dystolic) blood pressures when they come in anyway. When you give them the Lofexidine, you have to monitor the blood pressure four times a day and, if the blood pressure drops, you can't give them enough to control their withdrawal symptoms, so we don't use it often. There is a protocol in the handbook but it's not in common use, although it is useful for low or uncertain use, particularly if the admission urine test result is negative.

HS: Can you just say some more words on the assessment you do. You said that your urine controls play a big role?

P: We assess everybody in reception upon arrival in the prison. That's the reception health screening. And according to what they tell us, they get urine tested for drugs and will then be admitted to the detox unit on the first night they come in. They will then get 10 mg of methadone on that first night and they will probably get some Diazepam if they are benzo dependent. If they are alcohol dependant then we start them on Chlordiazepoxide as well. So, they are always treated as far as we can on the first night. They get something. Then they are cared for in an inpatient detox unit where we have unrestricted observation. We have hatches in the doors, which are permanently open over 24 hours so the nurses can observe the women. So, as well as the initial assessment, we then monitor them for at least the first 72 hours and then we can see whether what we are doing is sufficient or whether they need additional medication.. The doctors/nurses interview is brief and therefore is not the same as in the community as we don't have enough time. It isn't practical, we can't sit down and have a lengthy interview with everybody as we would if they were in the community. So we use a self-assessment questionnaire and we ask them to give that back to us in the first 24-48 hours.

We then check that with other information that we have picked up during the various stages of assessment, and put all of them together and this gives us a better picture. So it's a mixture of all those things really.

HS: One of the reasons why we talk about substitution treatment in depth is that there are enormous organisational problems. We see people under police arrest, then go to remand and sometimes different juridical, professional and

financial circumstances are having influence on the assessment and treatment. How far are you cooperating with the doctor or the nurses or the whole team in the police arrest?

P: Increasingly, we are trying to get the police doctors to send the information to prison as the prisoner arrives. It's very patchy. We get the information sometimes and we don't get it at other times. That's quite a gap really. There is something called the criminal justice intervention programme (CJIP) which has just started this year and they are supposed to be the link through which information can be passed as people come into prison. An arrest referral worker can also do that. There are quite a lot of opportunities for information to be forwarded to prison but it is still very patchy at present.

So, it's very much around what we see; objective signs of withdrawal, what the patient says, what the urine test shows and then the confirmation we can get the next day about prescribed regimes. So there is quite a gap there and, equally, the other end. We are trying to make sure that, if there is a prescription in place upon release, our health care staff always inform the community prescriber so that they pick them up as soon as they leave prison.

HS. So can you – just for the maintenance situation and for the detox as well – say some words about the circumstances of the intake, how it is done? On the one hand, protecting privacy as probably not all of the other inmates should know that they are getting methadone?

P: Women's prisons have detox units to start with. Everybody in that unit is getting methadone so it's not an issue, not at all. When they leave the detox unit, they either come back there each day or they go to some other central point in the prison. But other medications are supervised as well in the prison. So people will go and queue to get the medication every day any way. Other prisoners are not so interested whether that person is getting methadone or whatever. We are certainly developing methadone clinics, as in the community. That has to be built into the prison regime. So people are aware of women going to get their methadone, they doesn't seem to bother them, it's not becoming an issue at all. Earlier on, the only people that we maintained were AIDS/HIV positive patients. That was a problem. Immediately you could see that if this person was being maintained and they were not pregnant, they must be HIV positive. But because now we maintain lots of people who are on treatment for some other reason, that issue has gone. So that was an issue, but that's now past. And if you go to a community

pharmacy or a community drug service for supervised consumption, people queue there, so it's not a big deal. Certainly it's not a big deal to women.

They should have the opportunity to come to the dispensary one at a time and we do our best to do that. We can only work with the buildings and provisions that we have, and none of those were ever designed with substitution treatment in mind. When we rebuild or develop new units, we plan dispensaries of a more suitable design. We are very often working with the inherited clinics that we have no control over, so we just have to use what we have got. But we don't often find women complaining about this at all.

HS: Yesterday you raised the point that you should be gender-sensitive, that you should take a gender-sensitive view. Can you explain how it's expressed in the division of labour you have? You are responsible for the women and your colleague for men I suppose. So what are the key issues in a gender-sensitive aspect of the work?

P: We have far less women in prison, we've got 4 700 women in prison in England and about 72 000 men. Because there are so many more men in prison, there is a full range of drug-use – from those with recreational drug use to dependency, occasional use and upwards. Because there are fewer women in prison, their drug-use is of the severely dependent type. The severity of drug-use of women coming into prison is out of proportion to the men. So, all women go straight to the in-patient detox unit. While in the male prison, they have levels of assessment and, by comparison, only a few need in-patient care. You begin from a different starting point, because their drug-use is so severe and complex. You also get health related issues from their drug using life style, the percentage of injectors amongst women is high, it is about 85%. Undetected pregnancies are not uncommon, some don't know they are pregnant until we detect it. And domestic violence, working as prostitutes, all of those additional problems, you don't see in the male estate. Very often, the problem is that you have to deal with the fact that they have lost their children. And many of the women have been abused in the past or traumatized and use drugs to dull that. And when they stop using drugs they become hugely destructive and self harm is a big, big problem for women in prison. In all cases where we have developed a good detox unit and service, the self harm during the detox is much reduced, and the prisons are impressed by this. It then sells itself because people stop trying to harm themselves during detox. Unfortunately what happens is, that because the detox is quite short (by community standards), they still tend to self harm

once they are abstinent which is another reason we try to promote longer regimes in order to reduce the risk of self harm. If women can control the rate at which they reduce, they don't self harm as the dose lowers, as they are in control. So self-harm in women's prisons is a major consideration.

HS: What else besides attempted suicide do you put under 'self harm'?

P: The most common attempts are ligatures. And these can be very successful, unfortunately. They are very good at it, don't ask me how. First night in prison, they have never tried to hang themselves in their life before, and they successfully tie a ligature which kills them. So the biggest problem of this sort is ligatures, followed by cutting, in women's prisons. Outside in the community they might swallow pills or overdose. One of the biggest things which tips them over the edge is lack of nicotine. So, we try to give a little tobacco during the detox phase to the staff, so they can rescue people. You can clinically manage all the other things, but during withdrawal they are very impulsive; one minute they are cheerful and the next they are desperate and when in that state they attempt to hang themselves. This impulsivity, in this poly-drug withdrawal, is a major problem of both self harm and behavioural management. They are often very disturbed, very agitated and impulsive. You sit with them, and one minute they're fine, and you walk away and you come back and they have attempted to hang themselves. So tobacco is a big issue.

HS: It's a tragedy. What could you do to appease them?

P: Give them nicotine, it's nicotine withdrawal, they are heavy cigarette smokers and when they come in they get very little in the way of tobacco because they only get one pack for a week, so we are just trying to encourage prisons to give extra tobacco at that stage.

HS: Do they have to pay themselves or who pays?

P: Well, a little bit of extra tobacco for the unit can be purchased via the general purpose fund. We don't give them packages, just an occasional extra cigarette. We don't encourage smoking cessation in the first six months (or a year) after detox. We say: no, it's too much, just carry on. The other thing we do is, we try to make the withdrawal less uncomfortable by doing things like giving them hot chocolate drinks at night, extra food at night, give them in-cell TVs which they don't pay for during the detox phase. All of these comfort things help, as does having open hatches in all detox unit doors, which are then staffed 24 hours a day by nurses. So the way we care for them is

arranged to reduce the stress of isolation and that has an effect as well as all the clinical regimes.

HS. What about the women coming from foreign countries? Does it make any difference?

P: No, most of the women from foreign countries are the importers, the mules, so, mostly, they aren't users. If they are, they are treated the same as anybody else. Not long ago, we had a lady from abroad who had been on maintenance for many years before coming in. She was expecting a short sentence and so we maintained her. She then got a 5 year sentence. So, once she settled down after the sentence we helped her to withdraw, at her own speed. Being from another country wouldn't make any difference. We sometimes get women in from Europe, on very high, unfamiliar Benzodiazepines that we don't have any experience of. We still treat them according to their clinical need, the same as if they were from the UK. We wouldn't even think about it.

Well, I do need to say, these services are very basic, this is just a baseline. We have done more in some places than others. I think the biggest thing we are trying to achieve, is the same level of care in all of our prisons. If you get admitted to a prison in Durham, and then get moved to London or Gloucester, it shouldn't make a difference to the care you receive. This is not absolutely the case at the moment but it will be, hopefully, within the next twelve months – everyone will be using the same assessment, the same prescribing regimes, and the same criteria of flexibility. So, she should get the same level of care in Durham, Gloucester, Birmingham, London or wherever and that will then be continued in whatever women's prison she is in until release.

There is increasing support from high up in the prison service now for maintenance.

...

You have to go with what you can develop and get it consolidated. If you rush too far ahead and are too controversial, you might lose the support. We should at the moment really try to promote maintenance and, indeed, relapse prevention prescribing such as naltrexone. But very much a focus on maintenance. I think we've got a culture change and quite a lot of work to do to get that widely accepted. It takes a long time to change anything in prisons. It is so time consuming and you have to put so much energy and persistence into getting things changed. We have to focus on the big things at the

moment, and that is as an alternative to detoxification, promoting maintenance.

HS: Yesterday we discussed that it is one thing to give out regulations or publish something and another thing to implement it. Do you have an overview of all of the 17 institutions? Do you know everybody, and everybody knows this is our philosophy, this is the benchmark, this is the basic level of care that is expected – and more is better?

P: Yes. I know everybody in all 17 institutions. I personally supervise all 17 prisons. They all know me, and I know them. I spent much of my time on the motorways, visiting all the prisons. I spend all my time assisting the development of services in those 17 prisons in order to achieve this standard, minimum level of care. It is my fulltime job.

PART IV :
Conclusions & Recommendations

A. Conclusions

This chapter discusses the findings from our field visits (see country reports) with the literature study, additional scientific results and the statements from our workshop on “Substitution Treatment in European Prisons” which was organised during the “7th European Conference on Drug and HIV/AIDS Services in Prison¹”. During a workshop several international experts contributed to a draft of the WHO on substitution treatment and harm reduction in prisons².

High prevalence of opiate use and drug-related infections in prisoners

The prevalence of drug use in prisons with according drug-related problems for the institution and the whole system has been convincingly demonstrated (Thomas & Moerings, 1994; Shewan & Davies 2000; EMCDDA 2003, 2001). A disproportionate number of prisoners have a history of drug use, drug problems and/or injection. There is indication that prison reception health screening is consistently even in underestimating drug use (Mason, Birmingham & Grubin, 1997). There is overwhelming evidence of severe problems for the individual’s health, that of partners, families and severe problems for the security, hygiene the cohabitation of inmates in prisons and health of staff. It is estimated that approximately one third of the inmates are supposed to be opiate dependent, and many more are experienced in drug use. In several prisons, this includes up to three quarters of the inmate population. Although there is less frequent evidence of continued drug use and an uptake of drug use while in prison (Stöver, 2001). This is associated with high risk of HIV/Hepatitis transmission due to sharing/reusing injecting equipment and drug solution (Lines et al. 2004; Davies 2004). Also there is an extremely high risk for drug using prisoners to relapse and overdose

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- 1 “Prison, Drugs and Society in the Enlarged Europe: Looking for the right direction” (organised by the *European Network of Drug Services in Prison – ENDSP*, and the *Central & Eastern European Network of Drug Services in Prison – CEENDSP* in Prague/Czech Republic from 25-27 March 2004).
 - 2 Draft “Prisons, Drugs and Public Health – The vital role of harm reduction in prisons in reducing the harmful effects of drugs in society” (*prepared by the WHO Regional Office for Europe, Health in Prisons Project*). Thanks to Alex Gatherer, health in prison project (WHO Regional Office Europe) for chairing the workshop.

shortly after release (Seaman, Brettle & Gore, 1998; Heinemann, Kappos-Baxman & Püschel, 2002).

Substitution treatment well indicated and effective

Although prisons systems, for a variety of reasons, are slow in responding to the epidemics of viral infectious diseases (such as HIV and Hepatitis) and injection drug use threatens the health and wellbeing of inmates and challenges the institutions. This was the background for introducing substitution therapy as one of the most effective treatment options for opiate dependent inmates. As shown in the literature review, several studies indicated that methadone maintenance (MMT) treatment could reduce heroin use, drug injection and injecting risk behaviour (e.g. needle sharing), participation in the prison-based drug trade, and increased participation in drug treatment following release from prison (Kerr & Jürgens, without year). Substitution treatment is contributing to a reduction of opiate related mortality soon after release from prison. Moreover, the initiation of MMT also contributes to a significant reduction in serious drug charges and in behaviours related to activities in the drug subculture. Offenders participating in MMT had lower readmission rates and were readmitted at a slower rate than Non-MMT patients. There is evidence that continued MMT in prison has a beneficial impact on transferring prisoners into drug treatment after release. Finally, as expressed in many interviews during the field visits, the prison system benefits from substitution maintenance therapy through reductions of withdrawal symptoms on admission, drug trade, increased productivity and may help to minimize the contradiction between control and care.

The background of this body of evidence indicating the eligibility and success of substitution treatment has been implemented in several countries as a regular service accessible for every inmate.

Diversification of drug-treatment approaches including substitution treatment

Many studies have shown that criminal justice interventions alone, without associated opioid dependence treatment, have very limited impact on drug-using behaviour and re-offending among individuals with drug use. Porporino et al. (2002) pointed out that continuity of treatment provision is one of the key concepts, particularly following release, and that it is linked to re-

offending rates. There is a consensus among professionals that drug treatment can be effective if it is based on the needs of prisoners, is of sufficient length and quality and there is continuity of aftercare in prison and in the community (Ramsay, 2003). It is the combination of treatment in prison and follow-up treatment afterwards that provides the best impact. "That's with drug free treatment, but logically there is no reason why the same thing shouldn't be applied to substitution treatment" (Farrell, 2004). These are important baselines for a through-prescription that means a continuity of substitution treatment from the community to the prison setting and back to the community.

As pointed out by the joint position paper of WHO/UNODC/UNAIDS (2004) on Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention "no single treatment is effective for all individuals, therefore services should be sufficiently varied and flexible to respond to the needs of clients, their severity of dependence, personal circumstances, motivation and response to interventions. The rational management of opioid dependence calls for the balanced combination of pharmacotherapy, psychotherapy, psychosocial rehabilitation and risk reduction interventions." Seeking an equivalence of health care in the community and in prison this outlined diversity of treatment approaches needs to be transferred into the prison setting.

Enlargement of the scope of substitution treatment

The substantial increase in the number of opiate users in substitution treatment in Europe in recent years (almost 400,000 patients in 16 countries receive substitution treatment. 60% solely in Spain, France and Italy) has had and will have an impact on the number of substitution treatment in prisons as well. Compared to similar studies conducted in the nineties (Turnbull & Webster 1998; Bollini, 1997) we found the number of countries providing substitution treatment increasing (only Greece and Sweden were the only countries providing no substitution treatment, Czech Republic delivered detoxification with buprenorphine in a prison hospital). Consequently, the number of patients receiving substitution treatment in prisons increased considerably (e.g. France where the percentage of prisoners receiving substitution treatment increased from 3.3% in 1999 to 5.4% in 2001; Morfini & Feuillerat, 2001). Much movement could be observed in recent years in the prison policy (protocols, regulations) and health care to follow the develop-

ments outside in the community and to introduce substitution treatment. In several countries the continuation of substitution treatment begun in the community has been done routinely, close co-operations and communications with community-based addiction centres are guaranteeing a high standard of professionalism (exchange of new developments, harmonisation in terms of organisation of subsequent substitution treatment after release etc.).

Although the scope has been enlarged, the solely quantitative view on the concrete treatment modalities shows insufficiencies, a process of quality assurance has to be initiated in many prisons regarding procedures and routines of administration, keeping confidentiality and many other treatment modalities discussed hereunder.

Limited access, limited equivalence of care

Despite The WHO recommends: "Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries where methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons ...". In several countries, community-based treatments most likely result in discontinuation once entering the prison setting, for various reasons, or in restricted access to few substitution maintenance treatment places. Still, in many prisons visited the demand expressed by prisoners for substitution treatment is much higher than the actual provision. Long waiting lists, limited space and lack of resources and personnel in many prisons are demonstrating that the increase of substitution treatment outside in the community has often not been followed by an adequately organized and financed substitution treatment in the prison setting. Especially the allocated budgets on the background of an overall overcrowding of the penitentiary institutions in Europe often leads to restrictions in the capacity for an adequate and qualitatively proper substitution treatment. It seems as if the prison services are swamped with the expectations of prisoners, professionals from the community and politicians regarding the implementation of adequate structures of health care. Substitution treatment often reveals the missing interlinks of health care in the community and in prison as this medical treatment effects both systems.

Abstinence orientation

What are the reasons for the disproportion in several countries that only a small part of those prisoners receiving substitution treatment in the community will do so in prisons (e.g. France: 56% in the community whereas only 20% in prisons, see Michel 2004)? Apart from insufficient resources to provide adequate substitution treatment programmes in prisons and limited places in the community, several other reasons for a resistance towards this form of treatment and barriers to service access can be identified. The predominant obstacle for the introduction is the *basic abstinence-orientation* of doctors, nurses, responsible persons in the prison service, and finally prisoners themselves. The goal of the sentence (to enable prisoners to live a life without committing criminal offences) is identical with abstinence from illegal drugs (which have to be purchased on the illegal market).

This abstinence orientation can also be pursued when substitution drugs are solely used as means of detoxification after admission to prison. Then it fulfils the function of a means to wean off opiate dependent persons, and it is more a technical understanding of this therapy potentials.

According to Auke van der Heide (2004) one of the underlying problems is that many doctors regard addiction not as a disease, but as a moral behaviour. Because of this congruency the pedagogic approach of counselling, treatment and support was undoubtedly drug-free oriented for many years, despite harm reduction developments and the availability of substitution programmes on the outside.

An exclusive focus on achieving a drug free state for all patients in the long run jeopardizes the achievement of other important objectives which may be of higher priority at the moment, because of life-threatening impact etc. Substitution treatment's success' is more than abstinence orientation. It is substantially contributing to patient's stabilization on a number of levels, as well as societal reintegration. Substitution treatment is not an 'instant drug-free means'.

A discussion is needed about realistically achievable goals and step by step reachable targets regarding substitution treatment.

Prisoner' denial of substitution treatment

Prisoners have been socialized with the above described drug-free orientation and they themselves often do not question the unavailability of substitution programmes in prison. Or they don't demand such a treatment because they associate disadvantages with being a patient in such a programme (e.g. 'lack of privacy in terms of being known as a "drug user" to staff with anticipated negative consequences for the current sentence). Some experts on the Prague conference also point out that prisoners do not want to become known as patients in a substitution treatment because they fear that other prisoners will know this and they are put under pressure by criminal and aggressive behaviour. As a contributor puts it on the conference in Prague: "There is again the thing that everybody in the prison knows who is on substitution, and the patient doesn't want everyone to know this. It is again the discretion of the prison system." This is an argument of strictly looking at the conditions and the procedure of administering the drug which should be as discreet as possible.

Another argument brought forward in several countries is that prisoners often are not completely informed about the status of the medical service and the degree of confidentiality guaranteed: *"It should be very clear to the patient that the doctor or anyone from the medical staff is just coming for treatment, that he or she is not part of the prison system. It's often one of the things you get as a doctor in the treatment, somebody tells you that it's very clear that you are a part of the health system and not of the justice system (a contribution on the Prague conference)."*

In order not to stigmatise prisoners, procedures have to be thought of, which are aimed at not letting staff and other prisoners know what medication is given out. Several procedures have been practised in the prison visited to give substitution drugs out with other drugs etc.

In some other countries (e.g. Switzerland) it is up to the prisoners themselves to take the substitution drug when it suits them most (although this requires a lot of flexibility with the nurse staff): *"In community settings, patients are free to take the drug whenever they like. We're trying to copy the situation in their life, and it appeared the time that suited them best was 12:30, however, a couple of weeks later, we received a petition from prisoners signed by them that stated that they wanted to be able to take the drug at a time that suited them best. We explained to them that this time was the best for them in order*

not to be stigmatised, but they still had a problem with that." (A contributor on the Prague conference)

Another aspect is that substitution drugs (methadone, buprenorphine) are often seen as hedonistic drugs which are bought in the streets and not as drugs prescribed on therapeutic purposes, best in a therapeutic setting. For many prisoners the sentence advances (more or less) to the only drug free period and they either experience their ability being abstinent for the first time (after long periods of compulsory drug use) and/or are associate the prison sentence with 'getting clear again'. For many prisoners, this expresses the wish to avoid relapses after release drug-abstinence is combined with rehabilitation.

Finally it has to be said that one of the reasons of patients' resistance against substitution treatment in prisons is that there is no free choice of doctors whereas outside in the community mostly there is a choice finding a doctor meeting the substitution treatment needs of the drug user.

From other studies it is known that clients often do not equate 'success' on a methadone programme with becoming drug free. Success is defined as relative and much more complex state than a simple measure of abstinence. Often the stabilization and the absence of heroin craving is valued a success. Generally speaking, substitution treatment is often perceived to have a substantial impact on the quality of life in a number of areas. So it becomes necessary that a discussion is led about the basic objectives of such a treatment.

Informed consent for a detoxification treatment

It has been stated by several experts on the conference in Prague and discussions in some countries (The Netherlands, Germany) focused on the topic as well that it is problematic to stop a community-based, medically indicated substitution treatment, diagnosed, assessed and initiated in the community, without informed consent of the patient in the prison. In The Netherlands the debate is going on between the Ministry of Health, Welfare and Sport and 'The Health Council' who states that according to the agreement between provider (medical doctor) and user of the provision of medical services stopping a treatment is a form of medical treatment and therefore requires the informed consent of the patient/inmate, especially when a medical decision (from maintenance to detoxification treatment) is a fundamental change of treatment from care to cure. It is not an argument that people are shifted from

one treatment system to another (community-based to prison-based medical health care). This at least has to be justified from case to case.

Prisoners who went to court in several cases were given right to receive substitution treatment also in prison despite the refusal of doctors (The Netherlands, Germany).

Continuity of treatment: avoiding yo-yo -effects

Applying substitution therapy solely in the form of detoxification is restricting its therapeutic potentials. Substitution maintenance treatment with the aim of health stabilization and social rehabilitation is aimed at longer time lines. As research indicates, for most opiate dependent persons “the threshold of significant improvement is reached after about three months in treatment, with further gains as treatment is continued. Because people often leave treatment prematurely, and premature departure is associated with high rates of relapse into drug use, programmes should include strategies to engage and keep patients in treatment. Many patients need several years in treatment”. (WHO/UNODC/UNAIDS, 2004, 18)

Several prisoners interviewed who had a detoxification in prison said that they relapsed after release and after a while went into substitution treatment again. This yo-yo-process of substitution treatment, detoxification in prison, entering a treatment programme again, re-offending and entering a substitution treatment again is physically risky behaviour and absorbs much energy of those concerned. As previously stated, prisoners themselves opt for a cessation of substitution treatment either to gain certain advantages or as an option in the self-management of their addiction. As it has been put by the director of a treatment unit in The Netherlands:

“When they are over in that department they all think: I don’t use drugs outside. When they are outside, its a different story. When they are here its safe, they have work, they go to school, training courses, they really feel good and strong and healthy. It changes dramatically when they have the possibility to get outside the ward.” So sometimes it is the medical unit, the doctors themselves to present the disadvantages of a discontinuation (French doctor on the Prague Conference).

Another aspect has been that a cessation of substitution treatment for those inmates with a long history of drug and methadone use is perceived as essential loss of an option of self-medication (to manage craving and adverse

effects of their drugs with methadone) which could have always been chosen as a last resort (because methadone has been served as a coping strategy in times of heroin scarcity), describable in terms of a 'love and hate-relationship'.

As Michael Farrell puts it on the Prague Conference (2004) "... the issue is we've got people with chronic opiate dependence, we're detoxifying them, and then sending them back at it, and we're potentially adding to the burden the people already have with this process. My argument is chronic, long-term dependence should be maintained and not detoxified". The process is not to be seen in its full consequences as a liaison is often missing between prison doctors, staff and community health care services. But as relapse in drug use is high, and re-offenders are not necessarily put into the same prison, the process of a steady interruption of treatment is only realized when a person is re-admitted to the same prison.

Substitution treatment thus is a treatment with long-term potentials which demands a throughcare or a treatment started in the prison setting with connection to the community.

Many studies have shown that in particular, engagement in transitional after-care has been proven as crucial for reducing post-prison recidivism (Simpson & Knight, 1999; Vigilante et al., 1999; Butzin et al, 2002). Effective and successful drug treatment in prison requires a continuum of care that takes the drug-using inmate from the correctional environment to the re-integrative processes of community-based treatment offers (see also Hiller et al., 1999). This applies not only to drug-free but also to substitution therapy.

Low and/or high threshold substitution programmes

Andrej Kastelic (2004) raised the question of low and high threshold substitution programmes in prisons. Substitution in a low threshold option would mean emphasising harm reduction goals (e.g. prevention of relapse after release, prevention of infectious diseases, taking the pressure for dependent inmates to engage in illegal trafficking etc.). The low-threshold substitution treatment should then cover as many treatment demands and needs as possible, whereas high threshold programmes would be equipped with additional means and resources (e.g. psycho-social care and support), and would require more commitment and engagement from the patients and a higher therapeutic setting. Between both levels permeability has to be ensured.

This division is happening outside in the community in many countries already and worth thinking about in the prison setting as well.

The needs of women must be treated specifically

Mostly the different needs of women in prisons are not mentioned specifically. As Jan Plamer (2004) pointed out: *“The complexity and severity of the drug use in women’s prisons is far greater than for the male counterparts, where there is a range of drug using problems, whereas for women, they tend to be very severe drug users. They tend to use between 6 and 9 substances at the time they’re admitted to prison. They have a lot of health related problems on top of that. Therefore the clinical management or overall management of women in prison needs addressing separately to the needs of men.”*

This requires a set of clinical protocols that act as a minimum standard of care for women.

Drugs, dosage and duration

Some experts (Farrell 2004) point out the particular value of buprenorphine with its reduced overdose risk which makes it valuable for the prison setting and for the release situation. But as discussed in the interview with Jan Palmer³ the safe use of substitution drugs is also a matter of accurate supervision and control. Nevertheless, those substitution drugs available in the community should be available as options and with different therapeutic agents so there is a choice for the patients.

As it was reported from the US, in the prison in New Mexico, a pre-release buprenorphine pilot is about to be introduced. One of the advantages, despite the extra costs of the buprenorphine products is that it doesn’t have the ‘stigma of methadone’.

As shown in the literature review one of the crucial points of MMT to be effective is a moderately high dose of methadone and buprenorphine and the prescription lasting the entire period of imprisonment. A sufficiently high dosage (more than 50 mg) also seems to be important for an increase of the retention rate, which then can be used for additional health care services. So

3 See chapter “The need to treat women separately in substitution treatment”.

apart from timely entry into treatment, duration and continuity of treatment, and accompanying medical and psychosocial services the adequate medication dosage, is responsible for the effectiveness of opioid substitution maintenance therapy. However, these findings serve as a general orientation and are not to be seen as a binding principle.

Bernhard Spitzer (2004), psychiatrist and doctor in a men's prison in Stein/Austria pointed out that substitution treatment is not a short term range intervention. Therefore success can only be seen and measured on a longer term basis. It's success is amongst other factors dependent on the duration of the treatment, which has to be set up individually: *"A patient is an individual, so you can't have a one size fits all approach, you have to consider each person ... Referring to the methadone, we also use retarding morphine, and we use that only in certain cases. But this reflects the situation in the community, if someone has started a treatment in the community, he should continue on the same stuff while in prison. These retarding morphine improve the quality of life considerably, not in all the cases, though. I just wish to say that we can't only focus on methadone treatment, even though it has improved a lot, but we also have to talk about other substitutions, other medication. Substitution programs have to be developed on a case-by-case basis."*

Supervision of intake

Some debate has been going on how to best control the intake of substitution drugs. There is a consensus that the intake of substitution drugs (as well as the intake of other psychoactive substances, antidepressants etc.) has to be supervised in order to make sure the drug has been swallowed adequately and to avoid that other prisoners are blackmailing patients in methadone programmes to sell or provide their portion and finally to avoid overdoses from prisoners with no opiate tolerance. While this consensus counts for methadone, it is not the case regarding buprenorphine, where there is no risk of overdosing. Like in French prisons, the medication can be given to the prisoners for 3 days. As there is no risk of overdose with buprenorphine, it is argued that handing out the medication is part of a process initiating or supporting the responsibility of the patient, which he/she has to achieve when leaving prison. Also the goal of avoiding any involvement in the traffic of other illegal (injectable) drugs is put high on the priority list:

“If everything is ok, then the prisoner can get medication for up to 3 days. Everyone who wants substitution treatment will get it, so then there is not reason for them to get it in illicit trading. Of course, there will always be people who are trying to sell things, and this is something we will not solve unless we solve the problem of poverty...Now we have Subutex substitution treatment, and we have to see to it that we take care of those patients who are problematic, who try to hide the pills and not swallow them. The nurse has to be alerted to these patients and monitor the situation so that she can be quite sure that the drug is gone.” (French speaker in Prague.)

It has been said that the accurate supervision of intake of buprenorphine, which takes ten minutes before it dissolves on the tongue, requires quite some time, and the prisoner is monitored and observed by the nurse. If the number of inmates receiving buprenorphine is high, the administration of in a safe environment would need very many health professionals. So it becomes a policy of keeping the balance between prescribing the drug to those in need for it, within an environment which has scarce resources to control the whole procedure. Arrangements have to be organised in practice, as done in France, to give out the drug to reliable prisoners for several days. The danger remains that substitution drugs become part of the intra prison trafficking which then would discredit the whole programme. This has serious consequences for prison staff and everybody involved.

The problem is described by a doctor responsible for health care in prison: *“I have 4,500 prisoners and we would need 19 nurses taking into account 40 per cent of drug users among the prison population. It was immediately clear to us. This would mean that you would not be able to launch substitution programs, or we would be able to distinguish between problematic and less problematic patients, so that problematic patients would be required to come to the surgery and get supervised intake so that 85 per cent of patients, and I’m speaking of methadone, which is administered by a nurse everyday including weekends, I’m talking about Subutex. Today we have 600 patients on Subutex and the vast majority of them get it in their cell once a day or twice per week. Then they get their supply of Subutex to last for two or three days. And if they can’t cope themselves, they will tell us. This is also part of the care for prisoners before they’re released so we can observe their needs and deal with them. I think it’s better than to absolutely supervise everything that’s going on because that rid them of responsibility.”*

Substitution treatment in prison as part of a broader local, regional and national strategy

The study showed that substitution treatment in prison could only be understood within the context of a national strategy regulating treatment modalities and local/regional structures, implementing concrete treatment modalities. One consensus found in most countries is that those being in substitution treatment in the community should be able to continue while in prison (see also WHO recommendation 1993). This indicates that the scope of substitution in prison (the number of places) is closely linked with community capacities (to re-integrate drug users in substitution programmes after release, e.g. Ireland). This means that substitution treatment as a whole could not be started within a country from the prison first, when structures are not to be found in the community, and even high threshold structures outside (e.g. Sweden and Poland), which are difficult to access coming for patients leaving prisons make it very difficult to start or continue substitution treatment in prison.

So, improvement of substitution treatment in prison in some countries also needs an improvement of equivalent structures in the community and even on a national level. Vice versa there are some countries where despite the fact that substitution treatment in the community is widespread, legal regulations are facilitating substitution treatment (e.g. some states in Germany), this treatment in prisons is poor and confined to single cases (Keppler, Knorr & Stöver, 2004). Here efforts are needed both from the community and the prison service to harmonize treatment strategies in order to avoid treatment interruptions, yo-yo-effects (see above), complaints of the prisoners or transports to other regions and prisons when some prison doctors refuse to prescribe.

Medical services of remand prisons, arrest houses, police arrest do play a central role in the process of interlinking community and sentenced prison's policy and practice. They are often closely communicating and co-operating with community services, and their diagnosis and prescription policy is often decisive for the further treatment if remand prisoners are sentenced.

Finally, international questions have to be raised when it comes to foreigners who are drug dependent, are receiving substitution treatment and are supposed to be transferred to their home country where substitution treatment is not available. The same accounts for foreign prisoners with no health insurance.

Lack of information and comprehension of drug dependence and substitution treatment

Many doctors in our study expressed that more information is needed on the nature of drug dependence and the potential of substitution treatment. The practice of this treatment confirms that there are severe misunderstandings which may result in inadequate practice. Both the substitution treatment and the nature and dynamics of addiction require a long-term response.

“It’s more difficult to talk to the prisoners, sometimes you have to change your mind”

(Dr. Knud Christensen, chief medical doctor at Vaestre Faengsel, Copenhagen, Denmark)

Acknowledgement and integration of prisoner’s experiences and expertise

“Official reports scrutinising the needs of prisoners draw information from many sources, but the opinion of the prisoner is seldom sought.” Luke Birmingham (1997) formulated this in his article “Should prisoners have a say in prison health care?” He stresses the valuable contribution of the patients to the quality improvement of health care in general: “Policies which are implemented without taking these views into consideration are one sided and are unlikely to be effective” (p.1). This was one of the reasons why in this study prisoner’s views have been given space to formulate their needs and perception regarding substitution treatment. Most prisoners have previous, personal experience of prison health care, substitution treatment inside prison and in the community (either detoxification or maintenance). They are able and willing to make substantial and valuable comments on the health care and service delivery. The prisoners interviewed also acknowledged improvements regarding substitution treatment over time. Their treatment needs regarding the choice of the substitution drug (e.g. received in the community), dosage, confidentiality, psycho-social support, detoxification steps, maintenance modalities regarding organization of substance delivery etc. could contribute substantially to the improvement of this form of treatment. Moreover, prisoners in some focus groups said that they had not received sufficient help during detoxification and in some cases no services were provided.

We are used to integrating patient's views, needs, even judgements to a high extent within the community in order to improve treatment, organization and to save costs. Inside prison, within prison health care, the value of patients integration is often underestimated, coincidentally but not systematically, or even excluded.

“But many prisoners do have concerns which are valid, expectations that are realistic, and suggestions that if listened to could help resolve at least some of the problems that hamper the delivery of health care in prisons.” (Birmingham, p. 1)

One of the reasons for the sometimes rigid doctor-patient-relationship may be the patronizing character of this relation: *“It shows not only with the doctor, but also with the rest of the prison staff. We look at the prisoner as the bad guy saying, “You don't know anything, we will tell you what you should do you, and I know better how you should be treated.” It was coming to little discussion, because in many cases, it's the prisoner who knows better, about substitution and how he was treated before and how he was feeling with this dosage of methadone, and not a doctor who has no experience. In the beginning, they were not willing to accept that the patient has a much better expertise, and I think you should accept that the patient who is a drug user knows much better than you. This is very difficult to accept by many doctors.”*

Lack of confidentiality and prisoner's rights

Andrej Kastelic (2004) pointed to the ethical issues when working with prisoners *“... such as the right to privacy, not letting everyone in the prison know that someone is using methadone, or for the privileges, like leaving prison for visits, or early release from the prison. This is the reason that many prisoners don't want to accept substitution treatment, because they don't feel they have rights. They should consider users involvement or prisoners' involvement in policymaking, and something about informed consent. Every patient should know before getting any sort of treatment what is the primary physicians obligation to the state, to the prison, or to the prisoner. I hope that this can be a reality very soon.”*

Prison is a different setting than an outside addiction clinic and therefore circumstances have to be approximated to the ideal situation. This applies to the dispensing situation in prison when it comes to the point that for certain pris-

oners, who for security reasons cannot be sent to rooms in the medical unit, substitution therapy has to be administered to them somehow, taking into account both their privacy, but also security and safety.

Jan Palmer (2004) emphasized the necessity to build structures which guarantee confidentiality in order to protect inmates being dependent: *“Because as long as we have this kind of stigmatisation, we have to protect inmates from being dependant, and would be prepared to do something about it and come forward to treatment. What they need is absolute confidentiality. They have an enormous anxiety for coming out. You have mentioned that, and we have exactly the same experience. They do not want to come out, even if they know the risks because the supreme interest is to avoid conflict with other inmates, and as long as they have to fear conflict with other inmates, they will not come out.”*

Auke van der Heide (2004) pointed out that in The Netherlands, inmates can complain about their medical treatment, and many of these complaints are regarding methadone treatment: *“When they do that, they send a letter to us, and we try to mediate. Mostly, the result is that the patient and the doctor are satisfied. This way, the patient has an influence on the treatment. They use this possibility very intensively. Last year, we had almost 700 complaints, and I think that about 50 of these complaints dealt with the methadone treatment.”*

From the UK it has been reported by Michael Farrell (2004) that a legal action group is fighting for inmates rights: *“... in the UK ... there’s a legal action group of people who’ve been in prison, after coming out for failure of duty to care, sort of not receiving proper withdrawal treatment. It’s interesting that it is one way to get the system to move. Practitioners who previously weren’t prepared to take onboard policy directives now see themselves as potentially vulnerable by having legal action brought against them.”*

In many other countries possibilities do exist for prisoners to go to criminal court and to bring forward complains about wrong or insufficient therapy. However, this is a long lasting procedure and often it is not clear if prisoners are still in prison and could benefit from positive court decisions. So there is no user-friendly complaints procedure in place in prison in many countries, which also accounts for drug treatment services in the community (although there is a choice for the patient). Prisoners fear they would be victimised in one way or another.

Substitution treatment in prisons in Central and Eastern Europe

As Morag MacDonald (2004) pointed out in her study of existing drug services and strategies operating in prisons in ten countries from Central and Eastern Europe, substitution treatment was only available in Slovenia and in Poland. In the other eight sample countries substitution treatment was not available in prison, but detoxification was available in most of the countries, either at a Prison Hospital or provided by an external organization. Much debate is going on regarding that issue (see MacDonald 2004, 68ff). The implementation of substitution treatment in prison as it was done in Poland and Slovenia could serve as Good Practice as it has been done carefully including visits to other countries, training of the staff and doctors and in close co-operation and communication with community agencies and with accordance and support of key persons from the Ministry of Justice.

The specific situation and requirements of prisons to introduce substitution treatment is described by Uchtenhagen (2004): *“I think it’s very different if in a given prison, you want to introduce substitution treatment newly, where you didn’t have it before. I think that from the situation of a prison where methadone has been available and the practice of working with methadone is well known. So, a multitude or plurality of substances makes sense where there is already some experience. Whereas it is not advisable to introduce a range of new substances where there is no experience. I think there the methadone is the substance to start with.”*

Establishing good clinical practice

Ambros Uchtenhagen (2004) expressed the need of establishing good clinical practice in prisons, which is shared over the boarder. There are several good practice models (e.g. Palmer 2004) which may serve as good examples of how to design protocols of good clinical practice, containing descriptions of problems and suggestions to best solve them. These manuals are to be specified both to national, regional particularities and to target specific needs (e.g. women).

Good clinical protocols and standards are one thing, it’s a different thing to accomplish them. As it was stated during the conference in Prague, the therapeutic freedom of the doctors has to be acknowledged but at the same time a communication about standards and policies derived from evidence-based approaches should be communicated with doctors. This is often split:

The standards and protocols in the Ministries and the everyday prescription (or non-prescription) policy in practice.

Facing the heterogeneity of substitution treatment identified during this research project not only in Europe, or on national, but also on a regional and local, standards and protocols of good clinical practice are necessary in order to standardize treatment conditions.

Lack of data on substitution treatment in European prisons

In many countries prison health care is not monitored properly, so that only rough estimations on scope and quality of substitution treatment are available. The EMCDDA is currently conducting an inventory project with the 15 EU member states (Western countries) and Norway collecting figures on health care services in prison.

For an improvement of substitution treatment in prisons more evaluation on patients needs, service provision and connection with community services has to be carried out.

Training of doctors and medical staff

“Also, prisoners have the right to receive state of the art medical care” (B. Spitzer 2004). This statement is a plea for (vocational) training for all involved in the substitution treatment. The manifold developments in the field of addiction medicine, psycho-social support need to be transferred to the medical and psycho-social services in prisons. Not only the introduction of ‘new’ substitution drugs (e.g. buprenorphine), but also topics as the nature of addiction, comorbidity?, interactions with other drugs, have to be discussed permanently. Also the attitude of staff and their relationship towards prisoners in substitution treatment has to be discussed in these vocational trainings.

Manuela dos Santos Pardal (2004) emphasises, at least for the situation in Portugal, that she feels a lack of medical rules and training of health professionals in prisons, and a lack of specific information about substitution treatment. *“If they know how important it was, they would understand why the treatment must be improved. Prison administrators and prison systems use all the arguments in order not to change routines. A methadone program is one thing more that disturbs the system. If prisoners would be really informed about substitution treatment, about the importance for their health*

and every thing that is about the treatment, I think that more and more prisoners would ask for this treatment.”

As pointed out by Michel (2004) in their study on substitution treatment in French prisons, the vast majority of doctors interviewed prescribing substitution drugs have not been educated in the area of drug addiction. Most of them were learning as they went along. In some countries a special training before employment as a doctor in prison is envisaged (The Netherlands), in some other countries (e.g. Germany, Keppler, 2004) a special training for doctors on addiction medicine is required (in the community and in the prison) before the start of substitution treatment. Michel (2004) stated on the background of their studies that *“Doctors who work in prisons in contrast to community doctors have not chosen this program on purpose. Outside prison work, doctors started to proactively prescribe substitution therapy while prison doctors very often felt that substitution therapy was something that was imposed on them, that they were forced to do it.”*

Especially in those countries starting a new substitution programme information and education on all aspects of this treatment is needed.

Further research questions

Regarding inconsistencies between the prison and the community, should healthcare in the prison be provided by community-based services?

Prison is a supremely hierarchical organization - how do doctors get appropriate support from the top level?

What is the need and what are the requirements for psycho-social care within the substitution treatment?

Is there a need for clients' satisfaction with substitution treatment services and a need for guidelines regarding prescription and concrete organization of dispensing etc.?

How can the quality of treatment and development of integration with other services from the community be developed?

What role, if any, do professional standards play (best practice models of substitution treatment) and ethical codes (for instance “United Nation’s Declaration on the principles of Medical Ethics” or the “World Medical Association’s Declaration of Tokyo!” in the everyday practice and what

impact do they have for doctors and medical officers working in prisons who face difficult ethical decisions daily, also with regard to substitution treatment (Reed and Lyne 1997).

B Recommendations

Introduction

This study has shown the heterogeneity in how prison health care in general and substitution treatment for opiate dependent prisoners in particular are organised in Europe. This reflects the historical, cultural, social, economic and political differences to be found throughout Europe and even in one country. We found a diversity of settings and environments in which prison health care is provided and in which substitution treatment is either provided or at least discussed: in well-funded and severely under-funded prison systems, civilian and military prison systems, in institutions with drastically different physical arrangements for the housing of prisoners, in overcrowded systems, in men's, women's and juvenile's institutions, and in prisons of all security classifications and all sizes. Sometimes substitution treatments are being operated as individual pilot projects, or as routinely part of health care and as an integrated component of overall prison health care policy and practice.

In this background, it is not appropriate to make recommendations that are supposed to be suitable for all the different prison settings. Instead, we are providing recommendations that have already been made by international bodies, experts and guidance and suggestions for good clinical practice of substitution treatment in prisons. Recommendations have already been formulated by the European Network on Drugs and HIV/AIDS in Prisons. The Network brought together expertise on various matters and also on how to manage best substitution treatment for opiate users in prisons. In the annual Conferences in Oldenburg (1998), Rome (2003) and Prague (2004) experts from various levels have been working on improvement of this treatment form in prisons and links with service providers in the community. So far, we are introducing the results of this work first, and then building them up further, taking into consideration the results of our own research.

1 Recommendations of international bodies

The European Council recommendation (of 18 June 2003) on the prevention and reduction of health-related harm associated with drug dependence (2003/488/EC) recommends to its Member States that they should:

...

“6. provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psycho-social care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

7. establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

8. consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;”

The World Health Organization (WHO), Regional Office Europe (2003) in its Moscow Declaration on “Prison Health as part of Public Health” recommends to member Governments “... to develop close working links between the Ministry of Health and the ministry responsible for the penitentiary system so as to ensure high standards of treatment for detainees, protection for personnel, joint training of professionals in modern standards of disease control, high levels of professionalism amongst penitentiary medical personnel, continuity of treatment between the penitentiary and outside society, and unification of statistics.”

2 The “Oldenburg Recommendations”

The ‘Prison and Drugs 1998 Conference’ in Oldenburg/Germany (European Network of Drug and HIV/AIDS Services in Prison/ENDSP, 12-14th March 1998) gathered together 109 people to discuss prison drug services and to make recommendations on them. These participants included senior officials from prison administrations, prison doctors, prison officers, managers and staff of non-governmental organisations, probation officers, social workers and representatives of drug user organisations. They came from twelve member states of the European Union and three other countries. Recommen-

dations were drawn up in workshops on topics like ‘harm reduction’, ‘drug-free treatment’, ‘needle exchange’, ‘peer support’ and ‘substitution treatment’ in prison. The recommendations regarding the latter are presented in the following:

1. Substitution treatment includes both detoxification and maintenance.
2. Substitution treatment offers an opportunity to regularly engage with the prisoner, but it is not the whole, or the only solution to drug problems.
3. Although substitution is best used as one component of a comprehensive treatment regimen that includes psycho-social support, it may, by itself, provide prisoners with a period of stability that can help them to improve physical and mental health and social circumstances.
4. Individuals on maintenance in the community must have the option to continue to be maintained on entry to prison, and those receiving substitution treatment in prison must be able to continue with such treatment on release. Decisions on the continuity of treatment should be taken into consultation with the treatment programme in which the prisoner participates outside prison.
5. A clear treatment contract must be drawn up between the prisoner and the programme.
6. A thorough, structured, ongoing assessment, leading to a cohesive treatment plan is necessary.
7. Adequate human resources and facilities for substitution treatment must be provided.

3 From general recommendations to concrete policy and practice of substitution treatment in prison

In Rome (2003) during the conference “‘The reduction of negative health and social consequences of drug use in prison’, (ENDSP, Rome, 22-24 May 2003) a workshop has been organised entitled: “‘What is the role and value of substitution treatment in the process?’” Several experts from several countries were presenting results of their studies and experiences and discussing the above mentioned Oldenburg recommendations. All present agreed that the recommendations from the 1998 ENDSPs are very good for the period and that they contribute to the overall goal of improving access to and continuity of substitution treatment. They are a baseline containing general and some particular recommendations on possibilities and limits of substitution treatment. It became clear that once goals are formulated and agreed upon ener-

gies have to be concentrated on the initiation and organisation, that means policy of substitution treatment in prison (from the introduction, circumstances, requirements regarding doctor's and staff's training, political and legal suppositions) to the clinical management of substitution treatment in the prison setting. Clinical management focuses on all aspects of how substitution treatment (together with other pharmaco therapies) should be organised in practice (e.g. confidentiality, supervision of intake, urine tests, home leave, dosage increasing and reduction etc.).

Good policy and practice of substitution treatment have been described for countries and community settings (like consensus conferences, guidelines, regulations; Henry-Edwards et al. 2003). Moreover European expertise has been brought together (e.g. the work of "Euromethwork", see Verster/Buning 2003; EMCDDA 2000, or Pompidou Group 2004). These guidelines can not simply be transferred to the prison setting, but need to take into account the specific prison conditions. Different treatment settings necessitate different treatment options. The problems arising in prison are different to those outside in the community and require a flexible response: for instance admissions with multiple drug use arriving late the day and in high numbers require sufficient support and clear guidelines to guarantee a standard regime (see Palmer 2003, 5).

Nevertheless, several attempts have already been made to elaborate guidelines for good clinical practice in prison. Some of this work will be presented in the following. Keeping in mind the heterogeneity outlined above, these guidelines are not able to be generalized to all prison systems. So, basically, the introduction and organisation of prison-based substitution treatment reflects to a certain extent the way substitution treatment is organised and run in the specific country and/or community.

During the Rome conference some points of the Oldenburg recommendations regarding substitution treatment were said to be elaborated:

- It was felt that there needed to be a differentiation between different types of substitution (low and high threshold) and substitution drugs.
- Protocols/guidelines for good clinical practice/management needs to be set up with the following objectives:
- Bring about consistency in the management of inmates who are on a substitution programme when admitted to or released from prison; and

- Ensure that the provision of substitution drugs to inmates is managed safely and securely.
- The term and requirement of a ‘contract’ should be defined and adapted to routines and practice in the community.
- It was agreed that some information needed to be added in relation to an agreement for having treatment. There were also some issues raised around the guidelines given to patients about drugs that they would be given in terms of poly drug use and alcohol use.
- Informed consent should be received from the patient and agreement which indicates rules and also dangers of certain types of behaviours.
- Regarding Point 7 of the recommendations, suggestions have been made to implement multidisciplinary teams in place to support treatment. Multi disciplinary teams can contribute to the decision about continuing, starting or ending a substitution treatment for which the doctor always has ultimate responsibility. With regard to the introduction of substitution treatment in a given prison system, multi disciplinary teams should not be seen as an inevitable prerequisite or else substitution treatment could become too expensive.
- Participants agreed to instigate that the physical, social, psychological needs of patients are met. There is a need to stress a comprehensive and cohesive approach to treatment.
- Participants agreed that specific trainings for doctors in addiction medicine are a valuable contribution to an improvement of the quality of substitution treatment in prisons

4 Guidelines and protocols for clinical management and treatment of substance use

The WHO/UNODC/UNAIDS position paper on “Substitution maintenance therapy in the management of opioids dependence and HIV/AIDS prevention (2004, 28) points out that “substitution therapy for opioid dependence must be subject to principles of good medical practice. Evidence-based guidelines are in place in many countries, and need to be elaborated where they are not. Such guidelines should include criteria to define who are considered eligible for substitution therapy, as well as contraindications, and should outline best practices in clinical management, as well as relevant government regulations.

Efforts should be made to ensure that guidelines are widely disseminated and programmes for monitoring treatment quality and outcomes are put in place.”

However, most of general guidelines and recommendations do not contain a view on the specific conditions for substitution treatment in penitentiary institutions. In a general way, it is then stated that drug users in hospital, prisons and on holidays need specific requirements (see Verster 2000). Only a few guidelines are targeted at the prison setting and describe in detail service provisions either specifically on substitution programmes, (like methadone treatment – programme guidelines for the Irish prison Service) or within a broader drug service and control strategy approach (e.g. “Strategy for intoxicant abuse of the Finnish prison administration” etc.) for the respective country.

In the following, some guidelines are presented which do have an important impact on prison-based substitution treatment or are already directed to the prison setting.

Jan Palmer (2003) raises the issue of a gender specific view in the clinical management and of substance use and treatment needs when they are admitted to prisons. She is setting up minimum clinical standards of care for women drug users entering prisons (for England and Wales). The standard regimes ensure that every prisoner receives at least a minimum baseline of care. Furthermore, she describes the process of continuous quality improvement including induction process of nursing and medical staff, training and ongoing ‘professional’ nursing supervision.

The United Kingdom (Department of Health 1999) published guidelines for maintenance treatment. One striking point is the outline of the model of ‘shared care’, which means that the goals of substitution treatment (to help the patient to become or remain healthy) can only be achieved by a cooperation of medical practitioners and other professionals. This is a form of best practice encountered in this study in several prison settings.

The consensus statement of US-American “The National Institutes of Health” (NIH) explicitly stated that abstinence is not the most important goal of treatment. Moreover it states “Continuity of treatment is crucial – patients who are treated for fewer than 3 months generally show little or no improvement, and most, if not all, patients require continuous treatment over a period of years and perhaps for life. (NIH Consensus Statement 1997). Both the guidelines of the American Psychiatric Association (1995) and the

National Institutes on Drug Abuse (NIDA 1999) are supporting this view. They recommend a minimum treatment time of 12 months and even repetitive treatment efforts.

Other countries have elaborated quite detailed recommendations for clinical practice of substitution treatment (amongst others prescribing guidelines in UK, Germany and Belgium¹).

In Switzerland, for instance, a national substitution conference (NASUKO 2001) has been held in order to improve the process of quality assurance. Some key issues have been named:

- Dosage and treatment plan should be stronger and adapted to the individual needs.
- Opiate dependent persons often show psychiatric diagnoses. This should taken into consideration more when developing new treatment modules.
- Everyone prescribing substitutions means should ensure that the patient gets access to additional therapy and counselling facilities.

The need to train practitioners on addiction medicine has been included in many guidelines. Training on the nature of dependency and pharmacotherapy should be offered to all those involved in substitution treatment in order to assure the quality of this therapy: medical practitioners, alcohol and drug counsellors working with clients of substitution maintenance treatment programmes; health practitioners associated with infectious disease programmes; and general health professionals who may come into contact with clients on these programmes (nurses, medical officers).

As an additional strategy for the improvement of quality, on a local level, quality circles either among prison doctors/nurses involved in substitution treatment or with doctors/nurses in the community are considered to be a helpful and useful arena in which to discuss practice and to share experiences.

Finally, it has to be stressed that the contribution of the patients are valuable in order to improve the quality of health care in general and substitution treatment in particular. Most prisoners have previous, personal experience of prison health care, substitution treatment inside prison and in the community

1 For Central and Eastern European Countries see www.ceehm.lt

(either detoxification or maintenance). They are able and willing to make substantial and valuable comments on the service delivery.

C. Prevention and treatment of blood-borne-viruses (HIV and Hepatitis) within Substitution Treatment in Prisons

Substitution treatment in prisons offers a great opportunity to integrate HIV-/Hepatitis prevention and treatment strategies. Daily contact between drug treatment service deliverers (doctor, nurses, health/social worker) and patients is the supposition for a continuous personal confidential relationship – important prerequisites for HIV-and Hepatitis preventive interventions. Improving the awareness for HIV/AIDS and Hepatitis risks both of prisoners and staff is a strategy to support a change of attitude. Specific methods – outlined here – have been successfully applied within HIV/AIDS strategies throughout the world. Counselling, practical training aim at enabling patients to initiate and/ or maintain safer behaviour in drug consumption, sexual activities and procedures of skin penetration. Further more the delivery of preventive material as a prerequisite for a change of behaviour can support HIV-preventive strategies and can be conducted within the setting of a drug treatment (Stöver & Trautmann 2001).

1 Improving risk awareness of participants (Target: Change of attitude)

- Identifying risk behaviour and risk situations with regard to the transmission of BBV in the everyday life and connected to consumption patterns of clients.
- Identifying target, gender and culture specific risk situations and behaviour.
- Transfer of knowledge on the nature and character and transmission routes of BBV, via injectable drug use with shared syringes or equipment, unprotected sex and unhygienic skin penetration: piercings, tattoos, acupuncture.

2 Improving risk awareness of staff (Target: Change of attitude)

Improving risk awareness is not only a target for the work with prisoners, but for staff of drug treatment services and/or medical units as well. Staff should be informed on transmission routes, character and nature of BBV's in order

to improve knowledge and to get familiar with the specific settings drug users are in. Especially the so called “hidden-risks” of drug use have to be identified (i.e. “Is there a protocol for PEP (post-exposure prophylaxis) available in prison?”

3 Improving risk awareness of clients of substitution clinics (Change of attitude/behaviour): Methods

- Training of drug users in short intervals with refresher courses. The training has to be conducted interactively, with role games, exercises, quiz etc. instead of a confrontative structure (Stichting mainline 1999).
- Discussion about controversial and confidential topics, taboos (e.g. risk behaviour, topping up drugs while in substitution treatment) with prisoners either in group sessions or in single face-to-face communications.
- Peer driven – interventions: peer-support; peer education are methods which integrate the expertise of the concerned drug users into the strategies of HIV/AIDS and Hepatitis prevention. Both participation of the target group and the high value of the transported information from peers are part of important strategies in HIV-prevention. Key persons (peer leader) are educated and given support in order to disseminate information (e.g. on risk reduction) to the target group.
- Gender specific approach: e.g. female social and health worker should be employed in order to identify and discuss risk situations for women. This improves the confidentiality of the relationship.
- Campaigning may be a useful strategy to reach numerous people within a certain target group.
- Working on specific projects with clients: leaflets, brochures, newspapers, broadcasting etc. in order to stimulate peer-driven information.

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Appendices

A. Interview Schedule for Prisoners

1 Personal experiences

- Is substitution treatment (ST) provided in this prison?
- Do you receive methadone or any other ST in this prison?
If so, are you satisfied with the way it is done?
If not, what are the reasons? Do you agree with these reasons?
Is there transparency in the provision of ST (e.g. concerning the decision of who gets it or not)?
- Did you have any experience with ST prior to this treatment (in another prison)? What are the differences?
- Have you received ST in the community? What are the differences?
- Do you think ST in prisons is a controversial issue? Is it outside in the community?
- What do you think the key topics are in this debate? Who are the key people, stakeholders, associations?

2 Treatment aspects

- **Treatment options** for ST in prisons:
What specific procedures of ST have you experienced? (Detoxification, maintenance, relapse prevention, substitution treatment starting in prisons, low threshold substitution treatment, bridging the time until start of therapy?)
- **What substances** are offered (methadone, LAAM, buprenorphine (Subutex), codeine)?
What is the average dosage? Are there additional drugs prescribed (i.e. benzodiazepines?) Are you satisfied with the form of treatment (urine analysis, dosage, detoxification scheme)?
State the advantages and disadvantages you have experienced with these drugs?

– **Diagnosis and indication**

Who decides about the start of a ST in prison?

What do you think, which criteria are relevant?

– When **ST from the community** is continued, what is the practical procedure?

In which way is your doctor in the community involved/contacted?

– **Psychosocial care**

Is psycho-social care provided for patients in ST in prisons? Are you satisfied with psycho-social care?

If so, what kind of psychosocial care or assistance is on offer?

Is psycho-social care provided on a voluntarily basis, is it compulsory?

Who provides the psycho-social care? How is this connected with the medical part of the treatment?

– **Integration and links** of ST to other *drug treatment* offered (abstinence-oriented treatment, (psychotherapy)?

Do you receive ST as a basis for other *medical treatments* (e.g. interferon/HIV/ TB-therapy)?

– Are there **self-help and/or peer-support groups** in prisons dealing with patients who are or have been in ST (i.e., after detoxification)? Do you have experiences in that?

– **Practical procedure**

Who provides the medicine (e.g. the methadone)?

What is the concrete procedure (time, location)?

– **Access** to ST

What are the difficulties for prisoners in receiving ST?

– **Referral and release**

What happens to prisoners in substitution treatment who are transferred to other prisons, e.g., from remand prison to another type of institution?

How is ST continued after release?

3 Institutional aspects

- What are the **problematic areas** of ST in prison? (e.g. adjustment of dosage, anonymity, confidentiality, daily practical problems, information policy, perception of procedure of substitution treatment, topping up drugs, system of less transparency for the patient, etc.)
- What is the **general perception** of ST by the personnel in this prison? (As a means of detoxification, abstinence-orientation, gratification for well-being/ good behaviour, or maintenance)?
- **What impact does** participation in ST have **on release** or on the sentence (home leave etc.)?

B. Interview Schedule for Professionals

1 General situation of substitution treatment (ST)

1.1 Historical, legal and political aspects of substitution treatment (ST) in prisons

- Is substitution provided in this prison? (If yes, what type of substitution treatment?)
- What is the history, development of ST in prisons in your country/region/city and in your prison?
When was ST introduced in the prison setting?
What were the different stages in the progress of ST?
- What is the legal framework for ST in prisons
(Legal situation, laws and regulations, guidelines, health care standards, recommendations)
Which laws and regulations are relevant? Who was developing them?
Please describe the development of ST.
- Provision of health care
Who provides health care in prisons in your country?
- Financial matters
Who finances ST in prisons? Are financial aspects relevant for initiating or ending a ST? Is data available concerning costs per patient in ST?
- What are the professional and/or political reasons for (not) implementing ST?
- Is ST (still) a controversial issue of drug services in prisons (and partly outside as well)? What are the key topics in that debate? Who were the key people, stakeholder, associations (see above)?

1.2 Recommendations, Standards, Best practice

- Did you develop guidelines or “Best Practice” models for ST in prisons? (i.e. health care standards?)
- If there are standards on ST, are they applied? If not, what are the reasons? Is there any activity to facilitate the application of standards?

- Is the ST certified?

2 Practical procedures

2.1 Treatment aspects

- What are the **general aims** of ST in prisons?
(Health stabilisation, prevention of infectious diseases etc.)
- **Treatment options** for ST in prisons
What are the specific treatment options (Detoxification, maintenance, relapse prevention, substitution treatment starting in prisons, low threshold substitution treatment, bridging the time until start of therapy?)
Do you have/follow a particular concept for the ST?
- **Diagnosis and indication**
Who decides about the start of a ST in prison? Which criteria are relevant? Which other professionals/organisations are involved?
When ST from the community is continued: What is the practical procedure? In which way are doctors in the community involved/contacted?
- **Which substances** are applied (methadone, LAAM, buprenorphine (Subutex), codeine?) What are the experiences of advantages/disadvantages with which drugs? What is the average dosage? Are there additional drugs prescribed (i.e. benzodiazepines?)
- **Medical and pharmacological aspects**
Is there a special scheme for urine analysis, dosage, detoxification scheme etc.? Who gives out the methadone (profession, qualification), what is the concrete procedure (time, location)?
- **Legal aspects**
Is there a contract between doctors and patients?
- **Psychosocial care**
Is psycho-social care provided for patients in ST in prisons? If so, what kind of psychosocial care or assistance (concepts)?
Is psycho-social care an offer that can be taken voluntarily or is it obligatory? Who provides the psycho-social care?
How is this connected with the medical part of the treatment?

- **Integration and links** of ST to other treatment offers (abstinence-oriented treatment, (psycho-therapy)?
Is ST seen as a basis for other medical treatments (i.e. interferon/HIV/ TB –therapy)
What is the value of ST in prisons for other drug services? Are they linked and are they part of a whole strategy of drug services (which one)?
- **Involvement of outside agencies** in ST
Are external social/psychological support groups or professionals involved in the ST? What are the professional links between outside/inside? How is the cooperation/communication working?
- Are there self-help and/or **peer-support groups** in prisons dealing with patients who are or have been in ST (i.e after detoxification)?

2.2 Organisational aspects

- **Scope of ST** inside prisons
Is ST in prison only partly available (in your prison?) or covering a whole region/city or state/country?
How many prisoners are in ST? What is the development?
Is the number of places for ST limited? If so, for what reasons?
- **Access to and provision of ST**
What are the difficulties for prisoners to receive ST?
What are the difficulties with providing ST?
- **Referral and release**
What happens to prisoners in ST, who are referred to other prisons?
Transfer from remand prison to other type of institution?
How is ST continued after release?
- **Quality of substitution treatment**
Are there concrete protocols of how to organise ST on a day-to-day basis?
Is the procedure certified?
- **Evaluation**
Has ST been evaluated? Is there any evaluation report available?
From your personal experience: do you perceive ST being as a successful tool?

2.3 Institutional aspects

- What is the **general perception** of ST by the personnel in (your) prison(s) ...
as a mean of detoxification, abstinence-orientation, gratification for well-being/ good-behaviour, maintenance?
- What are the **problematic areas** of ST in prison? (e.g. adjustment of dosage, anonymity, confidentiality, daily practical problems, information policy, perception of procedure of substitution treatment, topping up drugs, less transparency for the patient, etc.)
- **What impact does** the participation in ST have on release or on the sentence (home leave etc.)?
- Is **training** on ST for medical staff provided?

C. Research Protocol and ethical issues

My name is Laetitia/Heino ... I am a researcher. I am conducting a research on 'Substitution Treatment in European Prisons' funded by the European Commission (Directorate General of Health) in 18 countries (the 15 EU Member States, Poland, Czech Republic and Slovenia).

This study is an overview study that aims to explore substitution treatments offered in prisons. This is not an evaluation, nor a comparative study, but rather an exploration (or snapshot study) into the procedure of the provision of substitution treatment in prisons.

The importance of this report is that we aim to:

- Elaborate an inventory of the substitution policy and practice in prisons – making the whole situation clearer and more transparent,
- Point out issues related to the cessation or continuation of Substitution Treatment from the community into the prison setting and between different prisons
- Initialise an exchange of information of medical doctors and health care workers in charge of prison health care services
- Identify 'good practises' of Substitution Treatment in prisons and make recommendations

In each country providing substitution treatment in prisons, I will visit at least 2 prisons and will conduct interviews (one-to-one and in a group) with prison staff, prisoners, professionals working in the community, and ministries.

I will use a list of open-ended questions (no questionnaires to be completed) to gain more in-depth insight from your experiences.

All of the information I get will then be analysed and presented in a report to the European Commission in the summer 2004. Findings and recommendations from the report will then be disseminated to relevant stakeholders across Europe. The report will also be presented at the "7th European Conference on Drug related Services in Prison" in Prague in April 2004.

Consent and Confidentiality Statement

Have you heard and understood the ‘Explanation Sheet’ that describes the nature and purpose of the study? Is there anything you did not understand or want to have clarified?

Participation in this study is *anonymous*. No names will be taken.

All participants will have their *anonymity* assured and *confidentiality* maintained unless information shared with the researcher indicates a risk to the self or others.

Participation in this study is *voluntary* – you do not have to take part and you have the right to withdraw from any stage of the study at any time.

Your participation in the study will involve taking part in an interview (individually or in group) with the researcher. Interviews and focus groups will be tape-recorded – only if you agree to it – in order to aid the researchers’ ability to record information and to allow her to focus on the interview (instead of the note-taking). These tapes will be destroyed six months after publication of the final report. The researcher is the only person that will listen to taped-interviews (and, when applicable, read notes made during interviews). All information gathered will be stored in a safe and secure environment.

Have you understood: the nature and purpose of the study, that information will be dealt with in confidence unless it poses a risk to the self or others, participation in the study is voluntary and that you have the right to withdraw from it at anytime?

Do you give your consent to participate in the study

D. Useful Websites

Aids Foundation East West:

<http://afew.org/english/index.php>

American Association for the Treatment of Opioid Dependence (AATOD) :

<http://www.aatod.org/>

amnesty international :

<http://www.amnesty.org/>

Archive and Documentations Centre for Drug Literature:

www.archido.de

Council of Europe/Pompidou Group:

http://www.coe.int/T/E/Social_cohesion/Pompidou_Group/

Cranstoun Drug Service:

<http://www.cranstoun.org/>

Canadian HIV/AIDS Legal Network:

www.aidslaw.ca

Central and Eastern European Network of Drug Services in Prison:

<http://www.ceendsp.net/>

Drug Scope:

<http://www.drugscope.org.uk/>

EC/Drug Coordination:

http://www.europa.eu.int/comm/justice_home/fsj/drugs/fsj_drugs_intro_en.htm

EMCDDA/Publications/National Reports:

<http://www.emcdda.eu.int/>

EuroMethwork:

<http://www.q4q.nl/methwork/home2.html>

European Institute for Crime Prevention and Control affiliated with the United Nations:

<http://www.heuni.fi>

European Network for Drugs and Infections Prevention in Prisons:
www.endipp.net and former www.ceendsp.net

European Network for the Target Group of Mobile Drug Users:
<http://www.ac-company.org/>

Harm Reduction Coalition:
<http://www.harmreduction.org/>

The International Center for Advancement of Addiction Treatment:
<http://www.drugaddictionrx.com/>

International Centre for Prison Studies:
<http://www.kcl.ac.uk/depsta/rel/icps/worldbrief/europe.html>

International Harm Reduction Development Program:
http://www.soros.org/initiatives/ihrd/articles_publications

International Harm Reduction Association:
<http://ihra.net/>

Justice Health (New South Wales/Australia):
www.justicehealth.nsw.gov.au

The Methadone Alliance:
<http://www.m-alliance.org.uk/>

Moscow Center for Prison Reform:
<http://www.prison.org>

New Drug Policy – Russia (in Russian):
<http://www.drugpolicy.ru>

UNAIDS:
<http://www.unaids.org/en/default.asp>

World Health Organization (WHO):
<http://www.who.int>

WHO/Regional Office for Europe:
<http://www.euro.who.int>

WHO/Health in Prisons Project:
<http://www.hipp-europe.org/>

E. Authors

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