PROCEEDINGS

International Conference on Prison and Health
De Leeuwenhorst, the Netherlands

21 October 2004

Organized by World Health Organization, Regional Office for Europe in cooperation with Pompidou Group, Council of Europe and Ministry of Justice, the Netherlands

Ministerie van Justitie
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Contents

Introduction

The WHO Regional Office for Europe's Health in Prison Project was established in 1995. Since then, annual conferences have been organized for representatives of the network, national and international institutions and experts interested in prison health.

The 2004 conference was organized by WHO Regional Office for Europe in collaboration with the Dutch Government and the Pompidou Group of the Council of Europe in De Leeuwenhorst, the Netherlands on 21 October 2004.

The main aim of the conference was to review drug related problems and harm reduction in prisons and develop recommendations for international collaboration in this field. The conference programme allowed for a general overview of drugs and prisons and more specific topics regarding the spread of HIV/AIDS and the TB/HIV co-epidemic. Presentations were given on the different areas of harm reduction for drug users in prisons including training programmes, substitution therapy and needle exchange programmes.

More than 200 participants represented 31 European Member States and international organizations. The speakers comprised policy makers and experts from both eastern and western parts of the WHO European Region.

This publication includes abstracts of all the presentations from the conference. The programme ended with a discussion on a Status Paper on Prisons, Drugs and Harm Reduction. This paper will be printed and available as a separate publication.

The WHO Regional Office for Europe would like to thank the Dutch Government and in particular the Ministry of Justice for co-organizing the conference. The important contribution of the Pompidou Group of the Council of Europe is also highly appreciated.

We would also like to give our special thanks to the co-sponsors of the conference:

- The Ministry of Health, Welfare and Sport in the Netherlands
- The WHO Collaborating Centre on Health in Prisons, London, United Kingdom
- KNCV Tuberculosis Foundation, the Netherlands
- AIDS Foundation / STD AIDS Netherlands
- Cranstoun Drug Services – ENDIPP (European Network for Drugs & Infections Prevention in Prison)
- The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Programme for WHO Health in Prisons Project Conference 21 October 2004

Organized by the WHO Regional Office for Europe in collaboration with
Ministry of Justice, National Agency Correctional Institutions the Netherlands and
the Pompidou Group, Council of Europe

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The Ministry of Health, Welfare and Sport in the Netherlands
The WHO collaborating centre on health in prison, UK
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European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Thursday 21 October 2004

9.30 – 10.00 Welcome and introduction

Mr P.H. Donner, Minister of Justice, the Netherlands
Dr H Nikogosian, Deputy Director, Division of Technical Support, WHO Regional Office for Europe
Mr ADJ Keizer, Chair of the Pompidou Group, Council of Europe and Senior Drug Adviser, The Ministry of Health, Welfare and Sport in the Netherlands, Directorate of Mental Health and Addiction Policy, the Netherlands.

10.00 – 12.30 Plenary session 1: General overview on drugs and prison

Chairpersons: Mr ADJ Keizer and Dr Lars Moller

10:00-10.30 Prisons, harm reduction and public health. Overview of the existing knowledge

Prof. dr. Wim van den Brink, professor of psychiatry and addiction,
Academic Medical Centre, University of Amsterdam, Director, Amsterdam Institute of Addiction Research
Dr. Giel Van Brussel, MD, MPH, Head public psychiatry department (including drug department) of the municipal health centre of Amsterdam.

10:30-10:40 Questions and answers

10:40-11:10 Coffee break

11:10 – 11:40 The challenges of harm reduction within the prison system: lessons from England and Wales

Mr Martin Narey, Chief Executive of the National Offenders Management Service.

11:40 - 11:50 Questions and answers

11:50 – 12:20 The Committee for the Prevention of Torture's (CPT) mandate, findings and recommendations regarding drugs in prisons

Dr Pétur Hauksson, Chair of the Medical Group of CPT, Council of Europe.

12:20 - 12:30 Questions and answers and conclusions

12:30 – 13:30 **Lunch**

13:30 – 14:30 Plenary session 2: Harm reduction in practice. Part I

Chairpersons: *Mr Cees Goos and Dr Lucia Mihailescu*

13:30 – 13:45 **Mainline – educational programmes**
Mr Hugo van Aalderen, MA, Managing Director of Mainline

13:45– 14:00 **Educational programmes in Central Asian Prisons**
Mr Dmitry Rechnov, Head of Penal System Projects Department AIDS Foundation East-West (AFEW)

14:00 – 14:10 **Questions and answers**

14:10 – 14:25 **Tuberculosis control through harm reduction**
Dr Jaap Veen, co-ordinator, unit Europe, KNCV Tuberculosis Foundation

14:25 – 14:30 **Questions and answers and conclusions**

14:30 – 14:40 **Break**

14:40 – 16:00 Plenary session 2: Harm reduction in practice. Part II

Chairpersons: *Mr John Boyington and Ms Gerda van't Hoff*

14:40 – 14:55 **Needle exchange in Spanish prisons**
Mr Xavier Roca Tutusaus, Spain

14:55 – 15:10 **Needle exchange in Moldova**
Dr Larisa Pintilei, Innovating Projects in Prisons

15:10 – 15:20 **Questions and answers**

15:20 – 15:40: **Substitution therapy in European Prisons – ENDIPP's 18 countries study on legislation, policy & practice**
Dr Heino Stöver, Ph.D., Associate Professor, Faculty of Law, University of Bremen & Ms Laetitia Hennebel, European Researcher, Cranstoun Drug Services, European Network for Drugs & Infections Prevention in Prison

15:40 – 15:50: **Substitution therapy in Poland**
Dr Marzena Ksel, Poland

15:50 – 16:00 **Questions and answers and conclusions**

16:00 – 16:30 **Tea break**

16:30 – 17:45 Plenary session 3: WHO Status Paper on Harm Reduction

Chairpersons: *Dr Haik Nikogosian and Mr Rob Beek*

16:30 – 17:30 **Discussion of the WHO status paper on Harm Reduction**
National delegates, International Organizations and WHO Network for Prison and Health

Brief comments from:
National Agency of Correctional Services, the Netherlands
(Mr Peter van der Sande, Acting Head of the National Agency for Correctional Services,, Director Prison Services)

Pompidou Group, Council of Europe (Ms Eva Koprolin)

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
(Ms Margareta Nilson, Programme Coordinator)

17:30 – 17:45 **Conclusions and recommendations**

17:45 **Reception and buffet**

Welcome and introduction session

Mr P.H. Donner, Minister of Justice, the Netherlands

Speech by the Minister of Justice for the WHO conference on the Health in Prisons Project (recorded on video the 11 October 2004).

(Announcement by Richard Geense): It is not common practice to address guests by means of a video message. However, for this occasion we are pleased to be able to use this technology, as the Minister of Justice, Mr Donner, is currently abroad. He nonetheless feels it is important to personally welcome you to this 10th conference of the WHO Health in Prisons Project, and to open the conference. On behalf of Minister Donner I welcome all of you, and our foreign guests in particular.

Video message from Minister Donner:

Ladies and Gentlemen,

As Mr Geense has just pointed out, it is not customary to address your guests by way of a video system. I hope you will nevertheless accept the way in which I'm welcoming you to the Netherlands. It is the only way, given that I'm abroad at the moment but didn't want to miss the opportunity to open your 10th conference. I'm glad modern technology allows me to solve the problem of being at two places at the same time.

Health in prisons is an important theme. Care for the health of prisoners is a first responsibility of governments. A prison sentence allows the government to incarcerate a person but not to affect his health. A prisoner can be deprived of his liberty, but not of his health. This imposes a particular responsibility on the authorities responsible for the detention of prisoners, to provide for a healthy and clean environment in order to avoid prisoners from contracting transmissible or contagious diseases as a result of their contact with other prisoners.

Prisons can even be used to improve the health of prisoners by subjecting them for a longer period to a regime that forces them to take care and to improve their health. The title of today's conference: 'Drugs, Prisons and Harm Reduction', points to that opportunity to improve the capacity of prisoners to protect themselves against transmissible diseases; through information, through preventive measures, through training of personnel and inmates, through interventions that prevent the negative consequences of drug use and the spread of transmissible diseases.

The protection of the health of prisoners requires particular attention, because the inmates of our prisons are often drawn from the most vulnerable sections in society. The proportion of drug users among them is extremely high. Moreover many of them have been infected with transmissible diseases, such as HIV/Aids, hepatitis B and C and tuberculosis, and have in consequence to cope with serious health probleMs

These illnesses occur more frequently in countries with a weak economy. The incidence of people carrying transmissible diseases, is higher in Middle and Eastern European countries than in Western European countries. With regard to a number of the Eastern European and

Baltic states, the World Bank has predicted that by 2010 they will have reached a level of between 6 and 10% of young adults having contracted the HIV virus - an epidemic that goes hand in hand with a dramatic spread of tuberculosis. The number of tuberculosis patients in Europe has now increased by a third, with Eastern Europe having again the highest incidence with approximately 9 persons out of every 10,000 having contracted tuberculosis - a ratio that has not occurred in the Netherlands since before the Second World War.

Much attention has been devoted this past year to prisons and drug-related problems, and the question of harm reduction. During the Ministerial conference held under the Irish presidency, the Dublin Declaration on HIV/Aids in Prisons in Europe and Central Asia was adopted in January. This was followed in May by the UN Resolution on Combating the Spread of HIV/Aids in Prisons. I hope this WHO- conference of the Health in Prisons Project; will result in a 'position' paper that will succeed in putting these health problems high on the political agenda.

This 'position' paper shouldn't remain a mere 'paper tiger'. It is therefore important to insure that it will receive the attention it deserves in the EU. Attention that should result in a follow-up in the form of concrete activities. In order to achieve that result I will support the initiative where-ever possible.

It is up to you in these coming days to think of practical solutions on how to prevent detainees from contracting serious diseases, in order to avoid unnecessary human and social suffering. This is not charity, but responsibility and care we owe detainees.
I hope the present meeting will inspire you and support you in carrying through this important responsibility.

Dr H Nikogosian, Deputy Director, Division of Technical Support, Reducing

Disease Burden, World Health Organization, Regional Office for Europe

Ladies and Gentlemen, distinguished guests, dear colleagues,

It is a great pleasure for me to be here today on behalf of the World Health Organization at this event to which we ascribe great importance. Health in Prisons is an issue to which we at WHO attach great value for public health and since 1995 we have had a special project in our programme of work.

I would like to start expressing my great appreciation to the Dutch Ministry of Justice, to the Council of Europe's Pompidou Group and to the co-sponsors:

- The WHO collaborating centre on health in prison, UK
- KNCV Tuberculosis Foundation, the Netherlands
- AIDS Foundation / STD AIDS Netherlands
- Cranstoun Drug Services – ENDIPP (European Network for Drugs & Infections Prevention in Prison)
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for sharing the task of this conference with WHO. I am very happy to see so many people from European countries get together in order to identify and examine examples of good practice in relation to existing guidelines to prevent drug misuse in custodial settings and on harm reduction.

There are, unfortunately, good reasons to put substance abuse and harm reduction in the limelight. It is a subject that for a long time has been causing great concern to numerous prisoners, to prison health services and to prisons authorities. However, because of its relevance to public health, we believe that this subject deserves a much wider interest beyond these immediately affected groups.

It is estimated that 0.31% of the global population are opioid users and we find the highest prevalence in East Europe of 0.99%. It has particular impact on the HIV/AIDS epidemic where too the most dramatic trends have been observed in the countries of former USSR. Of the region's 250,000 new infections, most occurred among men, the majority of them are injecting drug users.

By working with prisoners we address a particularly disadvantaged group in societies: prisoners and their direct social contacts. In normal public health practice we would give special attention to high risk groups and concentrate disease prevention and health promotion efforts on these groups. But in the case of prisoners it seems to be the other way round. In many instances prisoners do not have the same means and ways to protect themselves against health risks that the rest of the population have. During the last few years authorities in many countries have seen the impact on the society –HIV, Hepatitis and tuberculosis ere spreading from prisons to the society, but unfortunately we don't have access to data on drug use and the spread from prisons to the society.

Drug abuse has a tremendous impact on life in prisons and on the way prisons are being run. There is probably no institution in society that has felt the influx of drugs so much as the prison. In many prisons in Europe drugs have become a central theme, it has become a dominating factor in the relations between prisoners, as well as between prisoners and

staff. Many of the security measures are aimed at controlling drug use and drug trafficking within the prison system.

If elsewhere in society the drugs problem has become so much nastier because of the concomitant spread of communicable diseases this applies in particular to the prison setting. The main source of spreading HIV is sharing of needles and syringes both inside and outside of prisons. Unsafe sex accounts for a smaller percentage of the spreading.

We have learnt over the past 10-15 years about how to reduce the spread of HIV among drug users in the community. We have discovered that it is very possible to slow down or even to stop the rate of transmission. Drug users are apparently not the kind of irresponsible people that they are widely held to be, if only they are given the possibilities to protect themselves. All the difficulties encountered in communities present itself also within the prison setting. The opportunities for prevention in the prison are more difficult but still demand reduction and harm reduction are unknown in the prison setting in many countries.

There is a large body of scientific evidence that shows the effectiveness of harm reduction measures including substitution treatment in reducing illicit opioid use, reducing criminal activity, preventing overdose deaths, preventing HIV and other blood borne infections.

Much of the complexity arises from moral and legal dilemmas and not from technical considerations. I am sure we today will be listening to several very good examples on prevention, demand reduction and harm reduction in prisons and hopefully we can use these examples in our future work.

During the last session today we will discuss a WHO status paper on harm reduction. It has been sent to all participants and everyone is invited to comment the paper. During today's meeting we will be happy receiving written comments on the status paper and please to handle them to an editorial group led by Dr Alex Gatherer. It is our hope that this paper would be the best scientific background concerning harm reduction in prisons.

I once again thank all for coming here today and I look forward for a fruitful and interesting day.

Mr ADJ Keizer, Chair of the Pompidou Group, Council of Europe

and Senior Drug Adviser, The Ministry of Health, Welfare and Sport in the Netherlands, Directorate of Mental Health and Addiction Policy, the Netherlands.

Ladies and gentlemen, distinguished guests, dear colleagues,

It is an honour and indeed a great pleasure for me to address this WHO HIPP Conference, which has received the organisational support by the Council of Europe's Pompidou Group and the Ministry of Justice of the Netherlands.

The Pompidou Group as a partner organisation of the network has worked very successfully with the WHO Health in Prison Project over a number of years now. And – but this is just a pure accident of life – the Pompidou is currently … in fact, since it's last Ministerial Conference held in October 2003 in Dublin … under the host country's chairmanship.

One of the previous major events organised jointly by WHO HIPP and the Pompidou Group was the Conference on "Prison, Drugs and Society" which took place in Berne three years ago. The main aim of this Conference was to review the factual situation concerning drugs in prison and to produce, for the practical daily use of key staff and governors of prisons, recommendations and checklists. These recommendations and checklists are included in the Consensus Statement on Principles, Policies and Practices mentioned just now by Dr H Nikogosian from the WHO Regional Office for Europe.

Underlying the Statement are the guiding principles of the WHO Health in Prison Project… And, understandably, the Statement also refers to the norms and standards elaborated by the Council of Europe in the field of prison health, based on the most fundamental legal human rights instrument, the European Convention for the Protection of Human Rights and Fundamental Freedoms, more particularly its Article 3 enshrining the absolute prohibition of inhuman or degrading treatment of persons deprived of their liberty.

As you all know, the European Committee for the Prevention of Torture (CPT) was set up in 1990 to examine, by means of visits, the treatment of prisoners. With regard to prison health, the CPT, in its reports, made clear the importance it attaches to the general principle that prisoners are entitled to the same level of medical care as persons living in the community at large, a principle which is inherent in the fundamental rights of the individual. Along the same lines, the Consensus Statement stresses that imprisonment must not remove the dignity and remaining autonomy of prisoners, or their self-respect and sense of responsibility for their future health and welfare.

Obviously it is vital to relate to principles and to monitor their observation. However, complementary activities are also needed with a view to developing and improving national drugs and health strategies. Current strategies which address the ill effects of illicit drugs are based on laws aiming at the reduction of supply, demand, use and harm resulting from drugs. Over the last years, however, acceptance in Europe of the need for both demand reduction and harm reduction programmes in prisons has been growing. In this respect, the working document of this conference entitled "Status paper on Prison, Drugs and Harm Reduction" the purpose of which is to synthesize evidence on the effects of harm reduction activities in prisons, is very welcome.

Let me add that the Pompidou Group, according to its mandate, focuses on promoting integrated, multidisciplinary approaches to the whole range of drug abuse and trafficking probleMs And in this assembly I need hardly highlight the importance of prison issues for an international body like ours. The high percentage of prisoners in all countries who are, or have been drug users, is well known. The number of those who continue to consume in prison is worrying. As national studies reported to the EMCDDA show, in some EU countries or regions up to 26% of drug users in prison say they started using drugs in prison and up to 21% claim to have first injected drugs in prison. Action in prison is therefore not just about managing a pre-existing problem, but also about preventing the inception of drug using behaviour. HIV and hepatitis C prevalence are in general also higher in prison than in the population at large.

So there is much that can be done within our prison systems to reduce the harm from drugs and to successfully treat a large number of those prisoners who are addicted to drugs. And the promotion of health in prisons also constitutes also an efficient contribution to national strategies for tackling the problems of drugs (including alcohol) in society at large.

The prison setting, and indeed the whole criminal justice system's handling of drug-using offenders, requires multidisciplinary and the close coordination of police, magistrates, judges, prison services, health and social services and a number of other actors, including the voluntary sector. But despite public calls for cooperation, the reality is often one of conflicting objectives among service providers and professionals.

On the other hand, recent years have also shown a number of encouraging developments: For example, a number of well-evaluated projects show that, contrary to what many specialists used to claim, it is possible to reach worthwhile treatment goals in a prison setting and this through a variety of approaches. However, practical implementation of these broad policy orientations is still often beset by quasi-ideological quarrels over appropriate measures and conflicting priorities. Often the scope of the measures taken remains rather insular.

To ensure continued progress in the establishment of generalised best practice, it is essential for practitioners to share their experience; networks of practitioners play a vital role in this respect. And let's not forget the need for continued evaluation of programmes in order to build an evidence base which can be used to convince decision-makers and resource providers of the value of adopting these approaches.

The Ministers of the Pompidou Group decided at their October 2003 session that future activities should focus on promoting evidence-based drug policies and the interaction between policy, practice and research. This means in particular giving much greater importance to the consideration of day-to-day practice at the grass roots level. In this respect I noted with satisfaction on the list of participants the large number of practitioners in the assembly.

Furthermore, the needs, problems and experience of those actually providing services should be communicated more efficiently to the policy makers and the Pompidou Group could provide useful channels of communication on a political level for you to express such concerns and needs.

The Pompidou Group also greatly appreciates the WHO HIPP network's potential in the dissemination of the guidelines, the experience and proposals developed by international bodies. Let me add that the efficiency of this role was well demonstrated by the dissemination of the Consensus Statement on Prison, Drugs and Society, mentioned earlier.

I once again thank you for this opportunity to address your conference on behalf of the Pompidou Group and wish you a very successful working day.

Plenary session 1: General overview on drugs and prison

Prisons, harm reduction and public health. Overview of the existing knowledge

Prof. Dr Wim van den Brink, Professor of psychiatry and addiction

Dr Giel Van Brussel, MD, MPH, Head public psychiatry department

Academic Medical Centre, University of Amsterdam, Director, Amsterdam Institute of Addiction Research

In the past, addiction was seen as just another type of immoral or criminal behaviour, and drug addicts were prosecuted not only for drug dealing and drug related crime but also for drug possession and drug use (Van den Brink, 2003). Nowadays addiction is generally regarded to be a chronic relapsing brain disease that is difficult to cure but well treatable with substantial improvements in health and social functioning and reductions in drug related criminal activities (e.g. McLellan et al, 2000; Van den Brink and Van Ree, 2003). According to most researchers and clinicians, stabilisation and harm reduction are the primary treatment goals especially for malfunctioning drug dependent patients with a lack of motivation for stable abstinence and insufficient social support (e.g. Fiellin and O'Connor, 2002). In order to reach these goals, agonist maintenance treatment (e.g. methadone, buprenorphine) and harm reduction measures, such as HIV/AIDS counselling, access to clean injection equipment, bleach, and condoms, and adequate diagnosis and treatment of HIV/AIDS, Hepatitis C and tuberculosis are of paramount importance (e.g. Van den Brink and Van Ree, 2003; Wodak, 1995)

Drug addicts constitute a sizable proportion of the prison population in most countries in the world and (intravenous) illegal drug use and unprotected sex are common phenomena in most prisons. Drug free prison treatment programs are not very popular among inmates, complex in their execution, labour intensive and often quite expensive, whereas the effect in terms of stable abstinence, improved health and reduction of criminal recidivism is not clearly established (e.g. Wexler, 1995; Schippers et al., 1998; Melnick et al., 2001). In contrast, prison based methadone maintenance and the free access to clean injection equipment, bleach and condoms are well received, relatively inexpensive and very likely to be effective in the reduction of (intravenous) illegal drug use and the transmission of blood-borne infections without unintended negative consequences (e.g. Dolan et al., 1998, 2003a, 2003b). Based on the principle of equivalent access to health care for free citizens and prisoners and the positive results in a number of well-designed studies, harm reduction programs should be implemented in all prisons. These programs can improve their effectiveness if continuity of care is established after release from prison preferably through a close collaboration of probation officers and addiction treatment and public health services (e.g. Haynes, 1998).

Public Health is involved because HIV/AIDS and Tuberculosis spread not only among drug addicts, but also to the general public. The failing harm reduction approach for drug addicts, not only in prison but also in freedom, results in a wild fire like spread of HIV/AIDS. This can be seen in the surveillance data on HIV infections in Estonia, the Russian Federation and the Ukraine (AIDS Action Europe 2004). When the expected spread of HIV/AIDS occurs from drug addicts to the general public, the public health disaster will be accompanied by a major economic downturn for the countries involved (World Bank 2002).

Drug addiction and its public health sequels should be seen not only as a humanitarian health issue but as a main hazard for economic development. A continuum of harm reduction measures as exists in the Netherlands and elsewhere has been effective in curbing the dual epidemics of the addictive use of heroin and HIV/AIDS.

PowerPoint presentation – see annex 1.

The challenges of harm reduction within the prison system: Lessons from England and Wales

Mr Martin Narey, Chief Executive of the National Offenders Management Service in England and Wales

Highlights of keynote speech on the challenges of harm reduction within the prison system with lessons learned from England and Wales

Setting out the context, approaches to, and challenges for the implementation of harm reduction schemes in England and Wales, which were influenced by practical and political considerations, **Martin Narey** said that it was morally indefensible not to work to the reduce the harm that stemmed from risk taking behaviours. Drug taking and its effects cause serious public health problems and it is important to keep working to reduce those risks for the sake of prisoners, staff and the public at large. The creation of the NOMS which will better manage offenders across the criminal justice process and the more generous funding available will help with this work.

Context
Some 75,000 prisoners are held in English and Welsh prisons and with 16,000 of them sharing cells meant for one there are overcrowding issues that impact upon the quality of regimes offered.

Approximately 45% of male prisoners who declare having a drug problem report that they injected in the month leading up to imprisonment. In women prisoners it is some 80%. Infection rates amongst prisoners who are intravenous drug users are 0.5% for HIV, 20% for hepatitis B and 30% for hepatitis C. Whilst the number who persist in injecting is small there is an ongoing need to tackle both drug addition and the risk of blood borne viruses.

Meeting the challenge of drug taking
Prisons in England and Wales work to tackle the challenge of drugs in a number of ways. Treatment and harm reduction measures for problematic drug users includes needs assessment, treatment interventions, clinical management, rehabilitation and support and drugs testing to encourage individuals to remain drug free. Supply reduction is delivered through a coordinated range of practical supply measures. Effective coordination with community provision is sought to provide better through care. Specialist substance misuse services are commissioned for young people in custody. Whilst it is important to discourage the unnecessary use of imprisonment, and particularly short sentences, imprisonment presents a unique opportunity to reduce drug dependency and the harm it causes.

Harm reduction approaches
These are achieved through primary prevention, secondary measures, tackling drug dependence, more coordinated services and programme evaluation. Primary prevention includes health education through innovative programmes produced in the language young addicts understand. Secondary measures include the accelerated hepatitis B vaccination programme for those first received into prison – some 30,000 doses were administered in 2003/04. Detoxification is provided to tackle drug dependence - some 57,000 detoxification programmes were provided in 2003/04, a twenty-fold increase in ten years. More coordinated services including rapid assessment, referral to first night centres and to

residential clinical management centres to provide active withdrawal management prescribing are being trialled and evaluated. A comprehensive range of psychosocial treatment programmes are available - 5,700 each year together with educational advice for those not undertaking treatment options. Substitute opioid therapy is also available for those for whom detoxification is not an option and more is being done to increase such provision.

Reducing the risks of blood-borne viruses
A programme is currently underway to provide disinfecting tablets to all prisons so that intravenous drug users can clean their injecting equipment and other paraphernalia. Prison doctors can prescribe condoms if in their clinical judgement there is a known risk of infection. Needle exchange programmes are not available and Martin Narey's advice to ministers is that the case is not yet made for them.

There are issues around the numbers of prisoners, length of sentence, frequent transfers,the young age of offenders and public perception, which tends to identify more with the drug reduction route. However, the UK does keep the matter under review.

Conclusion
The English and Welsh prison system recognises that it is dealing with serious public health issues and is working to tackle them within the framework of political and public opinion and in a way that meets national needs. It welcomes the opportunity presented by the Conference to share learning and ideas.

The Committee for the Prevention of Torture's (CPT) mandate, findings and recommendations regarding drugs in prisons

Dr Pétur Hauksson, Chair of the Medical Group of CPT, Council of Europe

Article 3 of the European Convention on Human Rights provides that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". A lack of proper care of a person deprived of his or her liberty by a State that leads to an addiction-related illness or exacerbation of an existing disorder, could amount to a violation of Article 3. The Committee derives its mandate from the *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*. "The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment." (Article 1). The emphasis is on preventing violations.

Under the Convention, CPT delegations have unlimited access to places of detention and the right to move inside such places without restriction. They interview persons deprived of their liberty in private and communicate freely with anyone who can provide information. The CPT has two guiding principles - cooperation and confidentiality, since the aim is to protect persons deprived of their liberty rather than to condemn States for abuses.

The CPT's findings regarding drugs in prisons are described in visit reports, many of which have been made public by the States (http://www.cpt.coe.int). In certain establishments large numbers of inmates are seen to display a wide range of symptoms of various types of drug addiction in all its possible degrees of intensity. Prisoners even advertise the excellence of the products which they have for sale and the going price. Prisoners interviewed have stated that the quality of the drugs they acquired in prison was better, and the prices lower, than outside. These circumstances, together with the proximity of the vendors, makes it difficult to resist the temptation to acquire and take drugs; a number of inmates have claimed that they had started to take drugs for the first time after their arrival in prison. The CPT has made various recommendations to national authorities to the effect that they vigorously pursue their efforts to prevent trafficking in drugs in prisons, without unduly restricting prisoners' contacts with the outside world or limiting the regime activities and association possibilities offered to them. Such restrictions might, in the short term, curb to some extent drug trafficking, but would do nothing to resolve the underlying causes of the drug-problems of many prisoners. It is crucial that the foundations be laid for continuing progress to be made by inmates who participate in drug-treatment programmes. A full range of activities should be offered to all prisoners treated for drug abuse, including education, social skills training and vocational training.

Prison health care services have a key role to play and should be resourced and equipped to handle all medical aspects of the treatment of inmates with drug-related problems, *inter alia* as regards substitution and detoxification programmes (including the treatment of withdrawal symptoms). Further, they should pay close attention to co-morbidity and other problems associated with the taking of drugs (deterioration of the health of persons who take drugs; risk of disease transmission; treatment of specific conditions with a higher prevalence in the case of drug abusers, including psychiatric disorders; general hygiene questions). The health care services should also be involved in the coordination of the psycho-socio-educational services offered to such persons.

Plenary session 2: Harm reduction in practice. Part I

Mainline - Educational programmes

Hugo van Aalderen, MA, Managing Director of Mainline, The Netherlands

Mainline is a non-governmental organisation founded in 1990. We are specialised in preventive health care and providing information to drug users. Through our key tasks; health education and prevention for drug users on the street, Mainline has gained a great deal of knowledge on developments on substance use, substance users and health risks.

Mainline has been working in the prison in Alkmaar for six years in a Harm Reduction Strategy program. In the focus on the health of drug users in detention, we differentiate the following three elements:

1. Health and health risks in prison during detention.
2. Preparation for dealing with drug use and health risks after detention.
3. The period of detention as an important opportunity in the life of a chronic drug user, in which a focus on health and health risks has a great impact.

Compared to international standards, the quality of detention can be called good and the health of incarcerated drug users is relatively good.
Mainline staff works specifically with detainees convicted of drugs-related offences.
In the Alkmaar prison, the return rate of inmates is extremely high at 70%, signifying that prison is more or less part of a merry-go-round.
The period in prison is too short for them to break with their lifestyle. Being off the scene means these drug users can use the time to recover, an obligatory rest, after which they can return to their usual routine.
Mainline workers know most of the inmates from their activities on the streets of Amsterdam and other Dutch cities, which guarantees that a relationship of trust can be extended into prison.
We approach detainees individually. In no way do we focus on abstinence. Detainees are free to share their thoughts with Mainliners. We are health advisers. Our angle is always about health aspects.
Mainliners work during detainees' recreational periods, and not in their cells, so that they visibly have the freedom to talk to us if they want to and not if they don't.
Mainline outreach workers are free to speak to all detainees without having to confer to a case.

This strategy has a number of objectives:

1. The conversation as a benchmark
2. Confrontation with the moment
3. Keep close to reality
4. Stick to what is feasible
5. Attention to health as a main theme
6. Trust

The Mainline approach is different to other forms of treatment and help. Our point of departure is the way the drug user in detention reflects on his life. The common ways of dealing with drug users in detention are either treatment (in the form of methadone, or other medicines) or abstinence.

Our experience is that these programs have very little effect in the long term. But I wouldn't want to put a stop to detox programmes during detention. Detainees need to stop using drugs while in prison. The programmes certainly need to be there for the group for which abstinence is a real option. However, for most drug users in detention, abstinence is not feasible in the short term.

Harm reduction strategies aim at actual change in behaviour in small feasible steps. This gives drug users the chance to regain a grip on their own health, and therefore on their life, without having to take the most difficult step: kicking the habit. Moreover, it offers better guarantees against the spread of infectious diseases.

That is why I would like to see a situation in prisons in which Harm Reduction activities and abstinence treatment are offered independently of each other. This does not mean there should be no coordination between the two. Harm Reduction activities and abstinence treatment can complement one another as long as the complementary qualities are well described and are geared towards each other. Harm Reduction activities can –by focussing on feasible objectives – lower the barrier to activities aimed at abstinence and increase its success rate.

Also, a good Harm-reduction programme offers users a way out in which they can place their relapse into drug use in a broader, more workable perspective.

The advantage of independent Harm Reduction programs in prisons can be seen by the fact that workers are impartial to both the inmates and the prison administrator. This eases the fear of inmates that they might leak confidential information and helps to build a relationship of trust. It also means that outside organisations can communicate structural problems to the prison administration without having to provide details of information given in confidence. The fact that the members of the health organisation are health educators takes the stress off prison staff when confronted with certain questions and helps to provide good and up-to-date information suited to the target group.

This means that the prison staff must come to the conclusion that Harm Reduction methods will not only ease their daily lives, but will also improve the quality of life of the prisoners. In Alkmaar, they have come to this conclusion (or, let's say most of them have).

Mainline's work in prisons does not cure drug users, but it gives them more opportunities to do something about their situation.

Educational Programmes in Central Asian Prisons

Mr Dmitry Rechnov, AIDS Foundation East-West (AFEW), Head of Penal System Projects Department

The Drug Demand Reduction Program (DDRP) in Uzbekistan, Tajikistan, and the Ferghana Valley (including parts of Kyrgyzstan) is a strategic response to the dramatic rise in heroin/opiate injection use. The program is aimed at pre-empting an uncontrollable HIV/AIDS epidemic such as the ones that have recently developed in other former Soviet Union countries. DDRP mission is to engage all levels of society in reducing demand for heroin and other opiates. This entails providing a full spectrum of drug demand reduction services, such as:

- *universal prevention* (to keep those who have never used drugs from starting)
- *selective prevention* (targeting those at high-risk for drug use)
- *indicated prevention* (to motivate those already using or addicted to seek help, and provide them with a full range of drug-free treatment and rehabilitation options)

DDRP is mostly a 'drug free' program. It's focus is to primarily develop healthy alternatives of heroin/opiate use. Direct Harm Reduction interventions are not a program focus. DDRP does not support opportunities for needle exchange and substitution treatment, nor promote safe injection practices. Within the program on both selective and indicated levels, *AFEW* has transformed harm reduction messages into health promotion messages focused on HIV/AIDS and other infectious diseases.

These messages target vulnerable populations, including inmates, to reduce any potential for further drug-related damage while in prison.
DDRP/AFEW Prison Program Components:

- Trainings for medical and non-medical prison staff;
- Trainings for inmates;
- Provision of informational materials;
- Provision of condoms and bleach;
- Capacity-building and institutionalization of successful outcomes.

Trainings and Informational Materials for Inmates:
- Developing self-protection techniques among prisoners, including condom use and disinfection of articles which might come in contact with blood (razors, etc.);
- Developing outreach within pilot prison facilities for peer education;
- Increasing knowledge about drug-related health risks.

Trainings for Prison Medical Staff:
- Developing counseling skills including VCT and motivational interviewing;
- Building local in-prison capacity for developing health-related educational programs for inmates;
- Burnout prevention for prison staff.

Trainings for Non-medical Prison Staff:

- Increasing knowledge about drug-related health risks, including HIV/AIDS
- Developing self-protection techniques in the work place
- Promoting outreach and self-support programs for inmates
- Promoting the development of hygiene skills among inmates

Capacity-building and Institutionalization

- Facilitating national and regional Working Groups on health protection in prisons
- Organizing study tours to Western and Baltic countries
- Revising existing training curricula for prison staff
- Catalyzing the development of pre- and post- release services

Expected Outcomes

Both in-prison and national capacity-building activities lead to institutional changes within the penal system in DDRP countries that prevent HIV transmission and drug related health risks.

Recognition of international standards of healthcare in prisons creates a solid platform for developing wide-range program approaches, including those outside DDRP.

Tuberculosis control through harm reduction

Dr Jaap Veen, co-ordinator, unit Europe, KNCV Tuberculosis Foundation

1. Epidemiology of TB and HIV in Europe

WHO estimated in 2001 that there were 484,000 new TB cases in EUR, representing 6% of the global TB burden. The Russian Federation had the 9th highest burden of TB in the world. Within EUR, TB incidence varies enormously, from 5/100,000 in Sweden to 181/100,000 in Kazakhstan. High rates of TB are associated with socioeconomic crisis, health system weaknesses, HIV and multidrug-resistant TB epidemics, poor TB control interventions among vulnerable populations. Analysis shows that 2.6% of all new TB cases which occurred in Europe in 2000 were attributable to HIV co-infection. In the Russian Federation, 1% of all new TB cases were estimated HIV-positive and 35% of adult with AIDS have died from TB.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO estimate that EUR had about 1.77 million PLWHA in 2001, i.e. 4% of the global HIV/AIDS burden. The HIV/AIDS epidemic in Europe is the fastest growing in the world. In eastern and central European countries the HIV epidemic is mostly concentrated among specific risk group populations, mainly injecting drug users (IDUs), who are rising dramatically in numbers in eastern countries due to the world trafficking of drugs, unemployment and poverty.

2. Tuberculosis in prisons

Tuberculosis in prisons of the Former Soviet Union (FSU) is a large problem, not only for the penitentiary system but also for civil society.
The incidence rate in the penitentiary system in the FSU is estimated at 5000-7000 per 100,000 inmates.
On top of the TB epidemic come 2 major complications:

- The increase of multi-drug resistant TB (MDRTB) that renders the disease almost incurable. Already one of every four new patients has MDRTB, while of those who have had the disease before, and that is the majority of TB patients in prisons, one of every two is drug resistant. Only premature death or an aggressive campaign can interrupt the transmission of TB in prisons.

1. HIV is predominant among drug-users and drug-users often are imprisoned, thus it is a matter of time for the dual infection TB/HIV to become highly prevalent. The dual infection will lead to more TB patients and more TB transmission. Data on the prevalence of HIV infection in prisons are anecdotal. Small surveys have been done, but it is difficult to generalize the findings.

The TB problem is not confined to the prison sector itself. Persons, who were in pre-trial detention and are not convicted, may have become infected with TB, carrying the disease into civil society. Similarly for those prisoners that have come to the end of their sentence. Since many prisoners for lack of social support become recidivists, the risk of getting infected and carrying TB into civil society is increased with every incarceration. Prisons have therefore been named the ‘tuberculosis pump’.

Release is not the only way of transmission to civil society. Prison staff and visitors also run a considerable risk of getting infected with (MDR)TB. So despite incarceration TB patients still contribute to transmission of TB in civil society.

3. HIV in prisons

No proper data on the incidence of HIV infection among prisoners are available. In some penitentiary settings all prisoners are checked for HIV presence, but these data are either not reported or kept from making them public.

4. The dual epidemic of TB/HIV

HIV is the largest individual risk factor for developing tuberculosis. Since the emergence of the HIV/AIDS epidemic dual TB/HIV epidemics have emerged in all regions of the world. The HIV epidemic drives the global TB epidemic, the level of the HIV/AIDS epidemic largely determining the extent at which this happens. Under such conditions successful TB programs cannot stop the increase of TB patients; only mitigate the impact of the dual TB/HIV on the community at large. The impact of HIV on the TB epidemic will last; even when HIV transmission is brought to a full stop today, it will take 10-20 years before the tuberculosis epidemic is back where it was before the HIV epidemic. Health systems are struggling to cope with the increased burden of TB and HIV. PLWH are highly susceptible to infection with *M. Tuberculosis;* causing outbreaks of HIV associated TB in hospital settings infecting other patients and health workers, in families/close contacts of TB patients, and in people living in aggregated settings (e.g. prisons, barracks, migrant labourers, etc.). PLWH can have TB two or more times in succession when TB infection levels in the community are high. PLWH on ART remain at increased risk of getting TB.

5. Populations at high risk of HIV and TB

Injecting drug users are at risk of HIV, TB and in some settings of MDR-TB. Over two-thirds of newly diagnosed HIV infections in Eastern Europe are among IDUs. It is estimated that 1% or more of the population of the NIS are IDUs and that half of them are younger than 25 years. Sex partners of IDUs are at risk of HIV. IDUs often sell sex to support their injecting habit, which increases the risk of HIV transmission to the general population.

Sex workers are at higher risk of HIV because of behaviours such as unsafe sex and unsafe injecting drug use practices. Sex workers (SWs) may represent a significant channel of HIV transmission to the general population.

Prisoners are at high-risk of TB, particularly in crowded facilities. Moreover, prisoners often come from populations at high risk of HIV, because of the illicit nature of drug use and sex work and the high rates of property crime to support drug use by IDUs. The risk of TB infection and disease is consistently higher among prison inmates than in the general population, and this increases with the length of detention. Special issues for controlling TB among prisoners include: the fast progression of clinical TB in HIV-positive prisoners; the spread of TB to other prisoners and prison officers and staff; the spread of TB to the community at large when prisoners need hospital care or are released; and the additional costs of isolating, investigating and treating cases.

Migrant populations account officially for 2.7% of Europe's population, or 1% if considering only those from non-European countries. Both European and non-European migrants contribute to the TB and HIV epidemics. Difficulties in communication, accessing health care services, gender barriers and the often uncertain legal status of migrants pose particular problems for TB control and HIV prevention and care in this group.

Patients and health-care workers are often at greater risk of being exposed to M. tuberculosis. Nosocomial transmission of TB is most likely to occur from patients with unrecognized pulmonary TB who have not started any anti-TB treatment and have not been isolated. The emergence of MDR-TB, often combined with HIV infection, confronts the health care community with unique challenges. Nosocomial TB transmission in HIV-infected patients in Europe has caused outbreaks with high case fatality rates. HIV-infected patients have a high attack rate and a shortened incubation period for TB disease and are susceptible to re-infection, including re-infection with drug-resistant strains.

6. The response

Priority countries

Different countries in EUR face different challenges in responding to TB/HIV. The (51) countries vary considerably with respect to the HIV and TB epidemiological burdens and the type and quantities of new activities to implement for providing international recommended TB and HIV/AIDS services. A country with high case load, increasing epidemiological trend, inadequate resources and/or health system, represents a priority for intervention.
Table 1 groups countries with a combined perspective for priority intervention. The countries with both high need for HIV/AIDS prevention/control and TB control are also those with the highest need for addressing TB/HIV.

The response of Agencies and Governments to HIV/AIDS has mainly focussed on HIV prevention through behavioural change, with little emphasis on care and support.

The health strategy

TB in prisons should be regarded as a public health problem.
Prison medical staff is familiar with individual case management, but has no training in public health oriented interventions, like health education, medical check-ups, treatment adherence by observed therapy, defaulter tracing as a medical responsibility, monitoring of treatment results and program outcome. Medical and general staff should be trained in these aspects, and the proper conditions for diagnosis and treatment must be provided by the government.

The non-health strategy

TB control in prisons is not only a medical problem.
A complexity of factors influences the transmission of TB. Long sentences for relative minor crimes lead to overcrowding and increased transmission in dormitories where inmates have nothing else to do than smoke and talk in poorly ventilated dilapidated buildings. Malnutrition leads to decreased immunity. An internal hierarchical system that may prevent prisoners to seek medical help, also contributes.
Building more prisons helps to reduce overcrowding, but reforms of the penal code, reducing the length of stay or alternatives to imprisonment are probably more effective. Large scale amnesties of recent years have contributed to decrease the overcrowding and

thus to reduction of the burden of TB inside prisons; it has however increased the burden of disease in civil society. Social support to prevent recidivism is another aspect that eventually will contribute to contain the disease.

Interventions

Interventions can be medical or non-medical. Early diagnosis and adequate treatment of active TB and preventive treatment of latent tuberculosis are some of the most important interventions to improve quality of life and life expectancy of PLWH. And because TB is a public health hazard, effectively dealing with TB in PLWH also offers large benefits for society at large.

When dealing with a dual epidemic case finding (testing) and service delivery can be combined. The term harm reduction is mostly restricted to interventions such as needle exchange or substitution therapy.

These are not common programs inside prisons. Most prison commanders will state that they prevent the use of drugs in prisons, even knowing that the reality is otherwise. Seen from the TB controllers perspective all measures preventing transmission of HIV as used in the general population are valid also for the prison population and can be seen as harm reduction. Thus the free availability of condoms will prevent HIV transmission and indirectly prevent TB illness in infected prisoners.

Conclusion

TB in prisons in Eastern Europe is an enormous problem, affecting the society at large. It is aggravated by multidrug resistance and a rapid increase of HIV infections. Harm reduction interventions contribute to decrease the transmission of HIV and thus indirectly contribute to decrease the burden of TB. The dual epidemic can only be solved by a multidimensional and multisectoral approach.

Interventions against HIV and TB: transmission prevention and early diagnosis

INTERVENTIONS AGAINST HIV (THEREFORE INDIRECTLY AGAINST TB)	INTERVENTIONS DIRECTLY AGAINST TB
PREVENTING TRANSMISSION	
Safer drug use	
- harm reduction	
- substitution therapy	
Safer sex	
- condom promotion	
- reduction in number of sexual partners	
Voluntary counselling and testing for HIV	
Prevention and treatment of STI	
Prevention of mother-to-child transmission	
Antiretroviral therapy	Diagnosis/treatment TB infectious case
Safe blood	
Universal precautions	Environmental measures
DIAGNOSING EARLY STAGES OF INFECTION/DISEASE	
Voluntary counselling and testing	Sputum smear microscopy
	Intensified case finding

Plenary session 2: Harm reduction in practice. Part II

Needle exchange in Spanish prisons

Dr Xavier Roca Tutusaus, Head of Treatment Section. Rehabilitation Service.

Secretary of Penitentiaries Services, Justice Department, Generalitat de Catalonia

Catalonia is like a federal state in Spain and in 1984, the Government of Catalonia assumed the management of the prisons. In Catalonia we have the same penal and penitentiary laws, but we have differences in the management and about decisions of inmates, but not in the philosophy and the methodology of needle exchange program. Since this year, the Catalonian Government, the Generalitat developed a lot of different programmes and strategies to implement and to develop rehabilitation programs in the penitentiaries centres. We must recall 1977, when a new constitution was created in Spain. The article number 25 says: *"The measures of prison are addresses to rehabilitation*."

Now, in Catalonia, we have:

- About 7500 inmates
- About 30 % are foreigners
- About 20 % are pre-trial
- About 50% are drug users (23% by parental)
- 70,51% of drug users are HIV+ (24% of total)
- Prevalence of Tuberculosis 19/10000
- Prevalence of Hepatitis C 39,77 %
- Inmates with antiretroviral treatments are 11,6 %

Due to the strong relationships between drug and crime, we developed different programs for the treatment of drug addicts in prisons. When we developed these programs we had in mind a few ideas:

- The Inmates do not have any freedom, but they must have the same possibilities of treatment than a person in the community
- The treatment of drug addicts in prisons must be the most similar than in the community
- The treatment in prison must be continuing in the community
- The treatments are complementary
- Since 1984 we have developed different programs for the drug addict treatment:
    - Intervention groups (about 1000 by year) (like relapse prevention, etc.)
    - Maintenance in Methadone (1073 inmates in 31 of December of 2002)
    - Therapeutic Communities In and out Prisons (212 inmates in 2003)
- We derived inmates to Ambulatory Centers (from in prison to prepare the progression to open prison) (416 inmates in 2003)
- Furthermore, we developed different indirect interventions:
    - Another kind of intervention (health education, prevention of sexual diseases, Hepatitis, HIV, etc)
    - We give bleach with a sticker with information about how disinfected the needles
    - We give condoms in the intimate visits

The program of needle exchange in Catalonia is developed thinking this program is one more, not the only program to harm reduction. The exchange is made for health team

because we think that the most important is the relationship between the inmate and the health professional and the exchange about different information about the drug use, his consequences and the possibilities of different treatments. So, the needle is the leitmotiv and gives the possibility to know, inform, suggest or facilitate the contact with a different intervention (health education).

The exchange is one to one to any inmate who demands one and only the health team knows the name of inmate. Then, it's possible an inmate goes to different treatments programs (for example, relapse prevention, methadone program and exchange needle) but he only can has one needle. The possibility to achieve a needle in the day is easy: the inmate put his name to go to medical visit (one in the morning and one in the afternoon) and demand one to the health team. The weekend there are medical visits, too.

The needle exchange is not possible in psychiatric units and in high security departments and the syringe is retractile. Another needle or syringe is forbid and the bad use of needle or syringe of program could suppose the eject of the inmate of program

Now we have 2 penitentiaries centers (total number of penitentiaries centers is 9) with needle exchange without special problems of security, without more overdoses than before and without fights or aggressions with needles.

We concluded thinking about the needle exchange program must be integrated in different interventions and the importance about achieve the collaboration of prisons guard and no problems of security with the needle.

- In the next year (2005) we have in mind the next programs:
    - we will have the needle exchange program in all the penitentiaries centers of Catalonia
    - We are preparing a program for Tattoos machines
    - We will developed new strategies for the new and old drugs and for foreigner people
    - Justice department and Health department of Catalonia will be developed a pilot program to make better the treatment of drug addicts in a prison.

PowerPoint presentation – see annex 2

Needle exchange in the Republic of Moldova

Dr Larisa Pintilei, Innovating Projects in prisons

Current organization activities are focused on:

- Maintenance of work of points of exchange of syringes in prison of №18 Branesti, prison of №4 Cricova, prison of №6 Soroca, in a female prison of №7 Rusca.

- Points of an exchange of syringes in our prisons work round the clock, carrying out an exchange of syringes (1:1) with their subsequent recycling, by means of volunteers from among condemned.

- Negotiations with local and governmental authorities in order to obtain a support in starting an epidemiological surveillance on HIV infected in penitentiaries of Moldova.

- Extending the links with colleagues' abroad providing services of HIV prevention among inmates.

- Reviewing the HIV prevention and surveillance activities carried out in penitentiary institutions of Moldova.

- Organizing local events/meetings on HIV prevention among injecting drug users in penitentiaries.

- Holding working sessions with the staff of the Department of Penitentiary Institutions of the Ministry of Justice of Moldova in order to inform the authorities of harm reduction activities.

- Advocacy efforts addressing the importance of extending the harm reduction initiative in other penitentiaries.

- Educational activities based on the method of « From equal to equal ».

- Advocacy the rights of HIV-INFECTED condemned.

- Distribution of information materials (booklets, calendars, instructions) for employees and prisoners.

- Change of risky behavior of detained persons made by granting the competent information during carrying out of seminars on themes:
  - "HIV-INFECTION"

- « Illnesses transmitted in the sexual way »,
  - « Virus hepatitis »

- « Risk connected to the use of drugs and less dangerous behavior » (first-aid treatment at overdoses, care of veins) with granting anti-inflammatory means at post injection complications**.**

- Psychological rehabilitation of injecting drug users, detained in penitentiaries №4, №6, №7 and №18.

Support of local and governmental authorities

As a positive reaction from the part of Ministry's authorities, the following fact could be highlighted. The Department of Penitentiary Institutions of the Ministry of Justice has accepted and supported the HIV prevention initiatives in penitentiaries.

As a result of this fruitful collaboration four orders: № 115 from 03.12.1999, № 52 from 16.05.2002, № 141 from 05.11.2003 and № 142 from 22.09.2004 has been issued on introducing additional measures on HIV/AIDS prevention in prisons. One of the main stipulations of these orders was to register officially the functioning of needle exchange points in penitentiary institutions nr.18 in Branesti, Nr4 in Cricova, №7 Rusca and № 6 Soroca.

PowerPoint presentation – see annex 3

Substitution Treatment in European Prisons

Dr Heino Stöver, Ph.D., Bremen Institute for Drug Research and Ms Laetitia Hennebel, European Researcher, Cranstoun Drug Services

Introduction
Substitution treatment was introduced as a treatment for opiate-dependent persons around forty years ago. Difficulties and differences for its implementation remain, especially in the prison setting, where the availability, implementation, clinical management and evaluation of substitution treatment are often deficient.
This study has focused on examining the policy in place for the provision of substitution treatment in prison, as well as practical experiences in different countries. The report presents findings in each country, emerging issues across the countries, as well as recommendations.

The research 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 healthcare 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; Initialize 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.

Methods
The research project was conducted over a period of 18 months, from December 2002 to May 2004, covering 18 countries (the 15 Western EU member states, the Czech Republic, Poland and Slovenia). The research involved collecting data from various sources. National data were collected with the support of national contact persons. The majority of national contacts were ENDSP (and CEENDSP) representatives as well as key individuals working in the national prison service. Ongoing examination of research reports, national governmental and non-governmental websites was also conducted. This included general information on substitution treatment, in the community and prisons, as legislation, protocols, guidelines, and procedures of the treatment itself. Qualitative data were collected through interviews conducted during field visits and organized with the support of the national contact. The group of participants was made up of *Group A*: prisoners and professionals working in prison, and *Group B*: key individuals within governmental and non-governmental institutions located outside of the prison. An average of two prisons was visited in each country. In total, prison visits took place in 33 prisons with 184 prisoners (132 men, 52 women) in 33 focus groups out of 17 countries.

Results
It was found that access to and continuity of substitution treatment in prison in many countries in Europe is inadequate, compared to service provision in the community. The principle of the equivalence of care was seen as not being respected in many countries. It was also found that the provision of substitution treatment in prison varies from one country to the other, from one prison to the other, within a medical team, from one doctor to the other. Although psychosocial care was seen as an additional and necessary part of treatment to support the medical part of the substitution treatment in prison, it was found that such a support was rarely provided. The heterogeneity of the treatment has raised

difficulties for the continuity of care within the prison settings and from or to the community.It was reported that substitution treatment in prison has brought various security issues as methadone and buprenorphine are sometimes used on the black market. This was a particular concern for France (with the provision of buprenorphine) and generally a concern for the prison management across the countries.

Conclusions

The study has shown how substitution treatment is provided in a heterogeneous way in Europe. These differences reflect the historical, cultural, social, economic and political differences to be found throughout Europe and within one same country.

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). 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 were elaborated.

Recommendations were suggested underlying recommendations made by international bodies and experts, and drawing on the study's results, underlying the need to take into account the national, regional and local differences.

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PowerPoint presentation – see annex 4

Substitution therapy in Poland

Dr Marzena Ksel, Director Prison Health Services, Poland

Intravenous drug users (IDU) population in Poland is stipulated from 10 to 30 thousands people. On methadone maintenance therapy (MMT) in 10 programs is around 700 people. IDU are 3% from all prisoners, estimated evaluation research program by Institute Psychiatry and Neurology. In polish prisons we have two registered methadone maintenance therapy programs (MMTP) in remands prisons in Krakow and Warsaw.

The law regulation on MMTP has high level criteria to be meet by drug user, who would like to be on substitution. This also applies for people placed in penitentiary institutions. In additional, M MT for any inmate may be introduce in prison, only when place for continuation of substitution after prison is founded. For that, mostly the continuation of MMT started before imprisonment is provided in penitentiary institution. The future of MMTP in prisons is very much dependent from what will happen with substitution treatment in civilian MMTP.

PowerPoint presentation – see annex 5

Plenary session 3: WHO Status Paper on Harm Reduction

Discussion of the WHO status paper on Harm Reduction – Brief comments

National delegates, International Organizations and WHO Network for Prison and Health

Mr Peter van der Sande, Acting Head Director of DJI, the Netherlands

It is an honour for me to be at this conference and to have the opportunity to give my comments on the Status Paper. But before doing that I would like to say something about the Dutch prison system and the challenges we are faced with.

Since mid 2003, the Dutch Agency of Correctional Institutions is confronted with four major developments. In 2007, we will receive 17 percent of the total budget less to provide the same scope of services we provide today. Recent years were characterized by big capacity problems, which are continuing to grow. To illustrate this: in 1984 we had capacity for 4000 prisoners, by the end of this year it will be 16.000, and by 2008, we are aiming at 20.000.

Society expects more professionalism and decisiveness from our organization. Also, there is dissatisfaction about our contribution to the enforcement of custodial sentence among our cooperation partners, like the Public Prosecution, the Probation Office, and health care institutions.

We have responded by creating a new vision on the enforcement of custodial services. The two key concepts of this vision are functional implementation and demand steering. Functional implementation is defined by us as more effective, more efficient and more target-group focused enforcement of custodial sentences. Demand steering means that, in principle, we allow ourselves to be led much more than previously by the needs of our cooperation partners.

Let me say a little bit more about our target-group approach. Starting point is that we try to realize a change of behaviour for long term detainees (sentenced for over four months). We only use evidence-based interventions and we cooperate with probation and care organizations. An important precondition is the motivation of the prisoner.

We do not offer such interventions for short-term detainees. But harm reduction is of course also very important for this group. If possible, they will be sent through to care organizations.

Why combating HIV/Aids, Hepatitis and Tuberculosis? There are many reasons: first of all we want prevention of human in social suffering. Victims of HIV/Aids are mostly young adults. In some countries the HIV epidemic may become an obstacle for economical development.

Why harm reduction in prisons?
People we house are among the most vulnerable and marginalized in our societies. Many of them make insufficient use of the regular care facilities in free society. The proportion of drug users among them is extremely high. Prisons are a high risk environment – for inmates and personnel. Prisons are part of society at large: fences and doors do not stop transmittable and contagious diseases. Basic conditions for the prevention of drug use and harm reduction are: a safe and hygienic environment and decent accommodations. We need trained prison staff, social and medical staff and we have to offer a supportive structure (daily programme, work, training and education).

Drugs policy in prison
This brings me to our drug policy in general. In Dutch prisons, using drugs or alcohol is prohibited, and smoking is restricted. Drugs in prison undermine the safety in prisons. Nevertheless, drugs are being used. We do everything we can to prevent the import of drugs in our prisons. Substitution therapy is part of this policy. It is an accepted practice of harm reduction. This is also our policy in prisons. But: even in the Netherlands, not all governors and prison doctors apply substitution therapy in prisons. This, of course, has our close attention.

Our policies are based on the Dutch Health Council's recommendations on the treatment of drugs-addicted detainees in custody. This report was published in 2002, and reflects Dutch policy for treating drugs-addicted detainees based on current scientific knowledge at a national and international level.

Finally, I am pleased to give my comments on the Status Paper

Brief comments
The status paper is an important document. We observe that both inside and outside of prisons in Europe, the prevalence's of HIV, Hepatitis and Tuberculosis are rising. The paper points to the opportunities we can offer people we incarcerate to protect themselves against transmissible diseases: through information and education, through preventive measures and interventions to prevent the negative consequences of drug use and the spread of transmittable diseases. As our Minister said this morning, this is not charity, this is our duty of care we have towards detainees.

I have some remarks:
Firstly: the paper focuses mainly on drug use and harm reduction policies such as needle exchange and substitution therapy. As we all know, sharing needles is not the only way of contracting the HIV virus. Therefore in Dutch prisons we also educate prisoners about safe sex and condoms are available. We think it is very important to try and make prisoners conscious of their high risk behaviour. We should stimulate them to take responsibility for their own life. Therefore we must encourage prisoners in taking control of their life and give them opportunities to protect themselves against transmissible diseases

Secondly: as Mr Jaap Veen of KNCV Tuberculosis Foundation explained to us this morning, the Tuberculosis epidemic goes hand-in-hand with the HIV epidemic. Because of their health system weakness, for HIV-patient the risk of contributing TB is very high. Therefore prevention of HIV and prevention of TB should go hand-in-hand too, in order to stop the rise of co-infected people and multi drug resistant TB, especially among drug users. I think in the status paper this should get more attention.

Thank you very much for your attention.

Ms Eva Koprolin, Pompidou Group, Council of Europe

The Pompidou Group activities focus on promoting evidence-based policies and interaction between policy, research and practice. In this respect, the Status paper on prison, drugs and harm reduction is very welcome, being the result of research evidence and expert findings and submitted to a discussion among practitioners here today. The status paper certainly constitutes a positive element in building the bridge between the two poles of the policy debate.

The subject of risk reduction and damage limitation was first taken up at ministerial level during the Pompidou Group's 2000 Ministerial Conference in Sintra. The conference dealt with the general theme of "Risk reduction as a component of a comprehensive, multidisciplinary approach to drug abuse problems", while being fully/while being fully aware that such a theme is not free from controversy.

One of the technical working documents presented to the ministers and other policy makers at that conference pointed out clearly that risk reduction, if integrated into a global, balanced, multidisciplinary strategy, can represent an effective and pragmatic middle way between the extremes of drug policy.

Participants in this conference acknowledged that the pragmatic approach which puts emphasis on risk reduction is the weapon of choice for those countries facing the more serious drug use related consequences on health and social well-being. In this context, the need for a constant dialogue between experts, professionals in the field and politicians was stressed. International co-operation to exchange experience and evidence, as with our meeting today, was also considered vital.

Some government representatives referred to the positive results of risk-reduction measures, such as a drop in HIV contamination, better reintegration into society and less drug-related crime. Finally, in their political declaration, the Ministers encouraged States to adapt risk reduction measures both to the individual and to society, taking into consideration the local drug abuse situation and the related cultural context. And they also stressed the need to reinforce health promotion, preventive activities and risk reduction programmes against HIV infection, hepatitis and other infectious diseases.

Subsequently, in 2001, the Pompidou Group commissioned a review of the evidence and impact of substitution treatment for opioid dependence in member States on the basis of a questionnaire. In their conclusions, the authors stressed the substantial impact of substitution treatment on the containment of HIV and the reduction in the spread of HIV, as well as the reduction in drug related mortality during treatment for drug dependence. The study also concluded that there is a strong case for investing in treatment as the savings exceed by far the cost of such treatment. According to the review's findings, the potential benefits of individuals reducing their criminal behaviour and their involvement in the criminal justice system, in particular the prison system, could be significantly developed in most countries.

In recent years, Europe has gradually developed in a pragmatic direction. Strong views and ideologies seem less prominent. Opioid maintenance, needle exchange, measures to minimise stigmatisation, are today accepted in most if not all countries with restrictive policies. In relation to these risk reduction strategies, the same questions and problems appear inside prison walls as outside in the community.

As concerns substitution treatment, the need to set minimal standards for medically and psychosocially assisted treatment of opioid-dependent persons was discussed by international experts at a Conference jointly organised by the Pompidou Group and the INCB (International Narcotics Control Board) in October 2002. On this basis, in December 2002 the Pompidou Group Permanent Correspondents decided, on behalf of their governments, to produce a draft resolution on common needs in the field of substitution treatment to be submitted to the UN Commission on Narcotic Drugs. Even though this text as a draft resolution had no strict legal standing, it reflected a certain consensus. It invited the UN International Drug Control Programme, WHO and other relevant organisations to establish and publish worldwide guidelines. A list of minimum requirements was appended to it. In this light, the status paper could be perceived as an attempt to reinforce a common regional attitude in this process.

Ms Margareta Nilson, Programme Coordinator, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

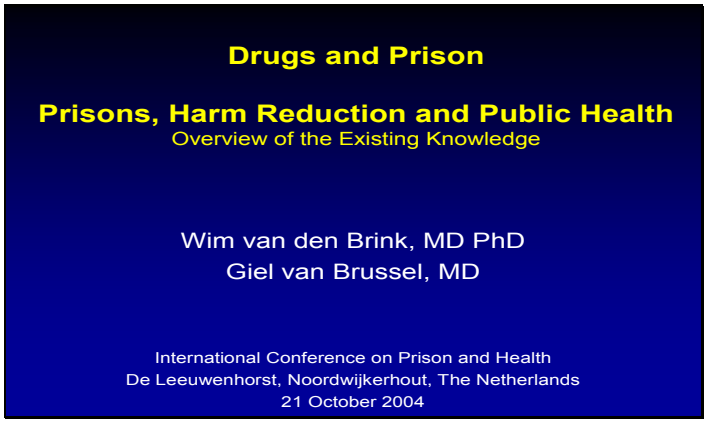
The WHO/HIPP Status Paper on Reduction of drug related harm gives an excellent set of quality criteria for services in prisons, which aim at reducing harmful consequences of drug use such as infectious diseases and overdose deaths. The EMCDDA puts particular importance to information about best practice and we regularly monitor the availability and the quality of interventions in the EU Member States. We see the publication and dissemination of best practice and its implementation as a contribution to the awareness and knowledge of policy makers, professionals and other decision makers about the state of the art in Europe and in the different Member States. The Status Paper is of great help to support and sustain these efforts.

PowerPoint Presentations

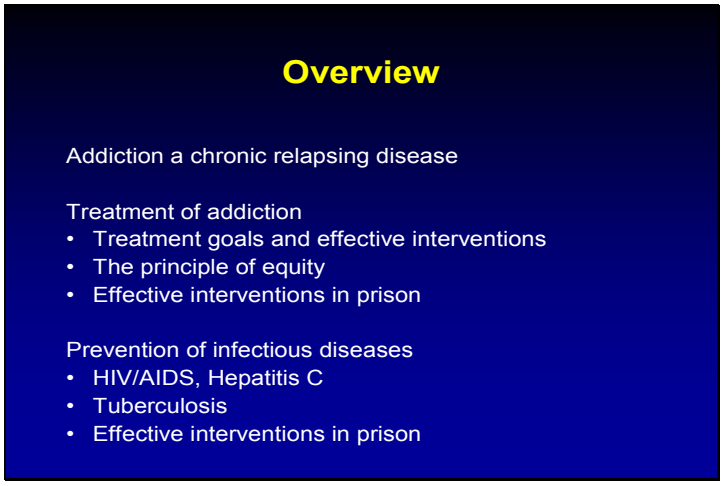
Annex 1

PowerPoint Presentation by Dr Wim van den Brink and Dr Giel van Brussel

Slide 1



Slide 2



Slide 3

Slide 4

Drug Addiction: chronic relapsing disease

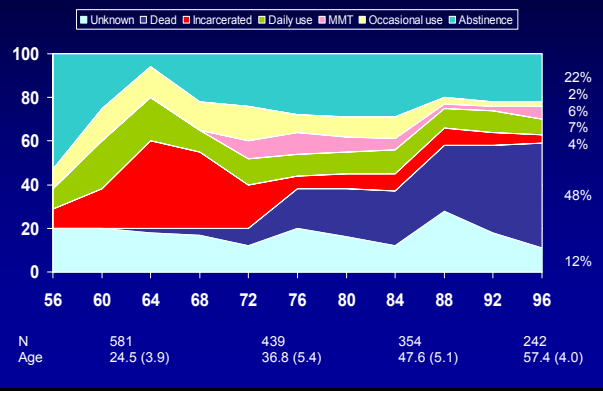
(Hser et al., 2001; McLellan et al., 2000; O'Brien & McLellan, 1996; Golstein & Herrera, 1995)

- **Drug addiction is chronic, lifelong relapsing disease with frequent medical complications (e.g. HIV,HepC, TB) and a high fatality rate**
- Each detoxification is followed by 80-95% relapse
- Long-term stable abstinence rates range between 10-25%
- Estimated heritability of drug dependence is about 40%
- Personal responsibility similar to other chronic diseases, e.g. diabetes
- Biological substrates identified for drug seeking behavior and relapse
- Pharmacological interventions rather ineffective in cure of drug addiction
- Pharmacological interventions rather effective care for drug addiction
- Treatment compliance similarly problematic as in other chronic diseases

Slide 5

A 33 year follow-up of narcotic addicts

(Hser et al., 2001)



Slide 6

A 33 year follow-up of narcotic addicts

(Hser et al., 2001)

Years of heroin use

- Mean 30.3 yrs (range: 0,8-5.4 yrs)

Years of continuous abstinence

- Median 3.4 yrs (range: 0-36 yrs)

Relapse probability 1985-1996

- Abstinent < 5 yrs 83%
- Abstinent 6-15 yrs 25%
- Abstinent >15 yrs 28%

Slide 7

Drug Addiction
Evidence Based Treatment

Slide 8

Evidence Based Tx Heroin Addiction

(e.g. Kreek et al., 2002; Van den Brink & Van Ree, 2003; NIH, 1997; Vlahov et al, 2001; WHO, 2004)

Treatment Goal	Process	Type of Tx	Evidence
Stable abstinence	Detoxification	Methadone reduction	+/-
		Buprenorphine reduction	+/-
		Naltrexone	+
		Symptomatic Tx	++
	Relapse prevention	Naltrexone p.o.	-
		Naltrexone i.m./implant	?
		CRA	+
		Therapeutic Community	+/-
Stabilization	Substitution	Methadone maintenance	+++
		Buprenorphine maintenance	++
		Heroine maintenance	+
Harm reduction	HIV prevention	Information/SEP/MMT	++
	Hep C prevention	Information/SEP/MMT	++
	TB prevention		?

Slide 9

Evidence Based Tx Heroin Addiction

- Detoxification without relapse prevention is inadequate Tx
- Detoxification with relapse prevention rather ineffective
- Unsupervised Naltrexone Tx associated with overdose cases

- Maintenance Tx relatively effective
- Combination of maintenance Tx with psychosocial support more effective and more cost-effective

- Needle exchange programs quite effective
- Tx HIV, Hepatitis C ……
- Tx of TB ……..

Slide 10

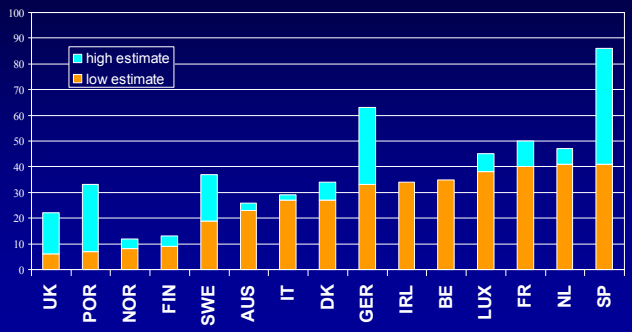
Substitution treatment coverage among problematic drug users in the EU (EMCDDA, 2002)

Table 1

	Substitution treatment among problem drug users		
	Estimated prevalence of problem drug use (*)	Estimated number of clients in substitution treatment	Substitution coverage rate (%) (*)
Belgium	20 200	7 000 (1998)	35 (*)
Denmark	12 752–15 248	4 398 (4 298 methadone and 100 buprenorphine) (1 January 1998) (*)	27–34
Germany	80 000–152 000	50 000 (2001) (*)	33–63
Greece	n.a.	966 (1 January 2000) (*)	
Spain	83 972–127 756	72 236 receiving methadone (1999)	41–86
France	142 000–176 000	71 260 (62 900 receiving buprenorphine and 8 360 receiving methadone) (December 1999) (*)	40–50
Ireland	4 694–14 804	5 032 (31 December 2000) (*)	34–100 (*)
Italy	277 000–303 000	80 459 (1999) (*)	27–29
Luxembourg	1 900–2 220	864 (164 in the official programme and +/- 700 prescribed maphenon (methadone in pill form) by GPs, 2000) (*)	38–45
Netherlands	25 000–29 000	11 676 (1997)	40–47
Norway	9 000–13 000	1 100 (2001)	8–12
Austria	15 984–18 731	4 232 (1 January 2000) (*)	23–26
Portugal	18 450–80 800	6 040 (1 January 2000)	7–33
Finland	1 800–2 700 (*)	240 (170 buprenorphine and 70 methadone)	9–13
Sweden	1 700–3 350 (*)	621 (31 May 2000)) (*)	19–37
United Kingdom	88 900–341 423	19 630	6–22

Slide 11

Substitution treatment coverage in EU countries (EMCDDA, 2002)



Slide 12

Introduction Harm Reduction in CEECs

Figure 3: Time chart: year of introduction of the first methadone substitution programme and syringe exchange programme

First methadone programme		Slovenia		Czech Republic	Poland		Bulgaria Hungary Lithuania	Latvia		Romania Slovakia			Estonia
First syringe exchange programme	Poland			Czech Republic Slovenia		Slovakia	Bulgaria Hungary	Lithuania	Estonia		Latvia Romania		
Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001

Slide 13

Maintenance Tx in Central and Eastern Europe

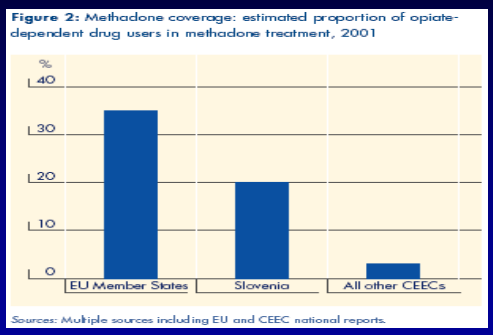
(Okruhlica, 2003; Subata, 2003)

Country	Heroin Addicts N	Agonist Maintenance	Naltrexone
Poland	30.000-40.000	700	Not registered
Czech Republic		360	Not registered
Slovak Republic	4.000-8.000	380	Not registered
Hungary	4.300	150	Registered
Slovenia	5.000-10.000	1.400	Registered
Estonia		0	
Latvia		85	
Lithuania		400	
Belarus		0	
Moldova		22	
Ukraine		200	
Russia	1.800.000	0	

Slide 14

Methadone maintenance in Europe

(EMCDDA, 2003)



CEECs = Central and East European Countries

Slide 15

Trends in Heroin Tx in Europe

- Provision of both substitution treatment and drug-free treatment has increased, but substitution treatment has grown more rapidly than drug-free treatment.
- Large differences between countries
  * Increased substitution: France, Norway, Finland, Spain
  * Increased drug-free: Denmark, Greece
- Lack of treatment facilities especially Portugal, Greece, Central Europe and Eastern Europe

Slide 16

Evidence Based Tx Cocaine Addiction

(e.g. Kreek et al., 2002; Van den Brink & Van Ree, 2003; NIH, 1997)

Treatment Goal	Process	Type of Tx	Evidence
Stable abstinence	Detoxification	Symptomatic Tx	+
	Relapse prevention	Disulfiram	+/-
		Vigabatrine	+/-
		Others	-
		Vaccination	?
		Contingency management	+
		CRA	+
Stabilization	Substitution	Dexamphetamine	+/-
		Methylphenidate	-
		Cocaine	-
Harm reduction	HIV prevention	Information/Needle exchange	++
	Hep C prevention	Information/Needle exchange	++
	TB prevention		?

Slide 17

Conclusions

- Heroin addiction has chronic relapsing course, is not easy to cure but well treatable
- Cocaine addiction might have a less chronic course, is not easy to cure and hardly treatable
- Evidence based treatments not always available, not always accessible, and not always provided according to the standards

Slide 18

The Principle of Equity

Slide 19

Equity or Equivalence

- **Health services (and thus addiction treatment services) in prisons should be broadly equivalent to health services (and this addiction treatment services) in the wider community**
- Services based on assessed need
- Services based on continuity of care, including aftercare
- Services based on evidence regarding effectiveness of drug treatment interventions
- Services directed to prevent the spread of communicable diseases such as HIV, HCV, TB

Slide 20

Drug Addiction
Evidence Based Tx in Prisons

Slide 21

Evidence Based Tx in Prisons

(Pearson and Lipton, 1999; Dolan et al., 2003; Stöver and Nelles, in press)

Intervention	Evidence	Conclusion
Boot camps	PL: 4 low quality studies	Not effective
TC (9-12 months)	PL: 1 good, 3 fair, 3 low quality studies	**Effective (15%)**
Group counseling	PL: 5 fair, 2 low quality studies	Not effective
MMT	PL: 4 fair quality studies Dolan et al.	**Promising** **Effective** drug use, syringe sharing
12 step facilitation	PL: 4 low quality studies	Unknown
Syringe exchange	Stöver and Nelles	**Effective, no risks**

Slide 22

Available Services in EU Prisons

- DIT GA IK NOG VERDER INVULLEN MET 4 PLAATJES:
- MMT, DRUG FREE, SYRINGE EXCHANGE, CONDOMS

Slide 23

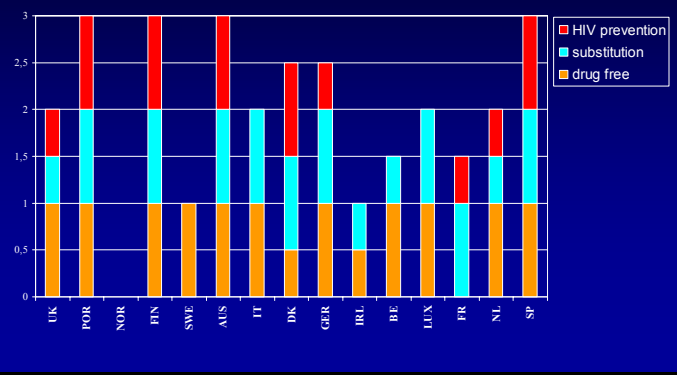
Assistance to drug users in prisons in the EU (EMCDDA, 2002)

Table 2

	Assistance to drug users in prison in the EU		
	Drug-free treatment in prisons	Substitution treatment in prisons	Reduction of drug-related harm in prisons
Belgium	Yes, in experimental phase	Gradual detoxification with methadone	Some local HIV prevention actions
Denmark	Cooperation with private treatment institution	Yes, if on methadone treatment before prison	Cleaning fluid provided, hepatitis B vaccination
Germany	Yes	Yes	Syringes exchanged in some prisons
Greece	Self-help groups	No	Information in some prisons
Spain	Yes	Yes	Yes
Finland	Substance abuse courses, drug-free wards	Yes, if on buprenorphine/methadone before prison	Cleaning fluid provided, hepatitis B vaccination
France	No	Yes (methadone or buprenorphine)	Information to prisoners, chlorine distribution
Ireland	Limited	Detoxification with methadone, maintenance for HIV-positive prisoners	No
Italy	Yes	Yes	No
Luxembourg	Yes	Yes, if on methadone treatment before prison and treatment initiation before release	No
Netherlands	Yes, compulsory treatment for hard core drug users	Limited, reduction programmes for longer-term prisoners	Yes
Austria	Yes	Yes	Yes
Portugal	Yes	Yes	Information, training of guards, condoms and bleach distribution, hepatitis vaccination
Sweden	Yes	No	No
United Kingdom	Yes	Methadone detoxification. Also available: sofexidine, dihydrocodeine and naltrexone	Disinfecting tablets in some prisons, counselling and information

Slide 24

Assistance to drug users in prison in EU countries (EMCDDA, 2002)



Slide 25

Harm Reduction in EU prisons

- Prison based addiction care well developed in UK, Spain, Sweden, Italy and some parts of Germany
- No substitution available in Greece, Sweden and some parts of Germany. Full availability only in Spain
- Most counties have drug-free prison programs except France
- Many countries follow the WHO Guideline on HIV and AIDS in prison: needle exchange only in Spain and some prisons in Germany (and Switzerland, Moldova)

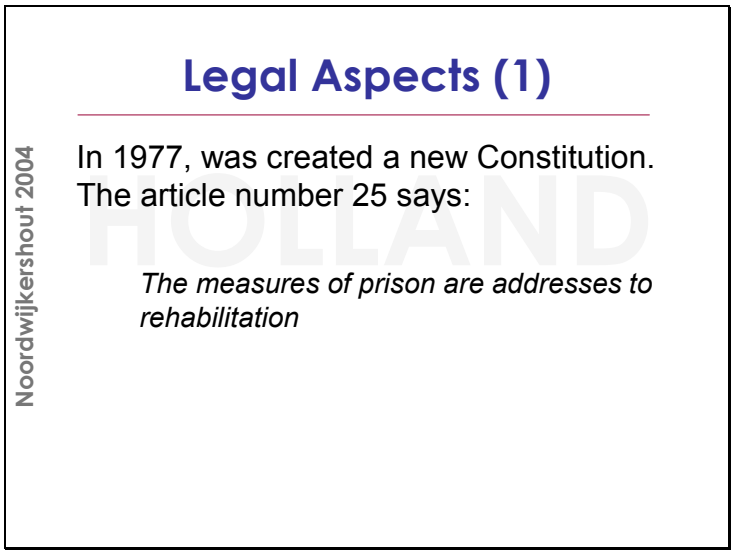
Annex 2

PowerPoint Presentation by Dr Xavier Roca Tutusaus

Slide 1

Slide 2

Slide 3



Slide 4

Legal Aspects (2)

Noordwijkershout 2004

In 1984, the government of Catalunya assumes the management of the prisons.

We have the same penal and penitentiary laws but we have differences in the management and about decisions of inmates, but not in the philosophy and the methodology of needle exchange program

Slide 5

Characteristics of inmates

Noordwijkershout 2004

- We have about 7500 inmates
- About 30 % are foreigners
- About 20 % are pretrial
- About 50% are drug users (23% by parenteral)
- 70,51% of drug users are HIV+ (24% of total)
- Prevalence of Tuberculosis 19/10000
- Prevalence of Hepatitis C 39,77 %
- Inmates with antiretroviral treatments are 11,6 %

Slide 6

Key Ideas of drug treatments

Noordwijkershout 2004

- The Inmates don't have freedom, but they must have the same possibilities of treatment than a person in the community
- The treatment of drug addicts in prisons must to be the most similar than in the community
- The treatment in prison must be continue in the community.
- The treatments are complementary.

Slide 7

Different programs (2002)

Noordwijkershout 2004

Since 1984 we developed differents programs

- Intervention groups (about 1000)
- Maintenance in Methadone (1073 inmates in 31 of December of 2002)
- Therapeutic Communities In and out Prisons (212 inmates)
- We derived inmates to Ambulatory Centers (from in prison to prepare the progression to open prison) (416 inmates)

Slide 8

Indirect Interventions

Noordwijkershout 2004

- Another intervention (health education, prevention of sexual diseases, Hepatitis, HIV, etc)
- We give bleach with a sticker with information about how disinfected the needles
- We give condoms in the intimate visits
- And more….

Slide 9

Basics of Needle Exchange

Noordwijkershout 2004

- This program is one more: not the only
- The most important isn't the needle: is the relationship between inmate and professional
- The needle is the leit-motiv and give the possibility to know, inform, suggest or facilitate the contact with a different intervention (health education,…)

Slide 10

Methodology (1)

Noordwijkershout 2004

- **The health team give one needle to any inmate who demands one**
- **Only the health team knows the name of inmates who have a needle**
- **An inmate could stay in a intervention program or methadone and in the needle exchange program**
- **The health visit is one in the morning and one in the afternoon. The weekend also is guaranteed.**
- **No needle exchange in psychiatric units or high security departments**

Slide 11

Methodology (2)

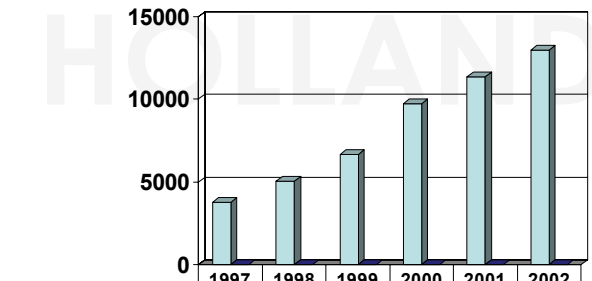
Noordwijkershout 2004

- The inmate only can have one
- The change is one to one
- The syringe is special: is retractile
- Any another needle or syringe is prohibit
- The bad use of needle or syringe of program could suppose the eject of the inmate of program

Slide 12

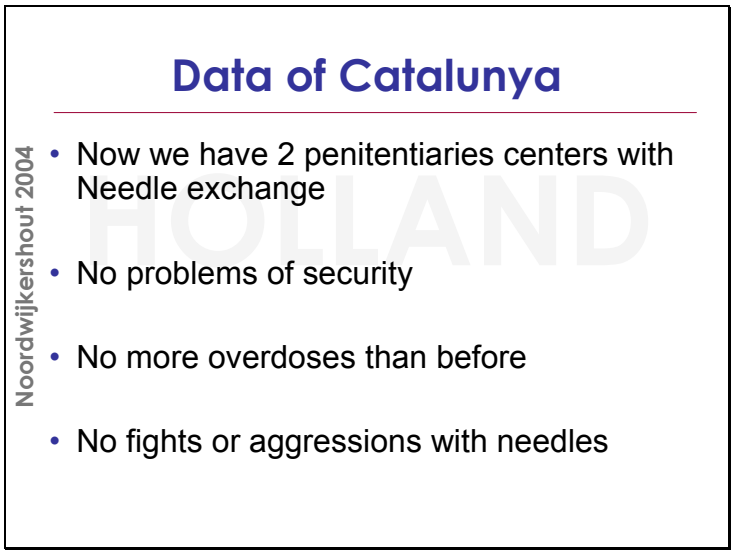
Data of Spain

Noordwijkershout 2004

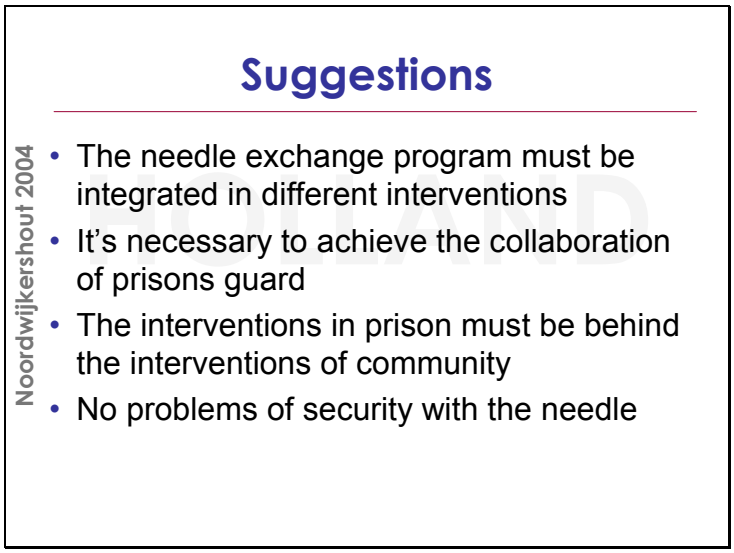


	1997	1998	1999	2000	2001	2002
Nº needles	3750	5018	6640	9752	11339	12970
Number of Centers	1	2	5	9	11	27

Slide 13



Slide 14

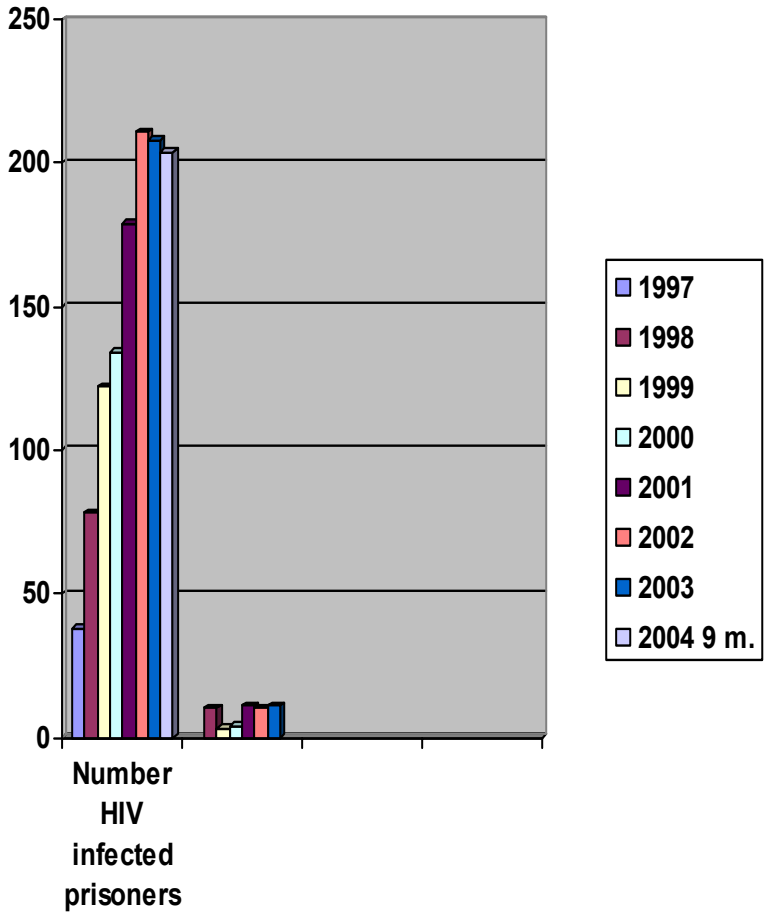


Slide 15

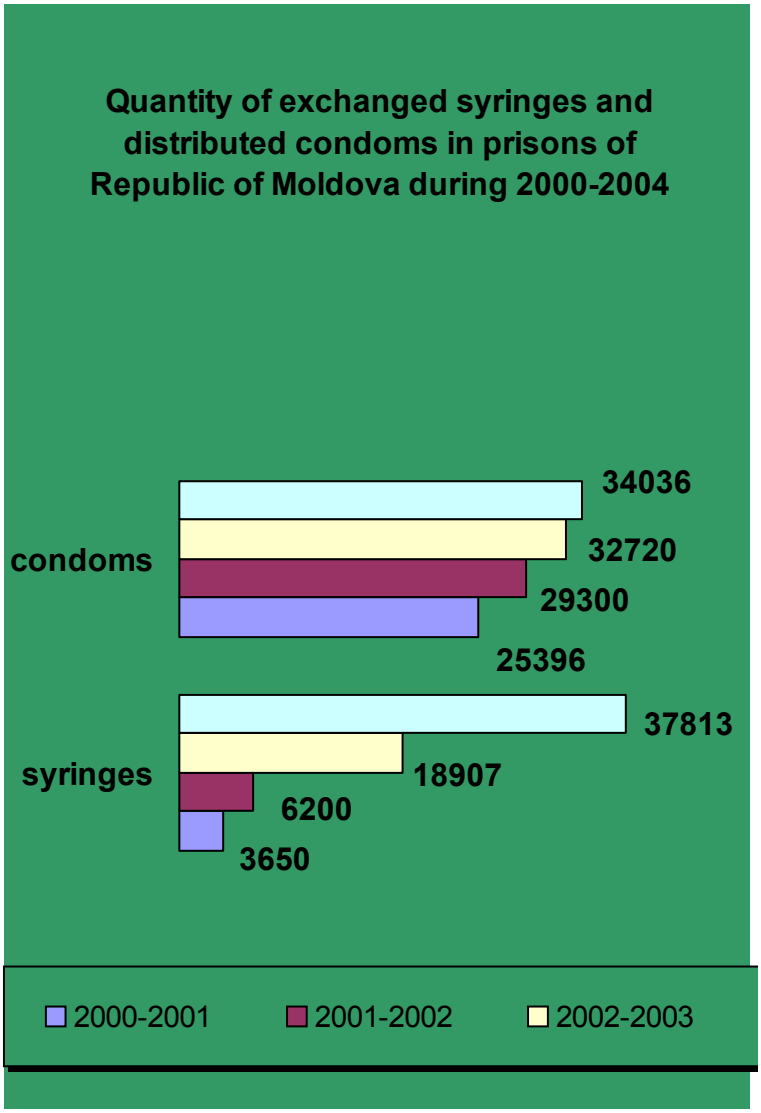
Annex 3

PowerPoint Presentation by Dr Larisa Pintilei

Slide 1



Slide 2

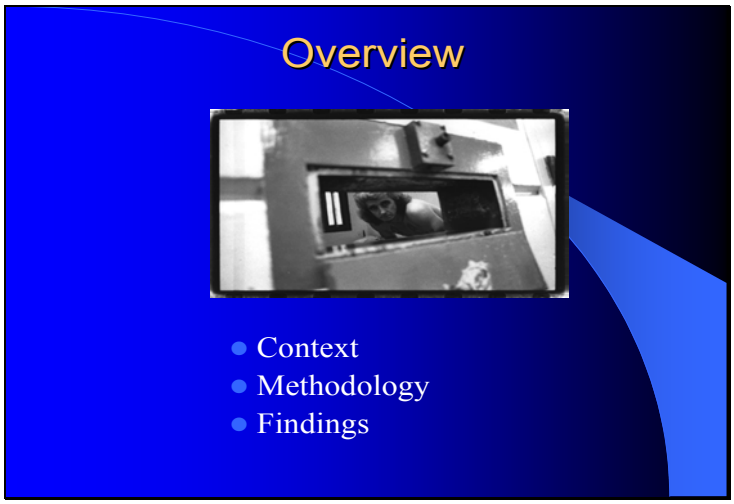

Quantity of exchanged syringes and distributed condoms in prisons of Republic of Moldova during 2000-2004
condoms
34036
32720
29300
25396
syringes
37813
18907
6200
3650
2000-2001
2001-2002
2002-2003

Annex 4

PowerPoint Presentation by Dr Heino Stöver, and Ms Laetitia Hennebel

Slide 1

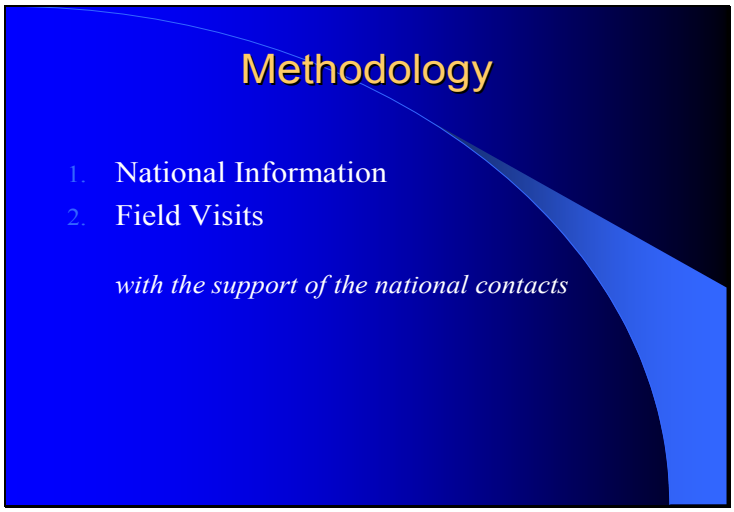
Slide 2



Slide 3

Slide 4

Slide 5



Slide 6

Slide 7

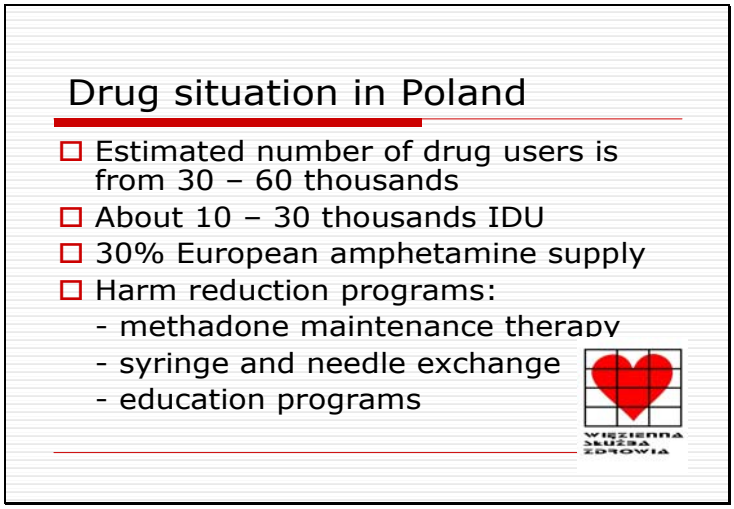

Field visits
- 17 countries
- 33 prisons (approx. 2 in each country)
- A total of 33 focus groups with prisoners
- A total of 184 prisoners (132 men, 52 women)
- Prison staff: medical team, psycho-social team, head of guards, governor…
- Key individuals at:
– Prison Service Headquarters
– Ministry of Justice
– Ministry of Health
– Other ministry
– National institution
– NGOs
– Individual experts

Annex 5

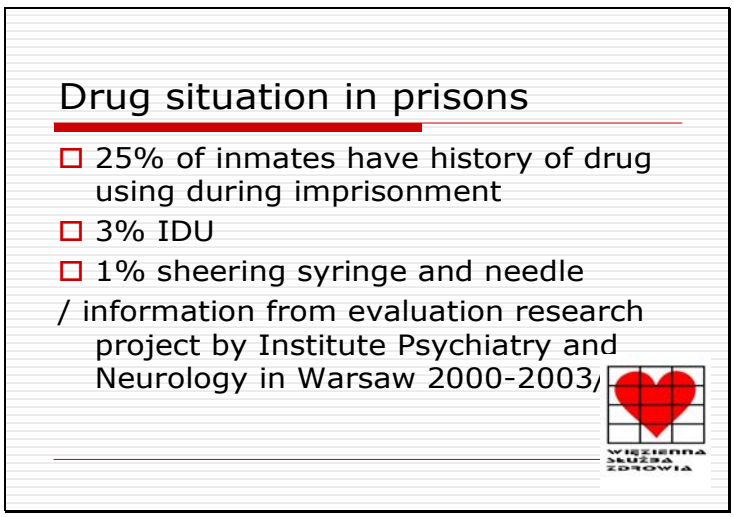
PowerPoint Presentation by Dr Marzena Ksel

Slide 1

Slide 2



Slide 3



Slide 4

Substitution therapy in Poland

- Law regulations - MMTP of high level criteria
- 10 programs in 8 polish regions
- Finance by National Health Service
- In present - 700 drug users on MMT
- The needs? 5000 – 10000!

Slide 5

Substitution therapy in polish prisons

- First MMTP started in 2003 at Remand Prison in Cracow
- In January 2004 second MMTP in four of penitentiary institution in Warsaw was registered
- At present moment Remand Prison in Lublin is waiting for registration to start MMTP

Slide 6

History of MMTP at Kracow RP

- The preparation took a lot of activities in 2001(finding the right place, to motivate staff including medical personnel and others)
- 2002 – preparation of MMTP and proceeding with registration
- 4th of January 2003 first patient for MMT was qualified

Slide 7

MMTP – how it works?

- Team MMTP at Cracow RP : doctor in charge of internal word, psychiatrist, psychologist, nurses
- In close cooperation with consultant from MMTP at university clinic

Slide 8

MMTP – how it works?

- Criteria for MMTP according to law:

- over 18 years
- at least 3 years of using opiates
- justified trials for abstinent therapy programs
- psychological and psychiatric evaluation
- patient agreement
- known living place, identity card and insurance ?
- length of time in prison?
- future court activities ?
- place for continuation of MMT after imprisonment is founded !

Slide 9

MMTP – how it works?

January 2003 – August 2004 – 18 prisoners
8 women and 10 men, (38 was diagnosed)

- Detoxification – 6 people
- Maintenance therapy – 12 people
- For 7 inmates MMT started in prison
- For 11 MMT was continuation

Slide 10

„Positive" sides of MMT

- MMTP gives possibility for continuation of therapy started before imprisonment
- MMTP gives possibility of „normal" life during imprisonment
- MMTP in prison decrease expansion of „narco-business" at penitentiary institutions
- MMTP decries possibility of HCV, HBV, HIV

Slide 11

Difficulties of MMT in prison

- Problems concerning qualifications
- No possibilities of changing the penitentiary institution
- To find the place for continuation of MMT after imprisonment

Slide 12

Future of substitution therapy in Polish prisons

Future of substitution therapy in polish prisons =

Future of substitution therapy in civil society

Slide 13


Thank You
for Your attention
Marzena Ksel
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