



Report

Reduction of Drug-related Crime in Prison The impact of opioid substitution treatment on the manageability of opioid dependent prisoners

BISDRO, University of Bremen

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Abbreviations

AIDS	Acquired immune deficiency syndrome
BISDRO	Bremen Institute for Drug Research, University of Bremen
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
EU	European Union
GP	General practitioner
HIV	Human immunodeficiency virus
IDU	Intravenous Drug User
MMT	Methadone maintenance treatment
OST	Opioid substitution treatment
PDU	Problem Drug Use
PMMT	Prison-based methadone maintenance treatment
RCT	Randomized controlled trial
Reitox	European Information Network on Drugs and Addiction
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
US / USA	United States of America
WHO	World Health Organization
WIAD	Scientific Institute of the German Medical Association

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1. Introduction

At any given day, more than 600.000 people are held in prisons in 27 EU Member States. Taken into account the estimated annual turnover rate, between 860.000 and one million prisoners pass through the system every year. Between 10% and 30% of sentenced prisoners are incarcerated for violation of drug laws. Based on these data at least 86,000 to a quarter million drug users or drug experienced people are incarcerated every year in the 27 EU-Member States.

Thus the management of opioid dependent inmates poses a major problem to health care and security services in prisons. Drug trafficking, drug use and drug use related offences inside prisons as well as violence concerning trading and purchasing of drugs are challenges for prison governors and the daily work of security staff. Opioid substitution treatment (OST) is an established treatment measure in the community and is effective in reducing opiate use, reducing HIV risk behaviour and criminal activity. The term "opioid substitution treatment" (OST) refers to the medically supervised treatment of individuals with opioid dependence, based on the prescription of opioid agonists (Thomas 2001). These can include methadone, buprenorphine, codeine, morphine, and diamorphine. The treatment options include the management of withdrawal on admission as a gradual detoxification (preceding abstinence-oriented treatment) or the long-term substitution maintenance.

The implementation of OST in prison settings is still not meeting the same standards as in the community and is far from being adequate. Recent studies indicate that opioid substitution treatment initiated in the community is most likely to be discontinued in prisons. This often leads to relapses both inside prisons and immediately after release, often with severe consequences as high mortality rates after release from prisons indicate. Other studies show the benefits of OST for the health and social stabilisation of the patients/inmates. This report gives an overview of the project 'Reduction of Drug-related Crime in Prison' funded by DG JLS (JLS/2005/AGIS/130) that was conducted by WIAD and BISDRO. The main aim of the study was to investigate the effects of opioid substitution treatment on the management of opioid drug using inmates in 7 European countries (Austria, England, Germany, Italy, Portugal, Slovenia and Spain). The present project is a follow-up study of the STEP-study (Substitution Treatment in European Prisons) (Stöver et al. 2004) which had the objective to examine practices and policies in place for the provision of OST in prisons in 18 European countries. While Stöver et al. were interested in how substitution treatment was applied, the aim of this study is to investigate the effects of OST on the prison and the manageability of the opioid dependent prisoners. Therefore, its focus does not primarily lie on a health related topic but on crime prevention.

The project was conducted over 24 months by research institutions in Austria, England, Germany, Italy, Portugal, Slovenia and Spain. The study investigates prison staff's and inmates' experiences with the effects of the introduction of opioid substitution treatment in the prison setting. Data collection was done with two standardised questionnaires in the respective native language: one for inmates under OST and one for prison staff. Additionally, an extensive litera-

ture review was carried out and data from qualitative interviews with key experts were part of the analyses.

Chapter two gives a brief overview of the methods and objectives of the study. In chapter three the results of the literature review on substitution treatment in European prisons are outlined whereas in chapter four the results of expert interviews conducted in the seven above mentioned countries inform about country-specific particularities in opioid substitution treatment.

In chapter five, the results of the quantitative study on the evaluation of the impact of opioid substitution treatment on the management of opioid dependent inmates in seven European countries are summarised. This includes a short overview of the used methods, i.e. the sampling, the process of the field work, the instruments used for data collection and the results of the analysis of the data on the institutional background of the prison, prison staff and prisoners.

Examples of good practice of the implementation of opioid substitution treatment in prison are outlined in chapter 6 and the main results are summarized and recommendations are presented for an improved practice in European prisons regarding opioid substitution treatment. Finally, models of good practice are described, which are based on the research carried out and the evaluation of an expert rating.

2. Methodology

2.1 Aims and objectives of the project

The key aim of the present study was to investigate the effects of drug substitution treatment in prison on the manageability and control of opioid drug using inmates in seven European countries (Austria, England, Germany, Italy, Portugal, Slovenia and Spain) with the following objectives:

- To carry out an extensive literature review on opioid substitution treatment in Europe
- To analyse policy and practices of opioid substitution treatment in prison for each participating country
- To look at the experiences of prison staff and prisoners after introducing opioid substitution treatment in terms of improved manageability of opioid dependent inmates (e.g. reduction of drug-related crime such as drug trafficking in prison, drug use/ trade-related violence, coping with withdrawal symptoms etc.)
- To identify gaps in service provision
- To identify models of good practice

2.2 Methods

A multi-method strategy was applied in order to obtain valuable information and data on the process of the introduction of OST and its effects on the institution, on staff and prisoners. Only an approach of triangulation is guaranteeing that all levels and different views from several perspectives are covered and contribute to a comprehensive overview of this treatment intervention in custodial settings. In the following, a short overview of the different methods used during the project will be outlined, whereas a detailed overview of the respective methodologies can be found at the beginning of each subchapter.

As a first step of the study, a systematic review of international literature on evidence of effectiveness of OST in prisons has been carried out, identifying studies through manual and computerised searches of relevant clinical and sociological databases. To isolate the research question in advance of the systematic review, the focus was settled on existing literature and data from well-known and established institutes. The literature was mostly in English and German, studies in French and Spanish were included as well.

In a next step, telephone interviews with experts from the seven countries were conducted. For each of the seven countries, the context of opioid substitution treatment in prisons is described based on data and procedures regarding the situation of substitution treatment in general in the

community and in prison. These data were linked with information from the expert interviews (a standardised questionnaire was sent to well known experts from the involved EU Member States) in order to further inform about particularities of the introduction of OST and experiences with this treatment in the respective participating country.

The core element of the study was a survey on the reduction of drug related crime in prison that was carried out in each of the participating countries. Questionnaires on the institutional background as well as questionnaires for prisoners and prison staff were distributed in different penal institutions that offer substitution treatment. Questionnaires for staff and inmates inter alia contained questions on socio-demography and the assessment of changes in drug-related issues and violence. The data was collected centrally at WIAD and analysed after adjustments of the dataset and tests for plausibility,

Finally, expert interviews on good practice have been conducted. Interviews were processed according to the methodological principles of qualitative interpretation and models of good practice of OST in prison have been identified.

3. Literature review on opioid substitution treatment in European prisons

The objective of this literature review is to look at current research on the implementation of opioid substitution treatment in prison in the European member states and its impact on drug related crime prevention in prison. Furthermore some statistical data on the prevalence of opioid substitution treatment in European prisons are provided.

3.1 Methodology

For the overview on statistical data and policy information, the Reitox National Reports were searched for information as well as the EMCDDA standard tables on drug-related treatment availability (2006) and the WHO Health in Prison database (WHO 2007).

An extensive review of international literature on evidence of the effectiveness of opioid substitution treatment in prisons was carried out in order to set the foundation for an evidence-based approach. Published studies concerning opioid substitution treatment in prisons were identified through manual and computerised searches of relevant databases. To isolate the research question in advance of the systematic review, the focus was settled on existing literature and data from well-known and established institutes.

This review has some limitations: Not all papers could be obtained, and only publications in English and German were included systematically, furthermore some in French and Spanish; other languages were not included.

Regarding the search in detail, the following workflows were made:

Manual and electronic search for the existing data

- in databases, publications, expertises, monographs, standards and guidelines of the EMCDDA
- in the national reports of the national focal points of the REITOX-Network
- in activities and information of the WHO Europe, Pompidou-Group and other international bodies working in the field (e.g. UNAIDS, UNODC).

The database search was conducted using a systematic search strategy (see below) for published literature and primary research studies in specific and general electronic databases (Cochrane, Dare, Medline, Psycinfo). Additionally reference lists of publications in relevant scientific journals as well as in the retrieved publications have been hand searched.

The following search strategy was applied:

(substitution* or methadone or subutex or buprenorphine or heroin* or codeine* or heroin-assisted maintenance or substitution treatment) AND (prison* or detainee* or correctional facilit* or correctional institution* or remand* or carceral* or jail* or inmate* or convict* or gaol* or penitent* or custod*). The search was limited to the time period 1995-30.11.2007.

A compilation of electronic reference lists using EndNote was undertaken, and the retrieved literature was analysed and possible lacks of information were identified.

3.2 Prevalence of opioid substitution treatment in European prisons

The provision of opioid substitution treatment in prison is not widespread in European member states. In countries that provide methadone in prisons, it is most commonly used for short-term detoxification and less frequently as a maintenance treatment. In some countries, such as Austria and Spain¹, OST is provided as standard therapy to all prisoners who began treatment in the community and are likely to continue it after release (Stöver et al. 2004). In others, including Greece and Sweden, it is not available in prisons at all. A recent study on practice and policies of in-prison opioid substitution treatment in 18 European countries (Stöver et al. 2006) concludes that there are heterogeneous and inconsistent regulations and treatment modalities throughout Europe. Even though the coverage of OST has extended considerably across Europe, a treatment gap remains between prisoners requiring substitution maintenance treatment and those receiving it. OST is very likely to be discontinued in prison, treatment provision is often not sufficient (Stöver et al. 2006). Most countries use methadone for opioid substitution treatment, in the community as well as in prison but for example in France buprenorphine is by far the most common substance used for substitution inside and outside prison (Michel 2005). Several studies on the effects of the divergent practices of substitute prescribing in penal institutions reflect the development of OST in prisons (Stöver et al. 2004):

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

The following table gives an overview of the prevalence of prison-based OST in the EU member states. Information was gathered from the Reitox National Focal Point Reports to the EMCDDA by the respective countries, the EMCDDA Standard tables on drug-related treatment availability (filled in questionnaires), and the Health in Prison database by the WHO. The newest available

¹ In Spain, it is provided to all prisoners who ask for it: all prisoners who began treatment in the community and are likely to continue it after release, and also prisoners who want to begin the treatment once they are in prison (note by Christina Visiers, expert for Spain).

data is provided, which is usually from 2006. If data is older, this is indicated. As data comes from different sources, it does not always match, and direct comparisons are difficult.

Table 1: Prevalence of prison based OST in the EU member states 2006

Country	Prison population	Prevalence of PDUs in prisoners	Number of prisoners in ST	Substitution coverage rate in prison
Austria	8.991	2247-4495 (25-50%)	772 (07.122007)	17-34%
Belgium	9.597	13.3% heroin user, 2.5% of these IUDU	300 (2005)	7%
Bulgaria	11.436	1728 (15.6%) (2005)	69 (2005)	
Cyprus	662		no OST	
Czech Republic	19.145	38,5%	40 (pilot project)	
Denmark	3.626	547 (2004)	300	55%
Estonia	4.463		no OST	
Finland	3.595	2975 (2004)	40 (2005)	1%
France	52.009	18276 (2004)	6.6% (2004)	14%
Germany	75.719 (31.3.07)	Approx. 25000 (2007)	500 (lim.)	2%
Greece	10.113	20%	no OST	
Hungary	15.720		1 (2005)	
Ireland	3.080	1080 (2004) (34%)	1295 (2005)	46%
Italy	39.348	15442 (2004)	1,860 (31.12.2003)	12%
Latvia	6.676	10%	no OST	
Lithuania	7.983		No OST	
Luxembourg	744	191 (2004) (28%)	191 (2005)	100%
Malta	352		ST possible in prison	
Netherlands	21.013	5358-8119 (2004)	In some cases methadone is offered in prisons	
Poland	89.805	2662	7 (2003)	0,3%
Portugal	12.803	3515-5900 (2004) 11%	734 (2007)	9-21%
Romania	32.292		Pilot ST in prison is planned for 2007	
Slovakia	8.380		no OST	
Slovenia	1.301	948 (2007)	509 (2007)	54%
Spain	66.129	26,387 (2004)	19.010; 15,32% of prisoners (2005)	82%
Sweden	7.175	4053 (2004)	No OST	
United Kingdom: England & Wales	80.229	Approx. 26,000	9,242 (9 months 2007/08 12,323 (for the whole year)	47%
UK: North. Ireland	1.462			
UK: Scotland	7.261	5238 (2004) 3% (2005)	700	13,4%

Please note, that these numbers are both data of documentation and estimations reported in different publications and institutions. Blank cells indicate that no information was found. Also PDU is not defined in each country on the basis of EMCDDA definition: 'Problem drug use' is defined for EMCDDA purposes as 'injecting drug use or long duration or regular use of opiates, cocaine and/or amphetamines'². (Sources: Stöver et al. 2004; EMCDDA 2006; International Centre for Prison Studies 2007; WHO 2007)

3.3 Evaluation of the impact of opioid substitution treatment on the manageability of opioid dependent inmates

² <http://stats04.emcdda.europa.eu/html.cfm/index5223EN.html>

There exists ample research on the effectiveness of OST in the community. Opioid Substitution treatment is effective in reducing or cease opiate use (e.g. Strain et al. 1999; Sees et al. 2000; Connock et al. 2007), reducing HIV risk behaviour like needle use and needle sharing, hence reducing HIV and viral hepatitis transmission rates (e.g. Hartel and Schoenbaum 1998; Sorensen and Copeland 2000), and also in decreasing criminal activity (e.g. Lind et al. 2004; Sheerin et al. 2004; Gossop et al. 2005).

The implementation of opioid substitution treatment for opioid dependent persons is often far from adequate in prison settings. Here the availability, the implementation, clinical management, and the evaluation of OST is often deficient (Stöver et al. 2004). The practice and policy of OST differs not only from country to country, but also within a country from state to state, and even from prison to prison (Michel and Maguet 2003; Michels et al. 2007; Stöver 2007). Notably, the disruption of treatment when entering the institution often leads to physical and psychological problems and increases the risk of intravenous drug use and sharing of injection equipment (Stöver et al. 2004). The drug user's views and experiences of substitute prescription were investigated in a British qualitative study. The participants reported substantial inconsistencies and heterogeneities concerning the prescription of substitution medication. None of the participants had experienced maintenance treatment, only detoxification was available and this was often perceived as too short and as not meeting the self-defined treatment needs. In particular, short courses of methadone detoxifications were frequently experienced as insufficient and inadequate. Most striking was the inconsistency in the implementation of OST inside prison compared to the community (Hughes 2000).

Although substitution therapy has been widely recognized as an effective treatment for opioid dependence in the community (Farrell et al. 2001; WHO 2004) having crime reducing effects (Lind et al. 2004) and although methadone and buprenorphine have just been added to WHO's Model List of Essential Medicines (WHO 2005a), it remains highly controversial for prisons, particularly in Eastern Europe, where OST is sometimes still prohibited in the community (Trimbos Instituut 2006), and where standards of OST as regards access and continuity are still missing. Despite this controversy, experience has clearly shown the benefits of this treatment in prisons (Heimer et al. 2005; WHO et al. 2007). The WHO states:

"The advantages of using substitution therapy are very great. These include reducing suicide and self-harm during withdrawal, improving regimen management problems during withdrawal and reducing the risk of fatal overdose following release from prison. The high-level endorsement by international organizations and the growing appreciation that this does work, and cost-effectively, indicates that the priority in the immediate future is to develop the clinical and other standards urgently required" (WHO 2005b, p. 15).

It has taken years to acknowledge that the benefits of OST in the community might also apply to the prison setting. This can be traced back to the prison ethos of coercion, which usually manifests itself in a strict abstinence-based approach to drug use. Therefore, while opioid-dependent individuals in the community may be treated as patients and receive OST, in prison they con-

tinue to be treated as prisoners who are supposed to remain drug free. This double standard leads to frequent interruptions in treatment and inconsistency in dosages.

However, the research situation on the effectiveness of OST in penitentiary institutions is rather incomplete and limited (Stallwitz and Stöver 2007), and especially very few high-ranking studies have been conducted. Most research on the topic has been carried out in the US and also in Australia with relatively few studies from EU member states.

3.3.1 Reduction of drug use and other health outcomes

Two randomized controlled trials (RCTs) on prison-based substitution treatment were identified: one from Australia (Dolan et al. 2003) and one from the USA (Kinlock et al. 2007). Dolan et al. (2003) investigated the long-term impact of OST in a group of 382 male imprisoned heroin users, of which 191 were in opioid substitution treatment and 191 in a control group. The results show that retention in OST is associated with reduced hepatitis C infection, re-incarceration rates and mortality. The re-incarceration risk was lowest during OST episodes of eight months or longer. OST periods of two months or less were associated with the greatest risk of re-incarceration. An increased risk of hepatitis C seroconversion was significantly associated with prison sentences of less than two months and OST episodes less than five months.

Kinlock et al. (2007) investigated the short-term outcomes of OST for the period of one month after release. 211 heroin using pre-release inmates were enrolled in the study and randomly allocated to three groups: (1) Counselling only, (2) counselling with referral to OST upon release, and (3) counselling plus methadone treatment. Significant differences were found for treatment entry in the community, with 7.8% in group one, 50% in group two and 68.6% in group three. Positive urine test results for opioids were found in 62% of group one, 41% of group two and only 27.6% of group three. Also positive urine test results for cocaine as well as self-reported heroin and cocaine use were lowest in group three, but not on a significant level. It can be concluded from this study, that OST is associated with greater treatment entry in the community, which again is related to reduced heroin use and criminal activity.

The use of heroin and other illicit drugs declines during prison-based OST. A Swiss study found only 7% positive urine samples for heroin in prison-based methadone maintenance treatment (PMMT) patients (Herzog et al. 1993), another study found 90% of PMMT patients clear of non-prescribed drugs (Gorta 1992). Evidence shows that OST can reduce injecting risk behaviour in penal institutions such as reduced frequency of illicit drug use in prison and reduced involvement in the prison drug trade (Dolan et al. 1998). The frequency of injecting was reduced in prisoners enrolled in OST for the entire duration of imprisonment (Lenton 2003). Dolan, Wodak, and Hall (Dolan et al. 1998) investigated whether PMMT reduces injecting risk behaviour and the transmission of blood-borne viral infections among prison inmates (cf. Dolan et al., 1996). Retrospective structured interviews were carried out in 1993 with 185 currently injecting drug users, imprisoned in New South Wales, Australia, within the last 2 years and recently released. Respondents, recruited at drug treatment services, were allocated to three largely matched

groups: 105 to group I (drug and alcohol counselling), 32 to group II (dosage and duration restricted prescription of methadone) and 48 to group III (prescription of methadone doses of 60 mg or more for whole duration of imprisonment). Members of group III were significantly least likely to report injecting heroin, sharing syringes and scored lowest on the HIV risk-taking scale while imprisoned. Although non-significantly, they were also least likely to have injected any drug in prison.

To contrast the prevalence of drug use and injection risk among incarcerated and community OST patients, Darke, Kaye, and Finlay-Jones (1998) conducted prospective structured interviews with 100 PMMT and 183 community OST patients in New South Wales. As opposed to Dolan et al. (1998) prospective reports and a control group were used. The aim was to compare the impact of the prison to the community setting. Participants, prison-based opioid substitution treatment and community-based opioid substitution treatment clients for at least 6 months, were recruited in two urban and three rural prisons as well as in community drugs services. Drug use and injection behaviours of the past 6 months were examined. Community participants were significantly more likely than their prison counterparts to have injected a drug (84% vs. 44%), to have used heroin (72% vs. 38%) and to have done so more often (20 days vs. 4,5 days median). However, incarcerated patients were on the other hand significantly more likely to have engaged in highly risky injecting behaviour, for example, to have borrowed (32% vs. 15%) or lent (35% vs. 21%) injecting equipment. The group difference in patterns of drug use was explained in terms of the considerably easier access of community drug users to both, drugs and sterile injecting equipment. According to the authors, OST can neither in the community nor in prison be expected to fully solve the problem of drug use and injecting risk behaviours but definitely to alleviate both. Considering the significantly greater incidence of injecting risk behaviours within the prison group, a combination of harm reduction measures, such as PMMT and syringe exchange, might be recommendable (Darke et al. 1998).

Research has demonstrated that OST provision in a prison healthcare setting was effective in reducing heroin use, drug injection and syringe sharing among incarcerated heroin users (Dolan et al. 2002). There is evidence that continued OST in prison has a beneficial impact on transferring prisoners into drug treatment after release. The initiation of OST in prisons also contributes to a significant reduction in serious drug charges and in behaviour related to activities in the drug subculture. In addition, OST can increase the uptake of antiretroviral and other therapies (WHO et al. 2007), and does reduce the mortality (Dolan et al. 2005), which is especially important on release (WHO et al. 2007).

There was also an impact of prison-based OST found on post-release drug use (WHO et al. 2007). Numerous studies report fatal deaths resulting from drug overdoses after release from prison (e.g. Harding-Pink 1990; Joukamaa 1998; Shewan et al. 2001; Bird and Hutchinson 2003; Singleton et al. 2003). The risk of methadone overdose for released prisoners seems to be higher as well (Cooper et al. 1999), and a continuous OST can reduce these risks. These findings on the high mortality rates do emphasize the need for a continuous OST and throughcare programmes for prisoners.

3.3.2 *The different medications for OST*

Most studies focus on methadone for substitution, only few studies exist on other substances like buprenorphine, slow-release morphine or heroin, although the results of these treatment forms were positive as well (Stallwitz and Stöver 2007).

A sufficiently high dosage of methadone seems to be important for an increase in the retention rate of the substitution programme. A sufficient dosage reported for prisons seems to be at least 60 mg methadone (Dolan et al. 1998; WHO et al. 2007), which was also reported for community-based methadone substitution treatment (Ward et al. 1998; Kreek 2000). High dosages of methadone are most effective in terms of treatment retention and reduction of illicit drug use, as well as health and social stabilisation, although already lower doses of methadone might show some positive effects (Stallwitz and Stöver 2007).

Direct comparisons of different medications in the prison setting are scarce. One example is a randomised double blind controlled trial comparing effectiveness and suitability of methadone with lofexidine in prison-based opiate detoxification (Howells et al. 2002). Disadvantages of methadone detoxifications can be overdoses, which have occurred a few times in prison settings (Cairns et al. 1996; Dyer 1999) also dissatisfaction with the treatment was reported for some prisoners (e.g. Dolan and Wodak 1996; Hughes 2000). According to the authors, lofexidine - an alpha₂-adrenergic agonist, as opposed to methadone that is an opiate derivative - is less dangerous and causes fewer side effects (Washton et al. 1983; Cairns et al. 1996). The relative efficacy, side effect profiles and participant acceptability were investigated. 68 recently admitted inmates of a southern English prison for male remand and short-term prisoners³ were randomised to receive either methadone (36 participants) or lofexidine (32 participants) for 10 days. The two groups were matched regarding recent typical daily drug use. No significant group differences were measured regarding withdrawal severity in the beginning and over the course of the trial. Not causing a significant difference, 87.5% versus 70% completed the methadone and the lofexidine detoxification, respectively, and more lofexidine (12.7%) than methadone patients (8%) showed a side effect of low blood pressure. While lofexidine might constitute a suitable alternative detoxification medication to methadone the subjective preferences and perceived needs of dependent opiate users also need to be taken into account (Hughes 2000; Howells et al. 2002). The authors recommend future research into the optimal treatment duration of both medications in terms of highest retention rates. In general, further research comparing the advantages and disadvantages of different substitution drugs appears recommendable.

In 1995, prisoners in Oberschöngrün prison in Switzerland were enrolled in a heroin maintenance trial that coincided with a community trial (Kaufmann et al. 1997). The prescription of heroin in prison was found to be feasible and does take place in two Swiss prisons. Although there have been heroin trials outside prison settings in other countries (Netherlands, Germany, Spain (Andalusia and Catalonia), Canada and the United Kingdom), which all showed that her-

³ DSM-IV diagnosed for opiate dependence and induced withdrawal

oin maintenance is a safe and feasible maintenance therapy for severe opiate addicts, no other heroin-assisted treatment was integrated into a prison setting.

3.3.3 Impact on drug-related crime prevention in prison

Numerous studies point out the positive effects of prison-based OST on crime rates and re-incarceration rates (Stallwitz and Stöver 2007), and also on the prison safety situation (WHO et al. 2007). An evaluative study of the methadone programme of the Correctional Service of Canada (2001) concluded that participation in methadone programmes had positive post-release outcomes. The study found that opiate users accessing OST during their incarceration were less likely to be readmitted to prison following their release – and were less likely to have committed new offences – than were those not accessing methadone. The study further concluded that:

An important implication of these findings is that CSC may spend less money on these offenders in the long term. The cost of the institutional MMT program may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving MMT. In addition, health related costs such as treatment for HIV or Hepatitis C infection would be affected by MMT availability in prisons (Correctional Service of Canada 2001).

In a French study, 420 dossiers of opiate addicts from 9 French prisons were included. Findings suggest that OST both with methadone and buprenorphine reduces re-incarceration rates after 3.5 years (Levasseur et al. 2003). An Australian study analysed court and imprisonment data in connection with OST data and found reduced crime rates (officially recorded offending rates) for participants in OST for a number of different offences, e.g. robbery, motor vehicle thefts, breaking and entering (Lind et al. 2005). A qualitative study found positive effects of OST on a stable lifestyle, improved family relations and reductions in debts and risky lifestyles (Taylor et al. 2006). Although the majority of research supports a correlation between prison-based OST and decreased re-incarceration rates, one early study found no difference between prisoners receiving methadone and those not receiving it (Hume and Gorta 1989).

With the purpose of evaluating the efficacy of PMMT and ultimately to inform drugs policy makers, Johnson et al. (2001) compared offenders, who participated in a PMMT program with a group of incarcerated heroin users not in PMMT in Canadian prisons. The authors analysed the effects of PMMT on release outcome, i.e. the readmission rate, and on institutional behaviour, especially regarding drug offences. Lists of offenders receiving PMMT in different Canadian prisons were obtained from the responsible health care representatives. The only inclusion criterion for participants was being a known heroin user, which was measured by urine analysis and a questionnaire interview at admission to prison. The experimental group comprised 303 inmates, who had received PMMT between 1996 and 1999. The 215 control participants were largely matched in the key demographic characteristics. To improve the opportunity of a follow-up study, only prisoners prior to release were included. Release outcome measures were (i)

time spent in the community before re-admission to jail and (ii) institutional misconduct before and after MMT initiation at a rate per months for the experimental group and before and after the positive urine analysis for the control group, also at a rate per month.

Compared to the non-PMMT group offenders participating in PMMT had significantly lower readmission rates, were readmitted at a significantly slower rate and showed a decrease of charges, while non-PMMT participants showed an increase. Within a 12-month period, the non-PMMT group was 28% more likely than the PMMT group to be returned to custody. In terms of institutional behaviour, the PMMT group had a significantly reduced rate of serious drug related institutional charges following initiation of PMMT. This likely indicates a decrease in drug seeking and drug taking behaviour among PMMT offenders in comparison to non-PMMT offenders after PMMT initiation. This study demonstrates that participation in an institutional MMT program can have a beneficial effect on outcome after release. The analysis of the results revealed a significant reduction in 'serious drugs charges' when comparing 'before and after MMT initiation'. Moreover, MMT participants were found to be readmitted at a lower rate and more gradually than the controls. However, this difference was not statistically significant. Consequently, additional research addressing issues such as continuation of treatment in the community and further community safety benefits appears recommendable.

Bellin et al. (1999) identified 1,423 inmates receiving high dose (a median of 70 mg) and 1,371 inmates receiving low dose methadone treatment (median of 30 mg) between 1996 and 1997 in New York's correctional system. In order to assess the impact of dosage on criminal recidivism, the duration between release to the community until re-incarceration was measured. The authors found individuals discharged on high dose methadone to be significantly less likely to return to jail than those on low dose with a median time of re-incarceration of 253 and 187 days, respectively. While a fixed higher dose demonstrably reduced recidivism, the authors recommend improved monitoring of individual methadone plasma levels both in the community and in prison in order to achieve individually ideal methadone doses.

Sibbald (2002) evaluated the effects of expanding methadone maintenance inside federal Canadian prisons. In 1998, the Canadian prison policy regarding methadone prescribing practices in prison stated that all inmates having received methadone in the community were permitted to continue the treatment in prison. In 1999, under certain circumstances all severely addicted prisoners were prescribed methadone, and since 2000, PMMT was offered to any prisoner with an opiate addiction. It was found, that after a year, 41% of inmates, who had continually received MMT, were readmitted to prison, compared to 58% of opiate dependent inmates, who had not taken part in the programme. This result has also been confirmed by Marzo, Levasseur, Blatier, and Ross (2002) in France. Inmates who received PMMT while incarcerated were significantly less likely (less than half as likely) to be re-incarcerated compared to those who merely received detoxification treatment (19% vs. 39%).

The prison safety is affected by OST in a positive way, as several studies show. When examining the effect of PMMT on institutional behaviour, Johnson et al. (2001) found that, compared to the non-PMMT group, the PMMT group spent significantly less time in involuntary segregation.

Consequently, it can be assumed that PMMT has a potential to calm disruptive institutional behaviour. Furthermore, a significant decrease in behaviours related to activity in the drug sub-culture for PMMT offenders relative to non-MMT offenders was observed. A correspondingly favourable impact was also reported by Mourino (1994). Neither did the programme cause any pressure within the prison social structure, as had been suspected, nor did non-dependent inmates demand access. Quite the reverse was the case, as prison officers reported a significantly reduced rate of conflicts amongst participating inmates. Similar results were also reported by Joseph et al. (1989) and Magura et al. (1993). Neither the diversion of methadone, violence nor security breaches, which the prison personnel anticipated as negative side effects, did take place. Again, quite the reverse was reported by prison staff, who even perceived participants as easier to handle than non-participants.

A Swiss study (Kaufmann et al. 1998) carried out a feasibility study on the factors involved in the organisation and implementation of a heroin trial in the Swiss prison Oberschoengruen. Besides, it was intended to investigate whether participants were able and willing to comply with the trial conditions. During the entire duration of the evaluation study, neither medical or social complications nor security related problems such as violence or stealing of heroin were reported by prison staff or inmates. Inmates in PMMT in New South Wales reported decreases in drug use, drug-related prison violence, crime following release (Bertram and Gorta 1990b) and considered PMMT to be more effective in preventing the transmission of HIV in prison than in the community (Bertram and Gorta 1990a). The non-appearance of undesirable consequences of PMMT anticipated by prison staff and PMMT objectors, such as disruptive behaviours, diversion of methadone or security breaches were also reported in other studies (Gorta 1987; Wale and Gorta 1987; Bertram 1991; Heimer et al. 2005).

On the contrary, scientific findings consistently suggest that prison-based methadone maintenance treatment has a calming effect on drug users' institutional behaviour, thus simplifying the manageability of inmates and their social re-integration after release. This phenomenon might be explicable in terms of the psycho-pharmacological effects of methadone, which counteract both psychological and physical cravings for opiates as well as the adverse symptoms associated with opiate withdrawals (WHO et al. 2007). Along these lines, Hume and Gorta (1988) even found in an investigation conducted in New South Wales that 86% of prison staff experienced a PMMT programme as providing benefits for the individual, the prison management and the community.

Taylor et al. (2006) emphasise the technical and logistical difficulties and associated health and safety aspects associated with PMMT. These include dispensing methadone adequately to all incarcerated PMMT clients, monitoring shortcomings and potential abuse of the PMMT system, for example, holding back methadone for illicit sale. A recent meta-analytical study found positive effects on retention, opioid use and criminality, both inside and outside prison, although some findings were inconsistent which might be due to different study designs (Johansson et al. 2007).

3.4 Summary

Although the prevalence of injecting drug use declines in prison compared to outside prison, drug use inside prisons, tends to be more dangerous with more risky injecting behaviour, due to the scarcity of drugs and injecting equipment (Shewan et al. 1994; Dolan and Wodak 1996). While in many cases prisoners discontinue or significantly reduce their drug use when entering the institution, others continue their use or might even start inhaling or injecting opiates (Allwright et al. 2000; Shewan et al. 2005; Wood et al. 2006).

Clear protocols and guidelines are needed to regulate entry into and conduction of substitution programmes in prison (Palmer 2003). This is also necessary for transferring patients to community based programmes (NSW Health Department 1999). Finally, OST entails a daily contact between health care service in prison and patient, a relationship that can serve as basis for raising further health issues and a linkage with other HIV/AIDS preventive strategy matters. Guidelines offer valuable information on the feasibility and practices of prison-based substitution treatment in different settings.

Prison-based substitution treatment is effective in reducing mortality, HIV infection, re-incarceration rates and crime rates. The frequency of injecting was reduced in long-term OST with a sufficient dosage. There is evidence for the feasibility in a range of prison settings. OST can have positive effects on prison safety as drug-seeking behaviour decreases. Health benefits are likely. No security or safety problems were found. Another important effect of prison-based OST is an increased treatment entry and retention. OST increases also access to help for antiretroviral therapies (WHO et al. 2007). Therefore, the implementation of OST into prison settings can altogether be strongly advised, as there is a positive impact on safety and crime issues in penal institutions, although the need for further research on prison-based OST exists, in particular high-quality studies. Another important issue is to analyse the impact of staff training and staff cooperation (see Stallwitz and Stöver 2007).

4. Policies and practices in introducing opioid substitution treatment

Throughout Europe, there has been a steady increase in the number of problem opioid users in substitution treatment. Chart 1 on the number of opioid maintenance treatment clients as a percentage of the estimated number of problem opioid users, shows that in some countries (e.g. in England and Italy), studies indicate a coverage rate of OST of approximately 50%. However, provision of substitution treatment in prisons still lags behind the coverage and standards of substitution treatment in the community. Studies indicate that a treatment gap persists between those inmates requiring substitution treatment and those receiving it and, in most of the countries studied, coverage is patchy (see Stöver et al. 2004). Heterogeneous and inconsistent regulations and treatment modalities appear throughout Europe sometimes even within one country, one region or even one and the same prison – in particular with regard to the introduction of OST. The European Commission concluded therefore that, *“harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equivalence adopted by the UN General Assembly, UNAIDS/WHO and UNODC, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services”* (Commission of the European Communities (2007, 199). This statement, based on the results of a survey, clearly demonstrates the current gap in prison-based treatment services (Stöver & Lines 2006; Lines & Stöver 2008).

However, the scope of substitution treatment has extended across Europe in general (see chart 2) and in prison settings: It is now only Cyprus, Estonia, Greece, Latvia, Lithuania, Sweden, and Slovakia who do not offer substitution treatment in prisons in the 27 EU Member states.

This chapter looks at the policies and practices of OST in place in prisons in 7 countries in order to identify the heterogeneity and diversity of how substitution treatment for opioid dependent prisoners is organised and how problems have been overcome in some countries.

Chart 1: Number of opioid maintenance treatment clients as a percentage of the estimated number of problem opioid users, 2005 (source EMCDDA 2007: 70)

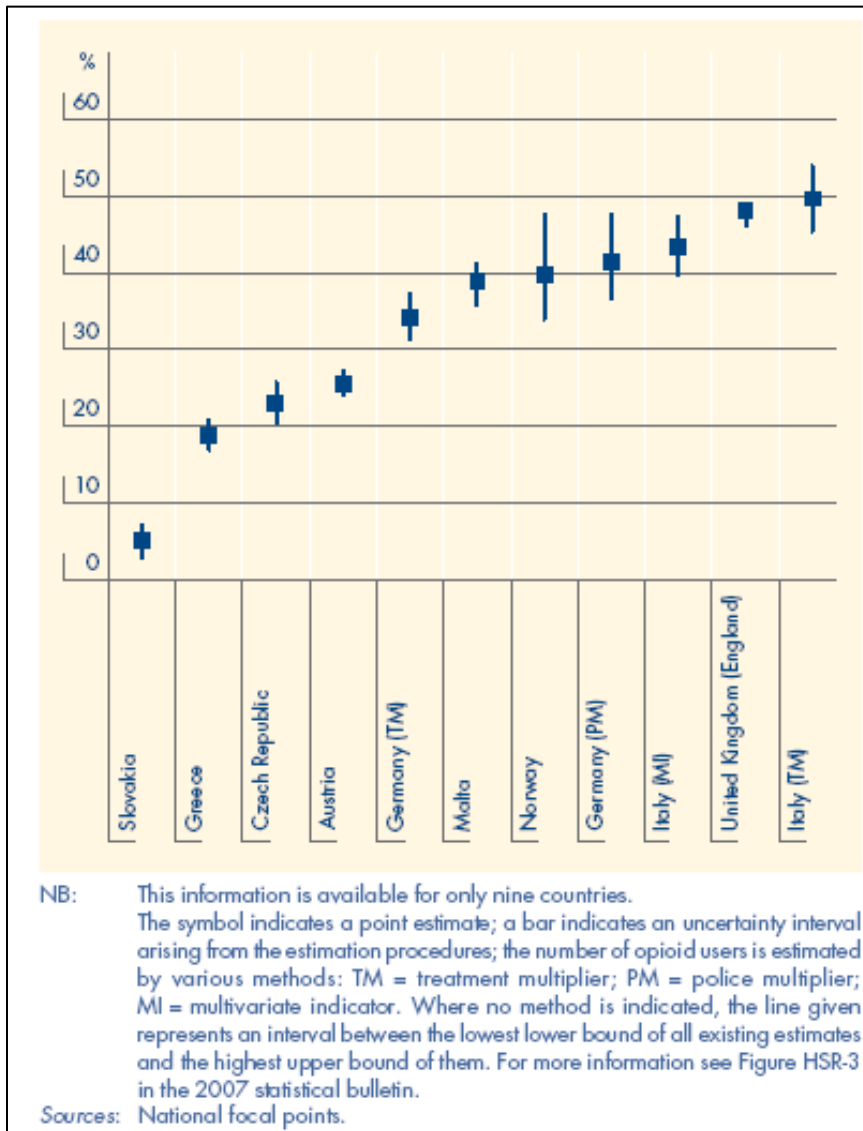
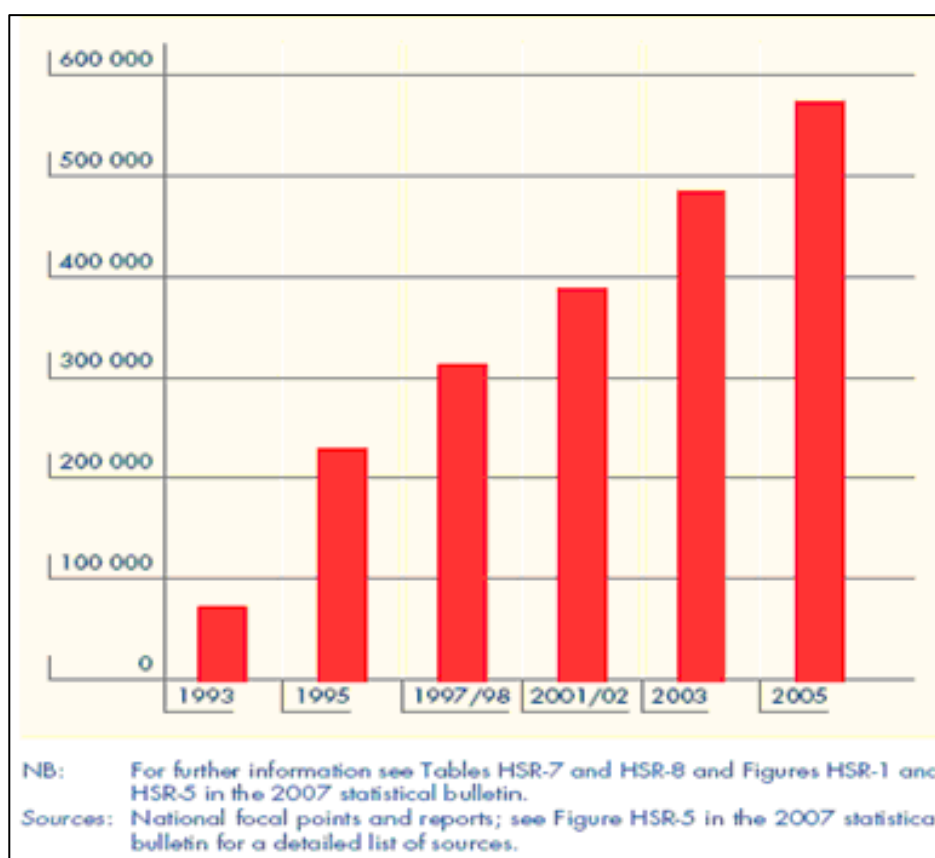


Chart 2: Estimated availability of opioid substitution treatment in the EU-15 Member States, 1993-2005 (source EMCDDA 2007: 33)



4.1 Methodology

For each of the seven countries, the context of opioid substitution treatment (OST) in prisons is described based on data and procedures regarding the state of substitution treatment in general in the community (history, legal procedures, prevalence data etc). With experts from all seven countries (see table 22 in the Annex) telephone interviews have been conducted (questionnaire is annexed). The results of these interviews have been integrated into the country-wise overview⁴. The results of expert interviews conducted in the seven participating countries inform about particularities of the introduction and experiences of OST in their countries. For each country at least one expert has been identified.

Information for the different countries vary as regards content and details depending on the interviews and data available.

⁴ Country reports are partly based on the study "Substitution Treatment in European prisons. A study of policies and practices of substitution treatment in prisons in 18 European countries" (Stöver et al., 2004)

4.2 Austria

4.2.1 Number of drug users⁵

In Austria, the number of “problematic drug users”, defined as those who frequently use “hard drugs” (predominantly opiates and cocaine) with poly-drug using patterns, is about 25,000-35,000 (ÖBIG 2007). EMCDDA data⁶ show a prevalence of problem opioid use of approximately five cases per 1,000 of the population aged 15-64, which is in line with prevalence data for the whole of Europe and Norway (between 4 and 6 per 100,000).

Spirig and Ess-Dietz (2001) point out that there is no systematic data collection about drug use in Austrian prisons. The profile and drug use of inmates has changed over the years. During the mid 80s, the number of people physically dependent on opiates, at the time of incarceration, was approximately 10%. Today, an estimate would be around 25-50% (Kahl 2006⁷). The results of the last representative survey (Spirig and Schmied 2003) revealed that 15% of men, 6% of women and 8% of juveniles were found to be consuming drugs intravenously. During their sentence, 3% of both women and men as well as 25% of juveniles consume drugs intravenously for the first time. If the numbers of regular users and occasional users are aggregated, the total is estimated at 50%. If the consumption of other psychotropic substances, such as medicine or alcohol, is taken into consideration, the majority of inmates are supposed to be drug users. The patterns of use are changing over time, poly-drug drug use is widespread.

4.2.2 Substitution treatment

4.2.2.1 Historical and legal background

According to the EMCDDA⁸, in 2005, 7,554 persons were in substitution treatment in Austria (2003: 6,413). In general, the number of patients in substitution programmes is constantly on the rise.

WHO guidelines and European Council Recommendation (No.R(93)6)⁹ provide the basic principles on which the Austrian prison health care system is based on. The principle of equality must be followed: inmates should be offered the same medical and psychological treatments that are available to other members of society.

⁵ Based on data of EMCDDA

⁶ EMCDDA: Prevalence estimates of problem opioid use. Accessed 12.2.08: www.emcdda.europa.eu

⁷ Walter Kahl, Österreichisches Bundesministerium für Justiz., persönliche Stellungnahme auf der 2. Europäischen Konferenz zur Gesundheitsförderung in Haft. April 2006, Wien

⁸ EMCDDA: <http://www.emcdda.europa.eu/html.cfm/index35975EN.html> Accessed 19.2.08

⁹ „Gefängnis und kriminologische Aspekte der Kontrolle von übertragbaren Krankheiten inklusive AIDS im Gefängnis.“

The medical care of inmates in prison is organized by the Ministry of Justice and provided by internal medical services. Needs assessments for drug users are done by a doctor upon admittance to prison. The guidelines for this assessment are provided by both the Ministry of Justice (e.g. on substitution programmes) and individual prison guidelines and concepts.

*Substitution Treatment in general*¹⁰

In 1987, guidelines for substitution treatment were laid down for the first time in the “Decree on Oral Substitution Treatment of Intravenous Drug Addicts” (“Substitution Decree”), based on the Narcotic Drugs Act (NDA). In 1998, a decree was issued by the Federal Ministry of Labour, Health and Social Affairs (FMLHSA)¹¹, in which guidelines for substitution treatment in Austria were specified, and, in the revised Narcotic Substances Act (NSA) of January 1998, the legal admissibility of substitution treatment was made explicit. The ‘ultima-ratio-principle’, stating that substitution drugs could only be prescribed on medical grounds and if other drugs were not sufficient for the intended purpose, was no longer binding. As substitution treatment had become an important form of therapy, it was included in the range of “health-related measures” targeting drug misuse as defined in the Narcotic Substances Act (Art 11 of the NSA). When the NSA came into force, the “Substitution Decree” (see above) was also amended according to the experience and knowledge gathered which enabled relevant indicators to be specified more easily.

All over Austria, substitution treatment has become an integral part of available drug services. The indicators for substitution treatment have been changed over time. Under the amended version of the “Substitution Decree”, issued in 1998 by the Federal Ministry of Labour, Health and Social Affairs (FMLHSA), pregnant women, patients with HIV infections and people addicted to opiates for over one year have been included in the primary target groups for substitution treatment. In the decree, with the exception of pregnant women, methadone continues to be defined as the substance of choice. In recent years, a diversification in prescribed substitution drugs has occurred: prolonged-action morphine and buprenorphine are used as well. In 2003, an analysis of substances used for first-time substitution patients showed that prolonged-action morphine was the drug most often prescribed, followed by methadone and, shortly after, buprenorphine¹². The decree also remarks that substitution treatment for people under 20 years should be administered sparingly, with the option of abstinence treatment considered thoroughly.

Regarding organisation and monitoring, the decree stated that:

- The relevant diagnosis shall be made by doctors familiar with the problem of addiction, i.e. psychiatrists (and neurologists) or other physicians with special experience or knowledge in the field of addiction treatment.

¹⁰ The following chapter is based on: Sabine Haas, Klarissa Guzei, Elisabeth Tüscherl, Marion Weigl, Austrian Health Institute (ÖBIG), Report on the Drug Situation in Austria, Vienna, 2001.

¹¹ Erlass des Bundesministeriums für soziale Sicherheit und Generationen, Orale Substitutionsbehandlung von Suchtkranken, GZ 21.551/6-VIII/B/12/98, Wien, June 1998.

¹² Personal communication with Dr. Sabine Haas, ÖBIG, Vienna, Austria.

- Generally, the substitution substances will be available on submitting a long-term, narcotic drug prescription, valid for a maximum period of one month.
- In the course of substitution therapy, the head physician must carry out regular examinations such as health checks and urine analyses.

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

4.2.2.2 *Substitution treatment in prisons*

Spirig and Schmied (2003) point out that, according to the decree of the Ministry of Justice, substitution treatment must be available, as standard practice in every prison. "The decision is made by the prison doctor. It is recommended to maintain an existing substitution but at the same time a step by step reduction. In special cases it is also possible for the inmates to get into a substitution programme during the sentence or before release" (Spirig and Schmied 2003, p. 25). Guidelines for substitution treatment in prisons have been issued by the Ministry of Justice (Bundesministerium für Justiz 2005).

On the 7th of December 2007, 772 prisoners were in substitution treatment. This is 9% of all inmates (8,560 prisoners in Austria at that time). 387 (50%) detainees received methadone, 273 received slow release, and 111 (14%) buprenorphine. This marks another increase in comparison with recent years (i.e. 531 in 2002, 335 detainees in 2001).

According to the Ministry of Justice (Bundesministerium 2005), OST is available in all prisons in Austria and is not limited to the length of the sentence. With regard to prisons, the Federal Ministry of Justice issued a decree stipulating that it will be possible for prisoners in any penal institution to continue substitution treatment initiated before imprisonment. Now, it is solely up to the physicians or psychiatrists to decide whether or not to continue the substitution treatment of a prisoner whilst, in the past, this decision also depended on the term of imprisonment. In individual cases, inmates may also start a new substitution therapy during imprisonment or before they are released. Prisons focusing on substitution treatment include the Penal Institutions of Josefstadt (Vienna,), with a capacity for 100 patients, Vienna/Favoriten, Innsbruck, and the prisons of Eisenstadt and Stein. As of 1st of June 1999, substitution treatment was complemented by support from the Penal Institution of Stein with a special ward for a maximum of 100 patients in substitution treatment. The number of prisoners undergoing substitution treatment has risen continuously, from approximately 50 persons in 1990 to more than 700 in 2007. In most cases, methadone is administered. "The substitution programmes must be handled by medical doctors who are trained in drug treatment. Additional specialists are consulted when needed. The costs of (external) medical care are paid by the Ministry of Justice because inmates are not insured" (Spirig & Ess-Dietz 2001).

4.2.2.3 *Summing up*

Due to a decree from the Ministry of Justice, substitution treatment must be available in every prison and is supposed to be standard procedure. The number of prisoners receiving substitution treatment has steadily increased in recent years. Additionally, a surprisingly high number of patients receive substitution treatment for the first time whilst in prison. Treatment modalities are relatively clear, prisoner's views were acknowledged and integrated in the treatment process. As an example, negotiation about dosage is possible and the decisions in favour of detoxification or maintenance are acknowledged as part of the doctor-patient relationship.

Like in the community, different policies and practices are applied regarding the substitution drugs of slow release morphine, which are judged differently by doctors in remand prison and in sentenced prison. If these drugs are prescribed in the community, often they are replaced by methadone in prisons, which is seen as pharmacologically superior and easier to handle in terms of control and supervision of intake.

4.3 **England and Wales**

The UK has different jurisdictions for prisons and also different administrative structures in England, Wales, Scotland and Northern-Ireland. England and Wales form a common prison jurisdiction. The Home Office and Ministry of Justice (the interior ministries) have responsibility for criminal justice and prisons in England and Wales, whilst the government responsibility for female prisoner healthcare in the 4 prisons in Wales has been devolved to the National Assembly for Wales. The 135 English prisons are overseen by the Department of Health¹³.

4.3.1 ***Number of drug users***

Latest estimates regarding problem drug users¹⁴ for England go back to 2001. These are based on the multiple indicator method and suggest 28,670 problem drug users, a rate of 8.91 per 1,000 population.

4.3.2 ***Substitution Treatment***

According to the EMCDDA¹⁵, substitution treatment remains the main drug-related treatment in the UK (63% of treatments in 2003/4). Most substitution treatment is for opiate dependence; the majority offered through specialist outpatient drug services, increasingly in shared care with general practitioners. Oral methadone is the drug of choice for substitution treatment but in-

¹³ David Marteau personal communication 17 March 2008

¹⁴ defined as "injecting drug use or long-duration/regular use of opiates, cocaine and/or amphetamines"

¹⁵ <http://www.emcdda.europa.eu/html.cfm/index36023EN.html>; accessed 17 March 2008

creasingly also buprenorphine that is in use since 1999. Furthermore, injectable methadone and heroin, albeit rarely, are also available in England.

In the whole of the UK, 135,000 patients were in OST in 2005, of which 109,000 were on methadone. 346 patients were in substitution treatment in Northern Ireland in 2005 (157 in methadone maintenance treatment). In Scotland 19,227 patients were in substitution treatment in 2005 of which 100% were in methadone maintenance treatment.

4.3.2.1 *Historical and legal background*

According to David Marteau, senior advisor Offender Health (England), the essential developments in prison drug treatment over the past five years have been the growth in the availability of

- a. substitution programmes, including methadone maintenance treatments
- b. hepatitis B vaccinations in prisons. In England, prisons are the most common location for the provision of hepatitis B vaccination programmes. In 2007, 82,738 doses of hepatitis B vaccine were administered to prisoners in England and Wales. The UK Health Protection Agency is preparing an annual report and a "Prison Infection Prevention Team" has been established that aims to:
 - Monitor the prison hepatitis B vaccination programme and improve vaccine coverage
 - Provide regular information to prison healthcare staff on infectious diseases affecting the prison population through the quarterly bulletin on infectious disease
 - Improve reporting of notifiable diseases in prisons
 - Facilitate development of policy for infection prevention in prisons¹⁶
- c. provision of disinfecting tablets. A prison service instruction has been issued to all adult prisons¹⁷ for the availability to prisoners of disinfecting tablets

4.3.2.2 *Substitution treatment in prisons*

England and Wales have a prison population of 79,842 (at 28th of December, 2007) and a prison population rate (per 100,000 of national population) of 147. About one third of the prisoners is supposed to be opiate dependent (approx. 26,000)¹⁸. Approximately 50% of the total prison population is supposed to be opioid experienced. 40% of all opiate users entering prisons report injecting drug use within the 28 days preceding imprisonment¹⁹.

¹⁶ http://www.hpa.org.uk/infections/topics_az/prisons/prisons.htm; accessed 17 March 2008

¹⁷ Her Majesty's Prison Service (2007) PSI 34/2007, Re-introduction of disinfecting tablets

¹⁸ Michael Farrell personal communication February 2008

¹⁹ Government Home Office, England & Wales (2003) An Analysis of CARAT Research Data as at 3 December 2002. Research, Development and Statistics Directorate, Home Office, London.

The prison population turns over twice a year, which equals to a number of over 50,000 opiate users a year. Approximately one quarter of them will receive OST within the year 2007/08. This coverage rate lies below of the coverage rate in the community, but is growing rapidly.

The number of prisoners in substitution treatment increased significantly in recent years. It has been reported that in 9 months of 2007-08 (April-December 2007²⁰), prisons in England and Wales reported the initiation of 9,242 methadone maintenance treatments, and 43,303 detoxifications. The full year projection for 2007-08 is therefore 12,323 methadone maintenance treatments. This number has increased from approximately 6,000 OSTs in 2006-07, and 3,000 in 2005-06 (detailed data have been reported for 2007 the first time). It is expected that the number will again increase significantly in 2008-09²¹. Thus, a rapid growth can be observed in the provision of OST in English and Welsh prisons. The rate of drug-related deaths has reduced markedly in cities with prisons that provide high levels of methadone maintenance, but no firm judgement may be made on whether there is a direct correlation between these two phenomena. A large multi-site comparative study is, however, due to begin later in 2008.

The overall experience for this programme (called "Integrated Drug Treatment System"(IDTS)²²) has been very positive. The objective of IDTS is to expand the quantity and quality of drug treatment within English and Welsh prisons by:

- "Increasing the range of treatment options available to those in prison, notably substitute prescribing
- Integrating clinical and psychological treatment in prison into one system that works to the standards of the National Treatment Agency (England) Models of Care and Treatment Effectiveness Strategy, and works to one care plan
- Integrating prison and community treatment to prevent damaging interruptions either on reception into custody or on release back home"²³.

The IDTS work closely with the Drug Interventions Programme (DIP²⁴) in particular to ensure that offenders receive seamless support and are retained in treatment after release.

The reasons for the massive expansion of OST in English and Welsh prisons can be found on three levels:

²⁰ Maintenance prescribing was not recorded formally until April 2007.

²¹ David Marteau, personal communication February 2008

²² [http://www.nta.nhs.uk/areas/criminal_justice/integrated_drug_treatment_system_in_prisons\(IDTS\).aspx](http://www.nta.nhs.uk/areas/criminal_justice/integrated_drug_treatment_system_in_prisons(IDTS).aspx); accessed 17 March 2008

²³ See [http://www.nta.nhs.uk/areas/criminal_justice/integrated_drug_treatment_system_in_prisons\(IDTS\).aspx](http://www.nta.nhs.uk/areas/criminal_justice/integrated_drug_treatment_system_in_prisons(IDTS).aspx)

²⁴ In England and Wales, a Drug Interventions Programme targeting drug users in the criminal justice system offers a range of social reintegration responses through Criminal Justice Intervention Teams, based in the community and in the prison system.

- a. legal action had to be taken after 197 forcibly detoxified ex-prisoners were paid £750,000 compensation on the 14th of November 2006²⁵ who claimed for assault, negligence and for breaches of the Human Rights Act 1998, alleging that their opiate dependency was mis-managed in prison. The prisoners complained that they were prescribed inappropriate and insufficient medication to meet their needs arising from their pre-existing drug dependency.
- b. the responsibility of health care in prisons has been shifted from the Home Office (Ministry of Interior) to the National Health Service (NHS) in 2004. In the following two years the foundations have been built via increased funding, changing attitudes and the training of staff, to enable health care to be delivered in the same quality as in the community.
- c. published guidelines with governmental funding for their implementation (see e.g. Department of Health 2006²⁶; Integrated drug treatment in prisons (IDTS)²⁷: Needs assessment guidance October 2007; Treatment Planning Documents October 2007). These guidelines reflect a comprehensive view on clinical management of drug dependence, as most of drug users are polyvalent drug users.

Training

Approximately 1 Million Euros have been spent in one year for vocational training of medical staff in prisons in order to introduce substitution prescribing into prisons by improving the knowledge, ability and skills to prescribe substitution agents, increase patient safety and initiate attitude changes. Offender Health and the Royal College of General Practitioners have jointly developed IDTS clinical training. The training is set at three levels:

Level I: A generalist course that comprises e-learning and a day's face-to-face training.

Level II: This is a course of five single-day training events, specialist mentorship and a practice development project. It is designed to move practitioners towards clinical specialist status

Level III: Advanced Secure Environments Module: This is an intensive two-day course that concentrates wholly on practice in prisons and police custody (see Marteau 2008).

4.3.2.3 Summing up

The massive expansion of OST in prisons is the result of three developments: (i) a shift of responsibility from the Home Office to the National Health Service, (ii) political and professional leadership and investment (iii) and a massive investment in training and education of staff in

²⁵ See The Independent 14th of November 2006, 26, and 15th of November 2006, 30

²⁶ Dept Health, England (2006) Clinical management of drug dependence in the adult prison setting

²⁷ National Offender Management Service, England & Wales (2006) Integrated Drug Treatment System: the first 28 days. Psychosocial support 1st edition

prisons. With these efforts, the number of patients in prison-based OST has been scaled up enormously within the last 2 years.

4.4 Germany

4.4.1 Number of drug users

According to the EMCCDA (2003), the number of problematic drug users lies in between 164,000 and 195,000 (2001-2005)²⁸. The use of opiates (lifetime prevalence) is considerably low. It lies at 1.4% in the age group of the 18-59 year old, which marks a slight increase in comparison to a lifetime prevalence of 0.9% in 2000. The lifetime prevalence of cocaine is with 3.0% much higher. The prevalence of cocaine use in the age group 18-24 is with 3.9% in 2005 five times higher than in 1980 (Die Drogenbeauftragte der Bundesregierung, 2004, 60f). According to the Robert-Koch Institute in Berlin, approximately 9% of all HIV cases are accounted for by intravenous drug users. Hepatitis C is most widespread in the population of drug users, according to the different populations studied, 60-90% of drug users are infected with HCV (Schulte et al. 2008).

4.4.2 Substitution treatment

4.4.2.1 Historical and legal background²⁹

Although the first, experimental methadone programme was carried out in Germany (in Hanover/Lower-Saxony) from 1973 to 1975 (with levomethadone, L-Polamidon®), substitution treatment was introduced on a larger scale only at the end of the 80s of the last century. The first methadone maintenance treatment (MMT) was started at the end of the 1980s (initially in North-Rhine Westphalia) as a response to the threat of HIV/AIDS. Since then, a number of other substitute substances have been authorised such as buprenorphine (2000), dihydrocodeine, and codeine. The German Narcotics Act was revised in 1992, finally clarifying that drug substitution treatment is legal. A randomized, controlled heroin trial started in 2002. According to the drug commissioner, the number of participants in drug-substitution treatment has risen over the past 15 years, from 1,000 to 70,000 by the end of July 2007.

Until the early 1990s, methadone could only be administered to drug users when tight indication criteria were met (e.g. emergency cases, such as life-threatening conditions of withdrawal or conditions of severe pain). In general medical practice, however, German doctors were prevented from using methadone to treat heroin addicts, since OST was considered to be medical malpractice. Nevertheless, there were a few general practitioners (GPs) who ignored the legal

²⁸ <http://www.emcdda.europa.eu/html.cfm/index39634EN.html>; accessed 17 March 2008

²⁹ See overview: Michels et al. 2007

regulations and prescribed methadone to opiate addicts, and as a result most of these doctors were persecuted and prosecuted. The final goal of the substitution treatment is abstinence. Other essential goals pursued are: to secure survival, health and social stabilisation, social and professional rehabilitation. Moreover, substitution treatment is supposed to help prevent infectious diseases (Die Drogenbeauftragte der Bundesregierung 2003, p. 76).

The German Narcotics Act was passed in 1971 and modified in 1982. With regard to substitution treatment, it was only in 1992 that the amendment of the Regulation on the Prescription of Narcotics (BtMVV – Betäubungsmittelverschreibungs-Verordnung) was introduced which clarified the legal position of methadone prescribers. Doctors prescribing substitute substances have to keep to the “generally accepted state of the art of medical science”, as defined by the Federal Medical Board. In March 2002, this board released “Regulations for the Substitution Treatment of opiate addicts”, according to which substitution treatment is indicated as permissible:

- When there is long-term opiate addiction and attempts to achieve abstinence have not been successful,
- When a drug free therapy cannot be carried out
- When substitution treatment offers the biggest chance for healing and recovery.

The main regulations, as documented in Section 5 of the Regulation on the Prescription of Narcotics (BtMVV), are summarised below. In accordance with section 13 (1) of the Narcotics Act, substitute drugs may be prescribed for the following regulation purposes (treatment goals):

1. Treatment of opiate addiction with the goal of step-by-step recovery to abstinence including the improvement and stabilisation of the general health status;
2. Treatment of patients addicted to opiates who have undergone medical treatment for severe medical illnesses;
3. To reduce the risks of opiate addiction during pregnancy and after birth.

Doctors are authorized to prescribe substitute substances if and as long as:

1. The patient is eligible for substitution treatment;
2. Substitution treatment is embedded in a comprehensive treatment incorporating psychiatric, psychotherapeutic or psychosocial care;
3. Patients are registered at the Federal Narcotics Control Board (Bundesopiumstelle) (effective 1st of July, 2002);
4. There is no evidence that the patient:
 - receives substitution substances on prescription from another doctor,
 - does not participate in accompanying treatment and care,
 - uses substances that endanger the purpose of substitution treatment,
 - does not use the substitute as directed by law;

5. The patient sees his/her doctor regularly (usually once a week);
6. Doctors have qualified for addiction treatment according to the guidelines of the relevant state or regional medical boards (effective 1st of July, 2002).

Doctors are obliged to document all relevant patient and treatment data. Substitute substances must not be prescribed for intravenous use. The substitute may be dispensed and/or taken under supervision in GP's offices, hospitals, pharmacies or other facilities approved by the relevant state authorities. For substitution treatment funded by the Social Health Insurance (SHI) additional guidelines have been drawn up by the Federal Association of Physicians and Social Health Insurance Organisations (Kassenärztliche Bundesvereinigung) which regulate the conditions for reimbursement of treatment costs (BUB-Richtlinien). These guidelines may be ignored with patients who have no public health insurance. Doctors are required to test patients' urine and to monitor poly-drug use. There are no rules regulating the frequency of taking urine samples. In practice, during the first weeks of treatment, doctors usually test their patients' urine at least once a week. According to the BUB guidelines, continued collateral use of addictive substances must result in the termination of treatment.

All doctors seeking to provide drug-substitution treatment must provide evidence of having sufficient qualification in pharmacology and drug addiction by participating in special medical qualification programs. Training covers topics such as opioid dependence, the role of substitute substances, understanding and caring for the substitution patient, assessment and management and clinical practice dosing procedures. By December 2006, approximately , 8,000 doctors had completed this vocational training (but only 2,700 actually provided substitution treatment; see Die Drogenbeauftragte der Bundesregierung, 2007). Depending on the number of substitution treatment providers in a given area, doctors can be authorised to treat up to 20 patients funded by Social Health Insurance (SHI). There is no such limitation given in the Regulations on the Prescription of Narcotics (BtMVV). Thus, doctors approved to treat 20 SHI patients may care, for example, for another 20 patients funded by social welfare or paying for their treatment themselves. Despite the fact that the BUB guidelines are effective nationwide, there are considerable variations between the federal states on the organisation and delivery of substitution treatment and accompanying psychosocial care.

As documented above, legislation on drug substitution treatment remains oriented towards abstinence rather than maintenance, although research findings and experience gathered from medical practice indicate that limiting the duration of participation in treatment does not prove successful for the majority of the patients (Gerlach & Stöver 2005).

Treatment modalities and costs

In Germany, treatment and prescription (medication) costs are generally covered by social health insurance schemes (SHI) which are mandatory for almost 90 percent of the population (in special cases, e.g. homelessness, doctors' fees are met by social welfare services). There is also the freedom to choose one's own general practitioner (GP) or hospital. However, this praised German health care system has failed in respect of opiate addiction treatment since public health insurers are not under a legal obligation to meet drug-substitution treatment and

prescription costs. Up to the present, they do not accept opiate addiction as a sufficient indication for treatment with substitute substances (see overview Gölz 2007).

Psycho-social care

The legal guidelines (of both the BtMVV and the BUB) recommend participation of patients in psychosocial care. However, in practice this is often seen as an obligatory requirement (Gerlach/Stöver 2006). The regulations do not provide any instructions on the frequency, mode and scope of psychosocial care provisions and, to date, there are no nationwide standards of how to organise and structure accompanying support. Psychosocial care is a collective name for a number of different areas. These may include, for example, legal advice, managing financial problems (e.g. debts, rents), recreational activities, crisis intervention, (psychotherapeutic) group sessions, assistance with finding accommodation and jobs, and qualifying for school and vocational training. Psychosocial care is not funded by the SHI. There are great variations in psychosocial provision between different states and communities, and variations in quality and funding (see overview Walborn 2007).

4.4.2.2 *Substitution treatment in prison*³⁰

Legal responsibility (Prison Act) for medical care of prisoners

Germany has lived quite well with its national prison law of 1977. The situation has changed with the decision of the government to include prison legislation into its "reform of federalism". In exchange for other legislative matters, the national parliament has ceded prison legislation to the individual Länder/states. This creates the strange spectre of one national penal code combined with sixteen different prison laws. Things have become even more confusing through the decision of the Federal Constitutional Court (in May 2006) that a legal basis for youth prisons has to be created until the end of the year 2007. This may mean in the long run the existence not of one but of thirty-two prison laws in Germany. This does not take into account the equally unconstitutional situation that pre-trial (remand) imprisonment is also still without a sufficient legal basis. On 1st of January, 2008, sixteen Youth Prisons Acts have come into force. Three of them are combined with Adult Prison Acts (Bavaria, Hamburg and Lower Saxony), one of which (Lower Saxony) does even include a legal regulation for remand prisons. For the remaining 13 Länder the old federal Prison Act is still in force until it will be substituted by regulations of the state (vgl. Feest 2008).

According to the Prison Act (§§56-66), the state (i.e. 16 Ministries of Justice) is responsible for providing adequate medical care to prisoners. Medical care must follow the guidelines of the National Health Insurance system and comply with the medical standards outside the prison. Therefore, substitution treatment within the prison system should follow the same regulations and standards that apply to substitution treatment under the National Health Insurance system outside of prison.

³⁰ See overview Stöver & Stallwitz (2007)

This principle of equality is basically reflected in two paragraphs of the Prison Act (Art. 3, of Feest/Bammann, 2004). It is based on:

- The principle of normalisation: meaning life in corrections shall resemble general living conditions outside prison as much as possible, and
- The principle of damage reduction: correctional authorities shall mitigate against the damaging consequences of imprisonment.

However, with regard to substitution treatment, there are several important distinctions (see also Keppler 2007):

- 1 In German prisons, patients may not choose their doctors, i.e., the relationship between patient and physician is somewhat coerced. In general, inmates have tendency to mistrust doctors and meet them with reservation and prejudice.
2. Outside prison, patients in substitution treatment are often required to disassociate physically, socially, and mentally from the drug scene, which was the focal point of their lives and personal experience. Behind bars, this disassociation is only possible to a limited extent.
3. Effectiveness and attraction of substitution treatment depends on the positive attitude of the treatment staff as well as on the entry threshold level. The prison system often has problems with both of these conditions.
4. Where politicians and the public are concerned, methadone maintenance was linked to expectations which were partly unrealistic and which exceeded medical outcomes. These expectations were not fulfilled. The large-scale distribution of substitute drugs was supposed to have a widespread effect which – in addition to medical and social stabilisation – should eliminate drug subcultures and drug scenes in and outside prison. The outcome, however, fell short of expectations.
5. Maintenance is considered very time and labour intensive, particularly in the starting phase of treatment and medical staff have to acquire the necessary ‘maintenance know-how’. This can sometimes be an arduous process. However, methadone maintenance remains costly throughout the programme, i.e., when the number of substitution patients increases.
6. OST is still approached in entirely different ways across the nation. It varies from state to state, from prison to prison and even within prisons (in case of different medical doctors³¹).
7. Drug testing for the additional use of psychotropic substances (such as Cannabis) is mandatory for all methadone patients. This also applies within the prisons. Due to a va-

³¹ An example is the prescription of buprenorphine, which is rejected by most of the doctors because of its control intensity. Nevertheless during interviews it has been revealed that within one prison different positions have been taken by different doctors.

riety of manipulation techniques in urine testing, usual testing procedures should be interpreted with great care.

There is a consensus both outside and inside the prisons that, besides providing the substitute drug, supportive psychosocial measures are sensible and can contribute to achieving therapeutic objectives. However, there are different models in practice in prisons. Some prisons do have an explicit ratio social worker/psychologist - prisoner, some provide psycho-social care within their normal general services. Table 2 illustrates the heterogeneity of provision of psycho-social care:

Table 2: Psycho-Social Care (PSC) and substitution treatment (source: Knorr 2007: 73)

State	PSC by internal and external staff	PSC by internal staff only Interne	PSC by external staff only	no PSC	No data
Baden-Württemberg	X				
Bavaria	X				
Berlin			X		
Brandenburg		X			
Bremen		X			
Hamburg				X	
Mecklenburg-West Pomerania				X	
North Rhine-Westphalia	X				
Rhineland Palatinate		X			
Saarland			X		
Saxony					X
Schleswig-Holstein	X				
Thuringia	X				

The number of drug addicts in prison

There are approximately 80,000 prisoners in Germany (including remand prisons). At least 25% of these are estimated to be intravenous drug users (IDUs) (Stöver 2002a; 2008). Detailed studies show that up to 50% of the prisoners have experienced illicit drugs (with even higher numbers in juvenile and women's prisons). However, despite rigid controls, about 50% of all imprisoned IDUs continue to use drugs, although in a reduced frequency. It is estimated that the opioid using population in prisons exceeds 10,000. These are only rough estimates since no specific data are available. Neither is any information available on the number of substitution patients in penal institutions. Only 6 out of 16 federal states in Germany provide substitution treatment in prisons (Hamburg, Bremen, Berlin, Hessen, Lower Saxony, North Rhine Westphalia, Baden-Württemberg). Criteria of admission and duration vary between states and substitution treatment is not available in each of the single state's prisons (Stöver 2007).

Consistency of substitution treatment in prisons

The practice of substitution treatment in prison is consistent with external practise in the community. Thus, in places where OST is freely prescribed in the community, it is also prescribed in the prisons. Conversely, in those regions and communities where it is offered rarely, it is seldom found within the prisons (see overview: Knorr 2007).

Until now, maintenance treatment has not been implemented on a regular basis or in all prisons. There is a distinct difference between Northern and Southern, Eastern and Western Germany. Only a few states continue substitution treatment in prisons if it was initiated before detention. These opportunities are usually restricted to short-term detainees in order to help them “bridge” the time spent in prison. Long-term substitution treatment has been rejected by most prison doctors in Germany (Stöver, 2007). Some penal institutions offer a “gradual withdrawal” program for addicts. A few drug addicted inmates who are likely to relapse after imprisonment, and for whom post-incarceration treatment has been planned, are permitted to begin OST shortly before their prison sentence ends in order to prepare them for release.

Basically OST is available in all Länder/states, but to a larger scale it is only accessible in the city-states of Hamburg and Bremen, in North Rhine-Westphalia, Baden-Württemberg, and in Thüringen. All of the other ‘old’ federal states offer it basically but in practice it is reduced to single cases (such as Bavaria and Saxony; see Knorr 2007, 67). Saarland is providing OST only in open prisons.

Number of prisoners in substitution treatment

No precise figure is available for prisoners in substitution treatment in German prisons. The current situation can be described as follows: it is estimated that methadone patients number approximately 500 among the 20,000 incarcerated inmates who use opioid drugs (25% of the total number of inmates, 80,000). Given that half quit their drug use (Stöver 2007) and only a third of the remaining group, 10,000 drug users, are eligible for substitution treatment, there should be at least 3,333 prisoners in substitution treatment in German prisons.

4.4.2.3 Summing up

Substitution treatment in German prisons is heterogeneous in access and treatment modalities. The access is very patchy and the number of patients who might receive substitution treatment is limited by a lack of resources and budget constraints. This accounts for the number of staff, both in medical units and among drug counsellors, needed to provide more substitution treatment in prison. Moreover, resistance – linked to the widespread drug-free orientation – can be found towards substitution treatment which views the provision of substitution drugs mainly as means of detoxification. In total, the demand of prisoners for substitution treatment is far bigger than the actual number of places.

Certain issues became apparent in the interviews held:

- Enormous differences in policy and practice of substitution treatment between prisons in the same state (Lower-Saxony) but even between prisons of the same administrative unit (e.g. duration of prescription ranging from expected 6-12 months sentence in one prison to indefinite durations in others, disparities in urine tests).
- Practices and policies are not discussed and there seems to be no attempts to harmonise these different approaches.
- Inflexibility of the system in introducing new substitution drugs (e.g. buprenorphine) due to practical obstacles and lack of experience.
- Lack of adequate patients' information (leading to a mistrust about the substance dispensed).
- Assistance is given in both prisons with regard to finding a doctor after release, this is part of an education process to enable prisoners to attend to one's affairs.

4.5 Italy

4.5.1 Number of drug users

In Italy, there is an estimated number of 8 problem drug users per 1,000 adult population which equals to a number of approximately 300,000³². EMCDDA reports that in 2005, there were 96,972 persons in substitution treatment that equals to a coverage rate of about 30%. (2003: 90,738). The number of units providing substitution treatment increased from 2003 from 561 to 981 in 2005. Chart 1 shows that more than 40% of all estimated problem opioid users are in substitution treatment. Several studies on drug use in prisons indicate a range between 27-30% of any illicit drug being used in prisons. About 40,000 to 50,000 drug using prisoners are supposed to pass through the prison system annually.

4.5.2 Substitution Treatment

4.5.2.1 Historical and legal background

Within Italy, treatment services are provided either by the National Health Service managed drug treatment programmes – the Servizi Tossicodipendenti (Ser.T) or Drug users Service – or by private, non –profit-organisations, mostly drug-free therapeutic communities. The Ser.T.s are public drug treatment units carrying out mainly outpatient treatment and are part of the national health system (NHS). In 2000, there were 555 Ser.Ts throughout Italy and 1,335 socio-

³² <http://www.emcdda.europa.eu/html.cfm/index41327EN.html>

rehabilitative structures. Staff in Ser.T.s are mainly doctors and nurses, with some psychologists and social workers.

Substitution treatment in Italy is almost exclusively provided by the Ser.T. (Reitox Italy 2001). Substitution treatment was regulated with the D.M. of 7th of August 1980 (Health Ministry Decree) regulating the 'Discipline of the use of preparations with analgesic-narcotic action in the treatment of drug addicts'³³, followed by the article D.M. (10th of October 1980) regulating the 'use of basic preparation of methadone and morphine for the treatment of drug-addicts'³⁴. Article D.M. (23rd October 1985) revoked the authorization for the experimental use of morphine in the treatment of drug-addiction, resulting in having methadone as the main treatment for addiction to opium-based substances in Italy.

The D.P.R. (Republic President Decree) 309/90³⁵ concerns the 'collection of laws concerning the discipline of narcotics and psychotropic substances, prevention, care and rehabilitation of the corresponding conditions of drug-addiction' and states that:

- The Department of Health is in charge of identifying individuals with a habitual use of narcotics (precondition needed for substitution treatment), and of giving instructions for diagnostic, care and medico-legal procedures to these identified individuals.
- The National Health Service managed public treatment services (Ser.T.) is in charge of defining the therapeutic treatment programme using substitution treatment, and of setting up the treatment modalities (mode, dosage, duration, check-up method).

There has been an increase in the number of Ser.T.'s patients receiving substitution treatment resulting in over 50% of Ser.T.'s patients (excluding prisoners). Although the emphasis has been on prevention and abstinence and thus a detoxification-based treatment, there has been an increase in long-term methadone maintenance (longer than 6 months) and a decrease in short-term treatments. Prescription of substitution treatment varies largely from one region to the other. The most widely used substitute in Italy is methadone (available since 1975), although the use of buprenorphine has been increasing since its introduction in 1999 and constituted in 2004 around 15% of all substitution cases³⁶.

There is no single model, set of guidelines, or good practice for substitution treatment in Italy. The Guidelines for Harm Reduction Interventions (Ministry of Health) state several different objectives of substitution treatment as (i) drawing and retaining patients in a treatment centre, (ii) harm reduction, and (iii) offering stability for interventions towards abstinence. Variances occur locally due to differences in the objectives as regards OST. There is little data about the

³³ D.M. of 7 August 1980 Regolamento dell'impiego di farmaci ad azione analgesico-narcotica nel trattamento dei tossicodipendenti.

³⁴ D.M. 10 October 1980 Impiego di preparato di base di metadone e morfina per il trattamento dei tossicodipendenti.

³⁵ The D.P.R. 309/90 Testo Unico delle leggi in materia di disciplina degli stupefacenti e delle sostanze psicotrope, prevenzione, cura e riabilitazione dei relativi stati di tossicodipendenza.

³⁶ <http://www.emcdda.europa.eu/html.cfm/index35927EN.html>

criteria for admission into a substitution treatment. Medium length of treatment is defined to last from 3 to 6 months, whereas long term treatment is defined as lasting over 6 months.

The funding of treatment services for drug users comes from the general allocation to regions for all health care provision, as well as from local taxation and from projects financed through the National Drugs Fund. Regions have autonomy in the provision of health care services, which are defined according to the local needs (Reitox Italy 2001).

4.5.2.2 *Substitution treatment in prisons*

Lifetime prevalence of heroin use was reported for 4–60 % (2000-2006), injecting drug use prior to imprisonment is reported for 2 % to 38 % of prison inmates (2000-2006). Studies available show that 1–52 % of inmates report have used drugs within prison and that 1–11 % have injected drugs while in prison (2000-2006)³⁷. The development and provision of substitution treatment in prisons started with the D.P.R. 309/90, which was generally unapplied (for the treatment of sentenced prisoners) until 2000, when the Legislative Act 230/99 became effective and all the duties, the responsibilities and the personnel of the drug services in prison were delegated to the National Public Health Service A.S.L..

The treatment of drug and alcohol addicts in prisons is regulated by Presidential Law 309/90, which brings together the norms contained in Law No. 685/75, Law Decree No. 144/85, Law Decree No. 103/88, the Penal Procedure Code and Law No. 162/90. Article 29 of Law 162/90 provided for assistance in the prison and states that: 'The Local Health Units, in agreement with the penal institutes and in collaboration with the Health Services within these institutes, should provide care and rehabilitation services for drug and alcohol addicted prisoners.'

Health care in prison is provided by the Penal Health Service (Prison Administration, Ministry of Justice), except for the care of drug users, which is provided by the Public Health Service (Ministry of Health) through the A.S.L. (Local Health Agencies) since 1st January 2000 (L.230/99). The Local Health Agencies, in collaboration with the Prison Health Service, are responsible for providing prevention programs and multidisciplinary rehabilitation and care services. They carry out awareness campaigns in the prison, prepare the individual treatment programs, and act as intermediaries between the operators in Treatment Centers (auxiliary agencies – Art. 114) and the Ser.Ts, which have territorial jurisdiction for the respective prison. The director of the institute must act as "guarantor" for all the activities Ser.T carries out in the prison and 'do his best' to implement these activities (informing new prisoners, etc).

The legal frame of substitution treatment in prison is provided in the D.M. 445/90 'Discipline concerning the determination of the limits and the mode of usage of the substitution preparations on the treatment programmes of drug-addiction stages: first directives'³⁸. With the circular

³⁷ <http://www.emcdda.europa.eu/html.cfm/index41555EN.html>; accessed 17 March 2008

³⁸ D.M. 445/90: 'Regolamento concernente la determinazione dei limiti e delle modalità d'impiego dei farmaci sostitutivi sui programmi di trattamento degli stadi di tossicodipendenza – prime direttive'.

number 20, dated 30 September 1994, the Health Department promulgated some guidelines for the substitution methadone therapies. Some Italian regions further defined the guidelines and the legal norms for the use of substitution treatment; for instance, the region Lombardy, which on 30th of March 1995 produced the deliberation of the Regional Committee number 5/65411. This allows for MMT to be offered inside prison further to specific rules by the Ser.T.

There are no evaluation studies available about methadone treatments in Italian prisons. The protocol of Professor Icro Maremmani for substitution treatment is used in the Lombardy area ('Manual of the Ambulatory Treatment with Methadone' - 'Manuale del trattamento ambulatoriale con metadone'). The procedure of the substitution treatment was certificated only by the A.S.L. (Local Health Agency) of the city of Milan in 2000. A consensus paper on OST was drawn from a conference held in Milan on 1st of February 2000, organized by the A.S.L. of the city of Milan and the prison San Vittore (in Milan), stating intervention guidelines for the provision and initiation of the methadone treatment in prison.

In Italy, the main substance of substitution treatment is methadone. Buprenorphine has only been recently (2002) initiated in the country. The prescription of other psychopharmacological drugs such as benzodiazepines is not recommended. The national and regional guidelines provide two different schemes for urine analysis during OST, which are however not applied. Methadone in OST programmes in prison is provided daily and is distributed by a professional nurse on the basis of a doctor's instructions.

The general aims of substitution treatment in Italian prisons mainly concern health stabilisation. Substitution treatment is limited to the biggest institutions and prisons, with differences from one region to another. Treatment options essentially focus on detoxification, and in very few prisons a focus on maintenance and initiation of substitution treatment starting in prison is found. The Ser.T is the external centre involved with substitution treatment.

The decision to initiate a substitution treatment in prison is made by a doctor. The most relevant clinical criterion is the evaluation of the degree of withdrawal through a medical check-up. Before the beginning of the treatment, the patient is asked to sign a contract an 'informed consent to the methadone treatment', which underlines the problematic side of substitution treatment in prison, such as confidentiality, daily practical problems, additional drug use, etc. To continue substitution treatment in prison (initiated prior to incarceration in the community) contact is established with the respective community doctor for official confirmation of the prisoner's programme (duration, dose etc). Prisoners transferred to another prison will continue their substitution treatment if the treatment is available in the new prison. If so, the 'file-card' with details on the methadone treatment is transferred to the new prison and the treatment can be continued. The same procedure applies for prisoners transferred from remand to sentenced prisons. In order to continue substitution treatment after release, contact must be established prior to release with a competent Ser.T; the request and plan to continue the treatment after release is sent by fax to the relevant Ser.T.

Substitution treatment in prisons is paid by the A.S.L., covering expenses related to staff, doctors, nurses, and laboratory analysis. It is calculated that there are 1,759 (4% of total addicts

inmates) prisoners are on substitution treatment in prison on a given day (30 June 2007, www.giustizia.it/statistiche_dap/det/2007) and approximately 5,000 a year. This means that roughly 10% of PDUs among prisoners are in OST.

Psychosocial care and training

Prisoners in substitution treatment do not receive specific psycho-social care. If the treatment is inserted into a global therapeutic programme, then there is a systematic link between the doctor/nurse and psychologist/educator. However, the psycho-social support is offered on a voluntary basis and available to all (not just substitution treatment) patients.

There is no specific training on substitution treatment offered to prison staff as training for professionals depends on individual regions and local health authorities. Professionals working in Ser.T tend to be specialised in drug issues and treatment of drug use. Although a few have acquired this specialisation through training as part of or after their vocational training, the majority tends to learn while working with drug users.

4.5.2.3 Summing up

The provision of substitution treatment in Italy in general, and in prisons in particular, varies extremely from one region to the other. However, there is a tendency to offer methadone treatment for detoxification. Maintenance (long term) treatment and buprenorphine are also offered but to a more limited number of prisoners.

In prison, health care to drug users is provided by the Public Health Service (Ministry of Health) through the A.S.L.. Ser.Ts are specialised centres for the treatment of drug use. Differences in the provision of substitution treatment from one region and prison to another are striking and problematic. The lack of throughcare (i.e. psychological care within the same prison after a detoxification substitution treatment, health care on release or when transferred to another prison) is problematic for long-term rehabilitation.

4.6 Portugal

4.6.1 Number of drug users

The most commonly used psychoactive substances in Portugal are cannabis, heroin, cocaine, prescribed drugs, amphetamines, ecstasy and hallucinogens (Reitox Portugal 2002). Poly-drug use of heroin and cocaine is increasing as well as the use of cocaine that is reported to become the preferred substance. Also the use of cannabis and amphetamines have risen in the past few years. The majority of drug users searching for treatment are heroin users (Reitox Portugal 2002).

It is estimated that there are 100,000³⁹ drug users in the country (all illicit drugs included). In 2005, 21,054 (2000/2002: 12,863) patients were receiving substitution treatment. Of those 15,054 received methadone, the remaining buprenorphine⁴⁰.

Amongst the prison population, communicable diseases (particularly HIV/ AIDS and hepatitis) are widespread. According to Fernandes (2003), 14% of Portuguese prisoners are infected with the HIV virus and 396 have AIDS.

The Instituto da Droga e da Toxicodependencia (IDT) estimates that between 25 and 42% of the total prison population in 2002 were drug users. 607 prisoners were on substitution treatment in 2002, 734 in 2007.

4.6.2 Substitution treatment

4.6.2.1 Historical and legal background

Between 1975 and 1980, the phenomenon of drug dependency emerged. Initially, it was seen as an issue related to justice, the Ministry of Justice responded by creating some community centres. Later on, drug dependency became a health issue with the Ministry of Health developing additional centres. In 1990, these centres (belonging to the Ministry of Justice and the Ministry of Health) were integrated into a common service centre: the Service for the Prevention and Treatment of Drug dependence (SPTT) managed by the Ministry of Health. By 2002, across the whole country, there were 53 centres for drug users in the community. SPTT was responsible for the licence and management of these centres as well as for providing standard procedures to private centres. The SPTT is the national authority on specialised treatments for drug use. Its organisational structure is broken down into Central Services, Regional Offices and Local Centres. The services provided are entirely free and accessible to all drug users who seek treatment. In 2001, as in previous years, the number of treatment units in the SPTT network increased. The treatment programme is tailored to each client's specific problem. The facilities and services include: Specialised Treatment Centres (45); Consultation Units (16); Detoxification Units (5); Therapeutic Communities (2); Decentralised Consultation Units (3) and Day Centres (4) (Reitox Portugal 2002).

After the 2002 general elections, the government stated that drug abuse was seen to be a health problem and so the focus should be on 'minimising the social problems'. Decree 120/2002 (3rd May 2002) stated that issues surrounding drug demand and the National Institute for Drugs and Drug Addiction (IPDT) should be coordinated by the Ministry of Health (the IPDT was previously located in the Council of Ministers). Decree 16-A/2002 (31st of May 2002) stated that the IPDT and SPTT should merge into a new agency: The Instituto da Droga e da Toxicodependência (IDT). The IDT was then created through the Government Decree nº 269-A/2002

³⁹ Figure given in interview with IDT.

⁴⁰ <http://www.emcdda.europa.eu/html.cfm/index35987EN.html>; accessed 17 March 2008

(29th of November, 2002). The IDT, created in 2002, manages the 45 CAT centres which are located in every province of the country. A CAT centre team is made up of a minimum of one general practitioner or psychiatrist, a social worker, a social psychologist, an occupational therapist, and nurses. The largest of the CATs (addiction care center) provide methadone treatment (Vice Director, IDT). IDT is about treatment, prevention, harm reduction and reinsertion. It was reported that the number of CAT centres is adequate. However, better liaison with all health services is needed, especially due to infectious due to drug use (Vice Director, IDT).

The Action Plan, Horizonte 2004, underlines the need for harm reduction programmes to be available for all drug users in prison. These programmes are managed by the General Directorate of Prisons (Ministry of Justice) in close co-operation with the IDT and the Institute for Social Rehabilitation (Reitox Portugal 2002). The IDT's mission is to 'guarantee the intrinsic unity of the planning, conception, management, control and evaluation of the diverse phases of prevention, treatment and reinsertion in the domain of drugs and drug addiction, in the perspective of the best efficiency on the co-ordination and execution of the politics and strategies already defined' (Government Decree, nº269-A/2002, 29 November).

Because of the large number of individuals convicted for a drug-related crime (approximately 3,930, equal to 42% of the total prison population by the end of 2001), the Drug Use Decriminalisation Law (nº 30/2000 of 29 November)⁴¹ was implemented and Commissions for the Dissuasion of Drug Use (CDTs) were created. Many drug users are referred to and assessed by these Commissions (Reitox Portugal, 2002), with the result that some of them are sent for treatment or to therapeutic communities.

The national strategy⁴² states that substitution treatment should only be used as a last resource, when other treatments have not been successful or for the prevention of infectious diseases. It also states that substitution is not seen as a life-long treatment but rather as a means to find physical, psychological, social and family equilibrium and allow for further attempts to join drug free programmes. In 2002, 91% of the 4,835 decisions made by the 18 CDTs were suspensions, as the consumers were not considered drug dependents, 25% were acceptances for treatment; 6% involved punishments, 5% were repeated incidences. The majority of them involved males aged from 16-34 (IDT 2004). A protocol (Protocolo entre os Ministérios da Justiça e da Saúde, signed on 21 of March 1997) implements the liaison between the health system and the prison system in relation to substitution treatment. Doctors or psychologists of CAT go to the prison to deliver methadone or prisoners are taken to the CAT where they receive methadone and psychotherapy.

Substitution treatment in prison formed part of the political agenda; there were discussions on whether the number of prisoners on substitution treatment was appropriate or excessive, the type of treatment (pharmaceutical versus non-pharmaceutical treatment) to be provided and the

⁴¹ On the definition of the penal regime applicable to the consumption of drugs and psychotropic substances, and on the social and health protection of people that use those substances without medical prescription.

⁴² A resolution of the Council of Ministers of the National Assembly, approved in May 1999, and published in the Official Journal of 26 of May 1999: Resolução do Conselho de Ministros nº 46/99.

need for stricter criteria governing access to substitution treatment (Director Health Care Office and Deputy General Director, Directorate General of Prison Services, Ministry of Justice).

OST in the community

Methadone has been offered in Portugal since the late 1970s. It was first delivered in a CAT centre in Porto, where it was offered in a powder solution which is drinkable once it is mixed with water (GP, CAT centre and vice director, IDT). At the time, methadone was the only therapeutic response offered to drug users and was highly criticised by all clinicians (GP, CAT centre). In other locations, CAT centres started to offer methadone to tourists on methadone treatment. The centres then started to offer methadone to problematic Portuguese patients and, eventually, it was provided to a larger sample of patients, numbering around 1000 patients on methadone in 1995 (GP, CAT centre).

Since the outset of methadone provision, the Ministry of Health has retained total control, any hospital or prison wishing to provide methadone treatment must make a request to the Ministry of Health. The Ministry of Health developed a protocol with the 'Association of Pharmacies' where (i) methadone is to be administered in pharmacy under a CAT prescription (the patient goes directly to the pharmacy to get methadone, instead of going every day to the CAT centre), and (ii) the Association of Pharmacies has developed a syrup to mix, stabilise and guarantee the quality of the medicine (GP, CAT centre). At the outset, methadone was industrially produced by military laboratories whereas, today, it is bought through international tenders. The powder is then sent to the military laboratory where it is prepared. The military distributes the methadone throughout the country and in all CAT centres. This has increased the availability of methadone in the country. In 2002 around 13,000 patients in the Portuguese community were on methadone. The average dose is 60 mg; there is no maximum dose. The dose tends to be higher for patients on HIV/AIDS and/or tuberculosis treatments (GP, CAT centre).

Today, methadone and buprenorphine are used for substitution treatment. Only CATs can prescribe methadone whereas buprenorphine can be prescribed by private doctors and CATs. Usually, the patient's family or friends are involved in the treatment to 'ensure' the uptake. Each patient on methadone is tested weekly for heroin, cocaine and methadone. If tested positive 3 times for illegal drugs, he is expelled from the methadone programme (Social worker, CAT centre).

In 2001, 12,863 patients of the SPTT were in substitution treatment (this does not include patients who take the substance at home): 3,576 patients were newly admitted. The majority of clients on methadone received their treatment in a CAT. Health centres, pharmacies, NGOs and others also dispense methadone. Of those in treatment, 9,664 took methadone, 42 LAAM and 527 buprenorphine (Reitox Portugal 2002).

4.6.2.2 *Substitution treatment in prisons*

It was reported that substitution treatment first became available in prisons in Portugal around 1999. Because substitution treatment is provided in prison with the support of a CAT centre (either directly, the CAT directly provides the treatment, or indirectly through liaison and continuation of care), the provision of substitution treatment in prisons follows the guidelines and system of substitution treatment in the community. Usually, prisoners go to the CAT centre for the provision of methadone and to receive psychological support. A 7% increase was verified in the number of clients using methadone prescribed by CATs (463 clients on the 31st of December 2005 in comparison to the 431 on the 31st of December 2004), administered in the prison setting.

Prisoners who receive substitution treatment are (i) drug users who continue methadone treatment started before incarceration in a CAT centre; (ii) drug users going through withdrawal: in this case the prisoner is sent to a CAT centre for evaluation; if appropriate, the prisoner will start treatment; or (iii) drug users who started using while in prison and are motivated to stop using and have asked for support and substitution therapy. If accepted, the prisoner is sent to a CAT centre for evaluation (Vice Director, IDT).

Although methadone and buprenorphine are both available in prison, only methadone is free of charge. Prisoners who wish to receive buprenorphine need to pay for the treatment themselves. Often, it is the prisoner's family who pays for it (interviews with prisoners and professionals).

Substitution treatment takes place on a detoxification or maintenance basis. It can be initiated in prison but, largely, is a continuation of community treatment initiated prior to incarceration. Substitution treatment in prison varies widely from one prison to the other, depending on the CAT centre and/or prison doctors in charge of the treatment. It also varies for one prisoner to the other, as their personal path and individual needs are taken into consideration.

A GP reported that, although substitution treatment is allowed in all prisons, in practice it is not offered everywhere. Out of 59 prisons, approximately 33 prisons offer treatment. Another GP at a CAT centre stated: 'At the level of ideas and principles, discussions are progressive and positive towards health treatment in prisons. However, practically nothing happens or very little development has taken place. It was possible to offer treatments similar to those offered out of prison, but practically it never took place ... Prisons could be used as a therapeutic centre, but for this more psychologists and doctors, staff who are properly trained, are needed'.

Psychosocial support and staff training

Ideally, psychosocial support should be provided to patients in substitution treatment. However, there is an obvious shortage of psycho-social staff in prison, as is illustrated in the two examples that follow.

Staff working in CAT centres are specialised in drug issues. Training is on-going and several courses for CAT health staff (and other services like private Therapeutic Communities) have been organised. 'CAT centre staff are all specialised on drug issues. It is their personal choice

to work in this field. They have no specific university training but they get trained on the job; some do a specialisation in drugs after medical school' (Vice Director, IDT).

All prison guards receive 4 months training and are tested on health, infectious diseases and drugs issues. It is important that they have enough knowledge to be able to identify symptoms (Health Service Director, General Directorate of Prison Services).

4.6.2.3 Summing up

Methadone is the main substance provided in Portuguese prisons. The CAT centres are external centres, specialising in drug treatment, that play a key role in the provision of substitution treatment in and out of prisons all over the country.

The prison administration, the medical staff and prisoners stated that methadone has a lot of advantages such as improving the health and psychological state of prisoners as well as the prison environment. However, psychological support was reported as being largely insufficient, although the existing support was seen as excellent.

Only a few prisoners take buprenorphine; the treatment is expensive and must be personally paid for. Naltrexone was perceived as a 'substitution treatment' and seen as beneficial to those motivated to become drug free.

4.7 Slovenia

4.7.1 Number of drug users

The number of problem drug users in Slovenia is estimated to lie at 7,399 persons (5.3 per 100,000 adult population) in 2001⁴³, of which approximately 6,000 are intravenous drug users (Reitox Slovenia 2002).

4.7.2 Substitution Treatment

4.7.2.1 Historical and legal background

In Slovenia, the Ministry of Health is responsible for the planning and implementation of health care and substitution treatment. In 1994 there was a joint consensus meeting with representatives from communities, prisons, and police. On this consensus meeting it was first allowed to prescribe methadone in the community and in prisons. By that time there existed no official methadone centre. Opioid substitution programmes started in April 1995 with the first 9 centres

⁴³ <http://www.emcdda.europa.eu/html.cfm/index39634EN.html> (no recent figures are available)

in the community. From 1995 on, OST started in prisons with the aim to provide OST in all prisons.

The national guidelines for methadone treatment were adopted by the Health Council in 1994 and updated in 2000. They provide recommendations for the identification of drug use, diagnostic methods, harm reduction strategies, methadone maintenance programmes⁴⁴, and therapy offered in centres and hospitals. First established in 1995, there are now 18 regional Centres for the Prevention and Treatment of Drug Addictions and 2 out-patient clinics that offer substitution treatment among their services. The number of people seeking assistance has increased since the creation of these centres (Kastelic & Kostnapfel Rihtar 2003; Kastelic et al. 2008), that are closely connected to prisons.

In May 2004, buprenorphine was registered as Subutex® and was launched at the 2nd National Conference on Addiction, organised by the Sound of Reflection Foundation, in Slovenia, June 2004. Suboxone® was launched in June 2007 during the First World Conference on Medication Assisted Treatment in Ljubljana, Slovenia and in 2005, slow-released morphine was registered.

Methadone treatment in Slovenia is offered as:

- short-term detoxification (decrease of the dose within one month),
- long-term detoxification (decrease of the dose over more than one month),
- short-term maintenance (same dose prescribed for up to 6 months),
- long-term maintenance (same dose prescribed for over 6 months)(Kastelic and Kostnapfel Rihtar 2003).

‘A methadone maintenance programme is successful, when it includes the whole treatment and is supported by medicine, counselling and administration, when it takes into consideration the patient’s individual needs, assure enough stable and trained staff and considers appropriate methadone dosages.’ (Kastelic and Kostnapfel Rihtar 2003: 13-14).

Specialised professionals reported that substitution treatment in Slovenia is not a controversial issue anymore and is seen as a medical treatment. Generally, it is well accepted, although some professionals favour abstinence to substitution treatment. It was reported that the public opinion on methadone is divided; 50% see methadone as supporting the drugs users’ use, allowing them not to tackle their habit and personal issues. The other 50% see it as a medical treatment, although ‘detoxification’ from methadone may be problematic. Finally, a NGO reported that distribution of methadone doses for the weekend on Fridays is likely to generate a black market (Trautmann et al. 2007).

⁴⁴ The National Drug Policy includes methadone maintenance programme as a fundamental drug treatment and harm reduction programme.

In 2007, the number of drug users on substitution treatment was 2,957 (2,335 on methadone, 439 on buprenorphine and 214 on SR-morphine; Head of the Centre for Treatment of Drug Addiction, Slovenia).

4.7.2.2 *Substitution treatment in prisons*

'Hospitalisation and imprisonment are not reasons for dropping out of the methadone program.' (Kastelic and Kostnapfel Rihtar 2003, p.13). In 2006, the number of known drug users in prisons was 948 of the total prison population (out of 4,183 prisoners)⁴⁵. 53,7% of them (509⁴⁶) were receiving substitution treatment and that was 33,2% more than in 2005. The number of patients in prison-based OST comprises one fifth of the total number of patients in OST in Slovenia⁴⁷.

Methadone is the substitution treatment substance offered in all the prisons. It has been available since 1995 and is prescribed by specialist doctors from the Network of Centres for the Prevention and Treatment of Drug Addiction. In 1998 a law on prevention, drug treatment, was launched and methadone was registered only in 2000 for the purpose of substitution treatment. Before that, OST was based on a consensus of the Ministries of Justice, Interior, Health, and Social Affairs (Kastelic 2007).

Buprenorphine has been integrated in Slovenian programmes very recently (2004) and is not yet offered in all prisons, although the National Prison Administration and the National Treatment Centre reported that it was only a matter of time before prisoners are prescribed buprenorphine. Substitution treatment is provided according to "Eurometwork" Methadone guidelines and Slovene Methadone guidelines.

Prisoners either continue maintenance treatment they received prior to incarceration or initiate treatment in prison. In a recent development opiate using prisoners who have not been in treatment were motivated again to start substitution treatment before being released. Patients on this treatment have regular urine and saliva tests. When transferred to another prison or released, prisoners on substitution treatment can continue their treatment according to the doctor's advice. As part of the public health network, all prisons are closely connected to the Centres for Prevention and Treatment of Drug Addiction. Continuous coordination and cooperation take place between prison staff and community health professionals.

A patient must fulfil certain conditions⁴⁸ to be included in a methadone program. The whole team of experts in community treatment centres (such a team exists within each prison), which

⁴⁵ Statistics provided by the National Prison Administration.

⁴⁶ <http://www.mp.gov.si/fileadmin/mp.gov.si/pageuploads/2005/PDF/uiks/LP2006.pdf>

⁴⁷ <http://www.emcdda.europa.eu/html.cfm/index35999EN.html>

⁴⁸ Conditions are: having a repetitive use of opiates, physical dependence to opiates, previous detoxification attempts, the willingness for methadone treatment, agreed and signed consent for methadone treatment, minimum age of 16, health insurance (the Government pays for all Slovene citizens and all prisoners have the right to health insurance like any citizen), a family doctor and residence in the same region as where the Centre is located. Although prisoners used to be insured, due to a contract between the Ministry of Justice and the National Health Insurance Company, currently the Ministry of Justice covers all health services costs for prisoners directly. A negotiation is currently

includes a psychiatrist, nurse, social worker, psychologist and therapist from the prison, must agree to the treatment (Kastelic and Kostnapfel Rihtar 2003).

Substitution treatment in prison is financed by The Prison Administration. In 2002, the costs for methadone treatment (only for the medication methadone) in prison amounted to 15,000€ approximately (Government Office for Drugs).

In Slovenia, it has been made clear that the rights of prisoners now are the same as of prisoners that choose a drug free way, unlike before when some prisoners in OST did not get the same privileges as regards education, work, home-leaves etc.

Psychosocial support and staff training

A range of psycho-social treatments should be offered to patients in opioid substitution treatment (Kastelic and Kostnapfel Rihtar 2003). Although medical staff is trained in OST through the Centres for the Prevention and Treatment of Drug Addiction, not all prison staff does receive specific training. Nevertheless, several workshops and information trainings were organised with prisoners and staff, such as workshops with prisoners on harm reduction, training for prison staff on addiction treatment in prison and workshops on methadone maintenance programmes. Moreover, international conferences in Slovenia, including work with prisoners, were organised by the Sound of Reflection Foundation: Heroin Addiction in Europe (1997), International Society of Addiction Medicine and WHO Symposium on Substitution Treatment (2000), International Harm Reduction Conference (2002), Adriatic Conference (2003), two national conferences on addiction (1999 and 2004), ENDDIP Conference in 2006 and The First World Conference on Medication Assisted Treatment in 2007.

Table 3 gives an overview of the number of persons in OST in Slovenian jails (penal institutions at regional/local level) and prisons (penal institutions at national level).

Table 3: Number of persons in OST in prisons in Slovenia

	2000	2001	2002	2003	2004	2005	2006
jail	49	121	88	142	142	180	242
prison	123	226	134	192	238	202	267
all	172	347	222	334	380	382	509

4.7.2.3 Summing up

Detoxification, maintenance and slow reduction of OST are all offered in Slovenian prisons without limitations in time. Decisions of the prison drug team are often discussed and decided together with the team from the community treatment center. Members of the teams are nurses,

taking place to have all health services for prisoners covered by the National Health Insurance, as applies to all citizens.

medical doctors, psychiatrist (GP/psychiatrist is often the same as the one in community treatment center), and each prison also has some therapists and social pedagogues.

At present, half of the known heroin addicts in prisons are in OST programmes, either methadone or buprenorphine (Subutex® or Suboxone®). The other half doesn't want to be in an OST programme. Not because of restrictions feared, but because they prefer a different treatment option such as drug free units in some of the prisons or they want continue to use drugs.

Slow release morphine is not being used in prisons, because it is complicated to control during intake and to be measured in urine tests.

So far, substitution treatment has been a successful harm reduction and public health intervention in Slovenia, offered with the cooperation and supervision of the Centre for Treatment of Drug Addiction even if there is a lack of good trained staff.

4.8 Spain

4.8.1 Number of drug users

As regards drug use in Spain, cannabis is the most frequently used psychoactive substance in Spain. Intravenous heroine use and opiate use have decreased and significant increases in cocaine-related problems have occurred in the last ten years. Furthermore, there has been an increase of the use of ecstasy and amphetamines for recreational use. Drug users are mainly poly-drug users, with a general tendency to mix alcohol, tobacco and cannabis with other substances (Reitox Spain 2002).

In 2002, from a total of 40,278 admissions to treatment for psychoactive substances, 58,2% were for heroin and 25.5% for cocaine (Observatorio Español sobre Drogas 2007). 'Those reported in 2001 for consuming or holding drugs in accordance with the Organic Law 1/1992, of February 21, for the protection of the civic security were 122,634.' (Observatorio Español sobre Drogas 2007).

4.8.2 Substitution treatment

In Spain, 90,488 persons were treated with methadone in 2002, 88,700 in 2003 and 86,017 in 2004 and 83,469 in 2005⁴⁹.

⁴⁹ National Plan on Drugs, Spain <http://www.pnsd.msc.es/Categoria2/publica/pdf/memo2003.pdf>; see EMCDDA: <http://www.emcdda.europa.eu/html.cfm/index35915EN.html> (accessed 18 March 2008)

4.8.2.1 *Historical and legal background*

The right for all citizens to have access to enjoy health protection and care is laid down in the Spanish Constitution of 1978. The General Health Act 14/1986, established the National Health System. Financed with public funds, it aims to provide universal coverage of and to ensure equal access to health services. The implementation of substitution treatment in Spain emerged slowly. In 1985, legal restrictions to opiate substitution programmes, that existed since two years, were introduced to control the possible diversion to black market. Since the second half of the 80s, HIV/AIDS was the major health problem associated with the use of drugs in Spain. Substitution treatment was finally regulated in the Royal Decree 75/1990, of 19th of January, amended by the Royal Decree of 5/1996, of 15th of January, as a reaction to the HIV/AIDS epidemic.

Spain made a substantial effort mobilising, organising and co-ordinating harm reduction interventions, although those were developed too late to prevent a major HIV epidemic. A rapid expansion of syringe distribution, methadone substitution treatment and outreach work took place in a short time. The development of the number of persons in methadone was remarkable, from ca. 9,000 in 1992 to over 80,000 only six years later. The number of units providing substitution treatment nearly doubled from 2003 to 2005 (from 1,170 to 2,229)

Methadone is the main substance used in substitution treatment. Buprenorphine was introduced in Spain in 2002 – first to be tested in Madrid – for ‘drug users who cannot take methadone’. It plays a minor role in Spain (from the 83,469 patients in OST in 2005 the majority received methadone: 83,374).⁵⁰

4.8.2.2 *Substitution treatment in prison*

The Spanish Constitution of the 6th of December 1978, underlines the equivalence of health care between the community and the prison. The General Health Act 14/1986, further states prisoners’ rights to access health services similar to those offered in the community.

Instruction 5/95 from the General Directorate of Prison Services on the global drugs policy, stated that within the framework established by the National Drugs Plan (Plan Nacional sobre Drogas), in coordination with other sectors of public administration or other organisations and institutions, such as the Municipal and Regional Drugs Plans (Planes Autonómicos y Municipales sobre Drogas) and Non-Governmental Organisations and Entities, prisons will run specialised drug dependence programmes for prisoners who voluntarily request them, consisting of prevention, harm and risk reduction, methadone treatment, breaking the cycle of drug dependency and social reintegration.

The Ministry of Interior (Directorate General of Prison Services) is currently responsible for providing medical care to prisoners, although according to Act 16/2003 on Cohesion and Quality in

⁵⁰ See EMCDDA: <http://www.emcdda.europa.eu/html.cfm/index35915EN.html> (accessed 18 March 2008)

the National Health System, this responsibility is being transferred to the regional health services. All prisons in Spain offer initiation of methadone, methadone maintenance treatment, and detoxification with methadone. Brief and progressive detoxification may also be offered with opiates and benzodiazepines.

Substitution treatment in prison has been developed as part of the harm reduction strategy since 1992, and was extended to all prisons in 1998. The number of prisoners in OST went from 2,000 in 1995 up to 20,000 in 2000 (General Directorate of Prison Services Spain, 2005). Opioid substitution treatment has proven to be highly efficient and effective in preventing HIV infections (Reitox Spain 2002). It is reported that 10% of prisoners are infected with HIV and 33% with hepatitis C (Marco 2007).

The only inclusion criterion into the programme is the confirmed diagnosis of opioid-dependence. The prisoner receives information about the particularities of the treatment, its risks and consequences.

Methadone is offered as a maintenance treatment or a detoxification treatment.

These two types of treatment are not exclusive. A prisoner may go from one to the other, according to the bio-psychosocial situation of the drug user. To reach efficacy, the bio-psychosocial focus needs to be part of a drug user's treatment. Methadone programmes must include health interventions, psychosocial interventions (with group and individual therapeutic sessions) and throughcare (or preparation for release and rehabilitation) (Ministerio del Interior 2001).

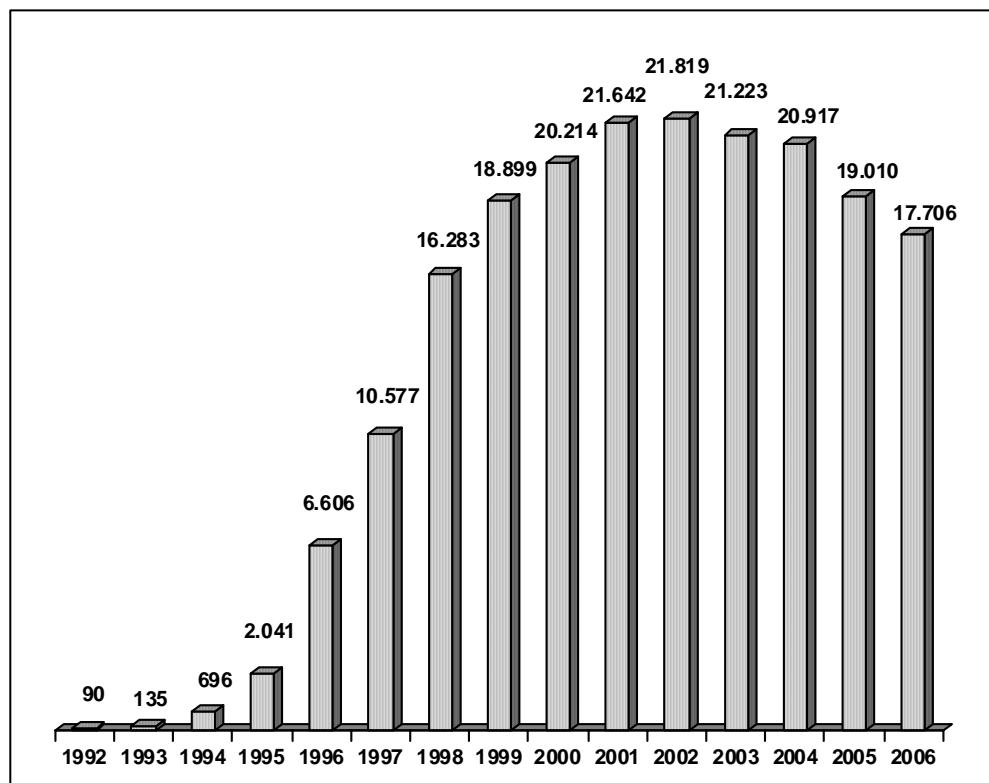
The Ministerio del Interior (2001) reported that methadone treatment is the most effective intervention for drug using prisoners. Moreover, it facilitates the reduction of general drug use, reduces the intravenous use of drugs, improves physical and mental health, as well as hygiene and health habits. It reduces antisocial activities, delinquent activities and recidivism. Quality of life and social integration are generally improved. The Ministerio del Interior (2001) stated that in order to reach all these advantages and benefits, methadone treatment cannot be limited to the sole prescription and distribution of the substance. Methadone must be delivered within a global therapeutic approach, taking into account individual differences and needs, and including psychological and social interventions. Methadone treatment includes psychosocial activities and preparation for release (and continuation of treatment on release in a community centre) and is thus a rehabilitation treatment.

Detoxification treatment with methadone is offered to drug-using prisoners who wish to abstain from drugs in accordance with their health, personal, social, penal and penitentiary conditions (Ministerio del Interior 2001). On the 31st of December, 2001, 7,531 prisoners (around 7% of total prison population) went through detoxification programme, and 21,642 (around 21%) went through methadone treatment (maintenance) (Ministerio del Interior 2001). The Ministry of Interior (2001) stated that the variety of treatment options and the plurality of therapeutic strategies are determining criteria for the successful treatment of drug users. This diversity also increases

the number of drug-using prisoners consulting and engaging in treatment in prison. It has been reported that methadone treatment is delivered differently from one prison to another. In 1999, as of 31st December, of the 6,589 prisoners on methadone treatment, 19% were on a dose less than 40 mg per day, 47% on a dose between 40 and 80 mg, and 34% on a dose higher than 80 mg per day. (Sanz Sanz 2000)

In Spanish prisons, during 2005, 19,010⁵¹ prisoners of 69 prisons (with a prisoner population of 75,415 persons in June 2007) were in methadone treatment⁵².

Chart 3: Prisoners in methadone treatment during one year (source: Dirección General de Instituciones Penitenciarias. España⁵³)

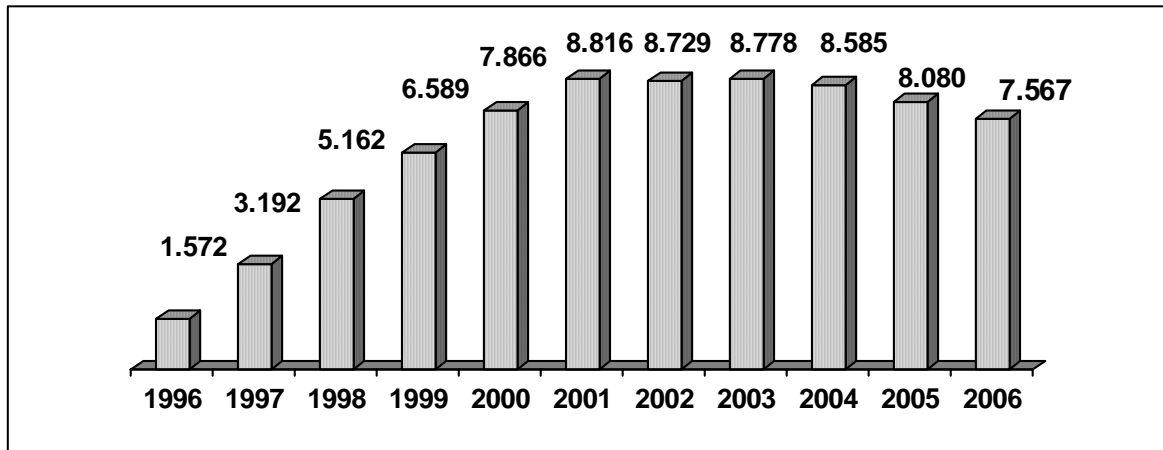


⁵¹ This number does not include prisons in the Catalan region

⁵² General Directorate of Prison Services (2007): <http://www.legislationline.org/?jid=47&less=false&tid=160>; accessed 19 March 2008

⁵³ <http://www.mir.es/INSTPEN/>; accessed 17 February 2008

Chart 4: Daily Number of prisoners in methadone treatment on the 31st December of each year (source: Dirección General de Instituciones Penitenciarias. España⁵⁴)



4.8.2.3 *Summing Up*

Methadone is provided in all the prisons of Spain, and is the only substance offered as maintenance treatment for drug-using prisoners. Like in most countries, there was reluctance at first to provide methadone treatment in prisons, although it was implemented as a ministerial health measure. The reluctance was due to the status of the medicine and the implication of providing the treatment in prison.

Psycho-social support is seen as an important factor for the success of treatment, although in practice psycho-social support offers seem to be insufficient.

4.9 Summary

The numbers of prisoners in OST is rising in nearly every country. This has to be seen in the light of three developments: (i) increasing prisoner population in many countries and subsequently higher proportion of drug users, and (ii) higher proportion of patients in OST in the community in most of the European countries, and (iii) growing acceptance of OST by medical professionals, politicians and key stakeholders. Table 1 shows that the coverage rate of prisoners in OST among the (mostly estimated) number of PDUs in prisons varies significantly within the 7 countries studied: 2% Germany, 12% in Italy, 9-21% in Portugal, 17-34% in Austria, 47% in England & Wales, 54% in Slovenia and 82% in Spain. These developments are also reflected in the proportion of OST in prison among all OST in the countries: 0,7% in Germany, 2% in Italy, 3,5% in Portugal, 10% in Austria, 10,4% in England & Wales, 20% in Slovenia and even 22% in Spain. This means that a considerable part of all the OST in some countries is delivered in the

⁵⁴ <http://www.mir.es/INSTPEN/>; accessed 17 February 2008

prison setting (one fifth in Slovenia and Spain). This indicates that especially England & Wales, Austria and Portugal have massively responded to the opioid dependence problems in prisons that major changes in the reduction of risk behaviour and management can be expected. To a certain extent positive results could already be shown at the example for Spain that showed a drastic reduction of HIV prevalence in the last ten years (Marco 2007). Clear policies, unifying guidelines and protocols are needed to improve coverage rates of OST apart from help through political leadership and professional commitment.

5. Reduction of drug related crime in prison: An evaluation of the impact of opioid substitution treatment on the management of opioid dependent prisoners

5.1 Methods

5.1.1 Sampling

The survey on reduction of drug related crime in prison was conducted in seven European countries (Austria, England, Germany, Italy, Portugal, Slovenia and Spain). The partner from Switzerland took part in the meeting in Bonn in 2006 and subsequently applied for authorization of the study at the national ethical committee which failed. In the summer of 2007, WIAD recruited a new Swiss partner, but the time for a new application for authorization was too short and Switzerland could not be included into the study.

The coverage rate of OST in prison not only differs from country to country but even within a nation a great variety was found as concerns the rate of prisoners in OST. For example in Germany, the biggest federal state North Rhine-Westphalia showed a comparably low rate of prisoners in OST. In some prisons there were not more than 1 or 2 prisoners who undergo such treatment and daily doses were not given for more than thirty days whereas in Bremen the number of prisoners in OST was much higher and doses were given for a longer period of time.

As the number of prisoners in opioid substitution treatment in all countries is relatively low, a comprehensive survey instead of a sampling was conducted in selected prison institutions that offered maintenance substitution treatment. The inclusion of different prisons in different European countries with their variety of circumstances and conditions concerning the organisation of opioid substitution treatment accounts for the validity of empirical findings which transcend national particularities.

Prisoners included into the study were: in OST at the time of the survey, male, 18 years and older, were in closed units, and either sentenced or on remand. Since the data collection instruments only existed in the respective native language and English, only prisoners who were able to speak one of these two languages were included⁵⁵. A certain part of the prisoners to be included also had experience with OST in the outside community. All in total, it was planned to include about 50 prisoners in each country into the study⁵⁶.

⁵⁵ Therefore, migration and the rate of migrants in prison were not systematically taken into account in this study. In Portugal most prisoners were not born in the country (which reflects an important cultural variable) and did not easily respond to questionnaires because of language barriers (note by Joana Almeida/Luís Mendão, experts for Portugal).

⁵⁶ Due to problems in getting access to prisons in England and Italy, the number of participating prisoners lies under the above mentioned.

Prison staff that was included into the study had experienced working in prison without and with OST (either in the actual or in another prison). It was planned to have about 25 to 30 staff members in each country taking part in the study.

Tables 4 and 5 give an overview of the distribution of study participants in the different penal institutions. A more detailed table can be found in the Annex (Table 23).

Table 4: Study participants – prisoners

Country	Prison name	Number of prisoners in OST	Number of participants
Austria (n=54)	JA Favoriten	100	18
	JA Josefstadt	130	21
	JA Simmering	36	15
Germany (n=55)	JVA Bielefeld-Brackwede I	7	2
	JVA Bremen	80	47
	JVA Rheinbach	12	6
England (n=8)	HMP Leeds	140	8
Italy (n=15)	Casa Circondariale San Vittore	80	12
	Casa di reclusione Milano Bollate	80	3
Portugal (n=56)	EP Linho	6	6
	EP Porto	129	35
	EP Sintra	35	15
Slovenia (n=38)	ZPMZKZ Celje	12	10
	ZPKZ Dob	44	10
	ZPKZ Ljubljana	52	8
	ZPKZ Maribor	17	10
Spain (n=49)	CP d'Homes de Barcelona	300	19
	CP Quatre Camins	285	30
Total			275

Source: AGIS-Survey Staff

WIAD 2007

Table 5: Study participants - staff

Country	Prison name	Number of staff	Number of participants
Austria (n=23)	JA Favoriten	80	8
	JA Josefstadt	550	6
	JA Simmering	182	9
Germany (n=42)	JVA Bielefeld-Brackwede I	331	4
	JVA Bremen	350	36
	JVA Rheinbach	250	2
England (n=17)	HMP Leeds	450	17
Italy (n=19)	Casa Circondariale San Vittore	1800	12
	Casa di reclusione Milano Bollate	300	7
Portugal (n=30)	EP Linho	159	8
	EP Porto	297	15
	EP Sintra	224	7
Slovenia (n=21)	ZPMZK Celje	88	5
	ZPKZ Dob	207	6
	ZPKZ Ljubljana	134	3
	ZPKZ Maribor	118	7
Spain (n=32)	CP d'Homes de Barcelona	540	14
	CP Quatre Camins	810	18
Total			184

Source: AGIS-Survey Staff

WIAD 2007

5.1.2 Field work

Field work in the participating European countries was carried out by the respective project partners. From June to August 2007, the questionnaires were distributed in the prisons and filled out by prisoners and prison staff⁵⁷. Prison authorities were informed beforehand by a short information letter about the aims, objectives and the proceeding of the survey. Participating prison staff and inmates were briefed on the surveillance day about its content and aims.

Conducting research studies in prisons is a sensitive task, especially when questionnaires contain questions about 'disciplinary behaviour' such as illicit drug use and violence. The occurrence of both behaviours is in many prisons neither officially recognized nor is it acknowledged as problematical. While dealing with such sensitive subjects, it is important for the research to be underpinned by clear ethical guidelines for the protection of both the research subjects and the researcher. This research followed the ethical guidelines provided by the British Sociological Association⁵⁸.

Prisoners and prison staff were thoroughly informed before filling out the questionnaires that the study was totally anonymous and were guaranteed that the results could not be traced back to individual persons. All participants of the survey were informed that they could return blank questionnaires and could skip any questions they did not want to answer. Participants envel-

⁵⁷ In Portugal questionnaires were not given to fill out – participants were interviewed because illiteracy was very high (note by Joana Almeida/Luís Mendão, experts for Portugal).

⁵⁸ See: www.britsoc.co.uk/equality/63.htm

oped the filled questionnaires and put them in a box for collection. Additionally, staff members who were not able to fill out the questionnaires by the time of the survey were able to send the filled questionnaires at a later stage to the respective partner institution.

5.1.3 Data collection instruments

The main research tools were two anonymous standardised questionnaires - one for prisoners who currently undergo opioid substitution treatment and one for prison staff. A third short information sheet, which had to be filled out by the interviewers, gave background information on the individual prisons.

Questionnaires were designed by WIAD and BISDRO based on their long-standing experience in prison surveys as for example during the ENDIPP project. WIAD and BISDRO provided the questionnaires in English and German language. In all non-English and non-German speaking countries, the project partners were responsible for the translation of the research tools. The questionnaires mainly consisted of closed questions.

The prisoner questionnaire contained questions on

- socio-demography
- drug history
- opioid substitution treatment in the outside community and in prison
- changes in drug-related issues and violence
- changes in behaviour, motivation and abilities

The prison staff questionnaire contained questions on

- socio-demography
- experience with opioid substitution treatment in prison
- changes in drug-related issues and violence
- changes in prisoners' behaviour, motivation and abilities
- possible information demand on substitution treatment
- job satisfaction.

The English versions of the questionnaires are attached in the Annex.

The questionnaires were collected by WIAD and BISDRO and a dataset was created that was tested for plausibility, adjusted and analysed using SPSS. For the analysis, frequencies, means and cross tabulations were calculated.

5.1.4 Institutional background of the participants

Prisoners and staff were interviewed in the same prisons with comparable quantitative relations of the samples. Therefore, the institutional background of their perspectives and experiences,

i.e. the prisons and the organisation of OST they are talking about, are very similar. Table 6 gives an overview.

Table 6: General characters of prisons and opioid substitution treatment

Variable	Percentage	
	Staff	Prisoners
General characters of the prison		
Open institution	-	-
Open and closed units	79,3	86,9
Closed institution	20,7	13,1
Female prisoners	-	-
Male prisoners	57,6	56,4
Both	42,4	43,6
Adolescent/ juvenile prisoners	3,8	5,5
Adult Prisoners	59,8	48,4
Both	36,4	46,2
Public institution	100,0	100,0
Private institution	-	-
Public/ private	-	-
Characters of substitution treatment		
OST organisation by...		
the prisons' medical department	76,1	89,5
an outside organisation	14,7	7,6
both	9,2	2,9
Psychosocial support by staff of the prison (yes)	98,8	97,7
Psychosocial support by an outside organisation (yes)	47,9	42,7
Separate unit for prisoners in substitution treatment (yes)	17,9	12,4

Source: AGIS-Survey Staff/ Prisoners

WIAD 2007

The background for overwhelming majorities of staff as well as prisoners are prisons with open as well as closed units. Only small groups represent closed institutions. More than half of the participants speak about prisons for male inmates, the rest about prisons for male and female prisoners. Again around half of the staff and the prisoners work or stay respectively in prisons for adults, very small groups in prisons for adolescent or juvenile prisoners and the rest in mixed prisons. All participants are staff/prisoners of public institutions. Once more, overwhelming majorities of staff and prisoners have a background of prisons where opioid substitution treatment is organised by the prison's medical department and only small groups by organisations from outside or both. Almost all participants speak with the experience of psychosocial support provided by the prison's staff while somewhat less than half of them have a perspective with psychosocial support provided by an outside organisation. Finally, only small groups of staff and prisoners represent institutions with separate units for prisoners in OST (for further information see table 23 in the Annex).

5.2 Results for prison staff

5.2.1 Study population

In order to get information on the socio-demography of the study population, prison staff was asked for **sex**, **age** and **education**.

The distribution of men and women in the study sample is almost equal. With 54,4%, male staff members are slightly overrepresented. Included staff is between 21 and 64 years old, the medium age is 41.7 years. The distribution of age groups is shown in table 7.

Table 7: Sex and age groups (staff)

Variable	Percentage
Sex (n=182)	
Male	54,4
Female	45,6
Age groups (n=181)	
21-30 years	13,8
31-40 years	31,5
41-50 years	39,8
More than 50 years	14,9

Source: AGIS-Survey Staff

WIAD 2007

Included staff has high **educational levels** as regards their performed tasks in prison. 36,1% of all staff indicate to be trained respectively skilled. The high number of college and university degrees (45,9%) can mainly be explained by the fact that a high number of professions that require good educational levels are included into the study. 67% of the included medical staff and 77% of the social workers and psychologists have a college or university degree. About one third of included staff members are wardens, almost one third are medical staff (nursing staff [21,9%] and physicians [8,2%]), psychologists and social workers together amount to about 20%, 15,8% of the staff falls under the category 'other'.

Table 8: Education (staff)

Variable	Percentage
Current educational level regarding the performed task in prison (n= 183)	
Unskilled	1,1
Semiskilled	7,7
Trained/skilled	36,1
College/university degree	45,9
Other	9,3
Current professional rank (n=183)	
Administrative official	1,6
Warden	33,9
Psychologist	11,5
Social worker	7,1
Nursing staff	21,9
Physician	8,2
Other	15,8

Source: AGIS-Survey Staff

WIAD 2007

5.2.2 Work experience with opioid substitution treatment in prison

Regarding the **work experience with substitution treatment in prison**, the mean working time in prisons (in the current or other prisons) since the implementation of OST is 8,5 years. One third of all staff has worked up to 4 years with OST in prisons, about one quarter between 4 and 8 years, one third from 8 to 15 years and 14,2% more than 15 years. About half of the included staff never worked in prisons where OST was not offered. The mean time working without OST is 4,3 years. The mean time working in the *current* prison since the implementation of substitution is 7,5 years. Its distribution resembles the distribution of the time working in prisons since the implementation of OST.

Table 9: Work experience with opioid substitution treatment in prison (staff)

Variable	Percentage
Time working in prisons with OST (n=176)	
Up to 4 years	30,1
>4 to 8 years	24,4
>8 to 15 years	31,3
>15 years	14,2
Time working in prisons without OST (n=179)	
Never	50,8
0 to 6 years	17,9
>6 to 12 years	20,1
>12 years	11,2
Time working in current prison with OST (n=173)	
Up to 4 years	36,4
>4 to 8 years	25,4
>8 to 13 years	30,1
>13 years	8,1

Source: AGIS-Survey Staff

WIAD 2007

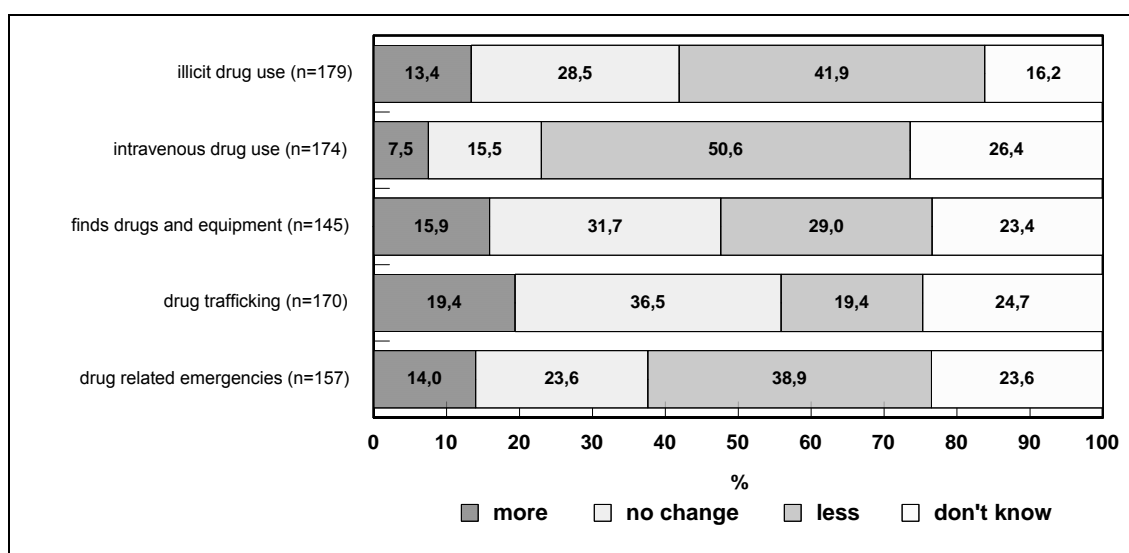
5.2.3 Manageability and control of prisoners

Participating staff was asked to assess effects and results of the implementation of opioid substitution treatment on the manageability and control of prisoners. In detail, questions were divided in **drug related issues**, **violence**, prisoners' **health status** and prisoners' **motivation, abilities** and **integration**.

As regards changes in **drug related issues**, most of the asked indicators are assessed to have positively changed. The answer category 'don't know' is chosen disproportionately often. 41,9% of the staff indicate that since the implementation of OST there is less illicit drug use in the prison, 13,4% indicate a rise in this issue. An obvious positive result was found as regards intravenous drug use: about half of the interviewed staff sees a decline in intravenous drug use – only 7,5% indicate that there is more intravenous drug use. As regards finds of drugs and equipment, the number of staff that indicates no change and that assesses it to be less both lie at around 30%. Drug trafficking is assessed by only around 20% of the staff to have declined, almost the same number assesses drug trafficking to have increased, but the majority (37%) does not see a change in this issue. Almost 40% of the interviewed staff indicate a decline in drug related emergencies, 23,6% see no change as regards this issue and 14% indicate a rise.

The fact that some staff indicates an increase in the above mentioned issues despite the introduction of OST could be explained by the fact that the implementation of OST reduced all these factors and especially intravenous drug use but at the same time the general drug consumption sharply increased in the recent years what could have neutralised these positive changes to a certain point.

Chart 5: Changes in drug related issues (staff)



Source: AGIS-Survey Staff

WIAD 2007

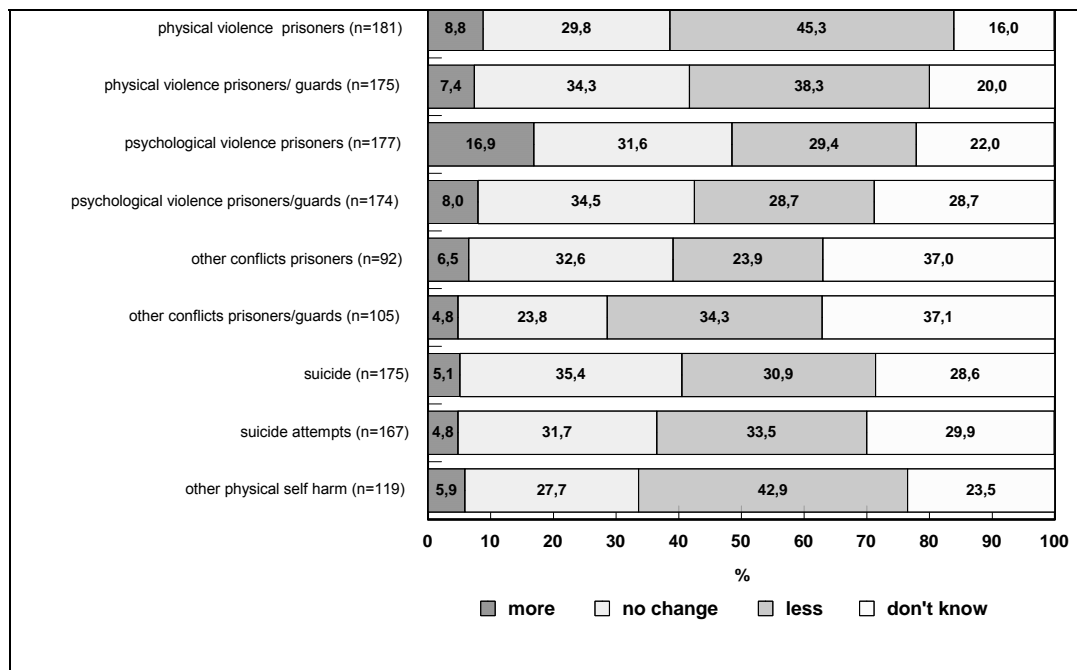
A crucial benefit from the introduction of opioid substitution treatment is the reduction of **violence** in prison.

Many of the indicators measuring violence are assessed to have positively changed. Analogically to the questions regarding changes in drug related issues, the answer category 'don't know' is again indicated disproportionately often.

Regarding changes in physical violence since the implementation of OST in prison, the majority (45,3%) of the interviewed staff indicates a decline among prisoners, 29,8% see no change and 8,8% assess physical violence to have increased. The majority of the participating staff also indicates that the physical violence among prisoners and guards has positively changed (38,3%), about one third indicates that there is no change and 7,4% see a rise in the physical violence between prisoners and guards. Positive changes in psychological violence are indicated less often. Around 29% of the staff assess psychological violence among prisoners and between prisoners and guards to have declined. About one third indicates no change in these issues. As regards other conflicts among prisoners almost one quarter of the participants indicates a decrease, almost one third of the staff does not see a change in this issue. Other conflicts are assessed by over one third of the participants to have decreased, a quarter does not see a change regarding this issue.

As regards suicide and suicide attempts, about one third of the staff indicates a positive change, i.e. a decline in these issues. Changes in the frequency of suicide are assessed by 35,4% to be the same, for suicide attempts it is 31,7%. Other physical self harm is assessed by 42,9% of the staff to have declined.

Chart 6: Changes in violence (staff)



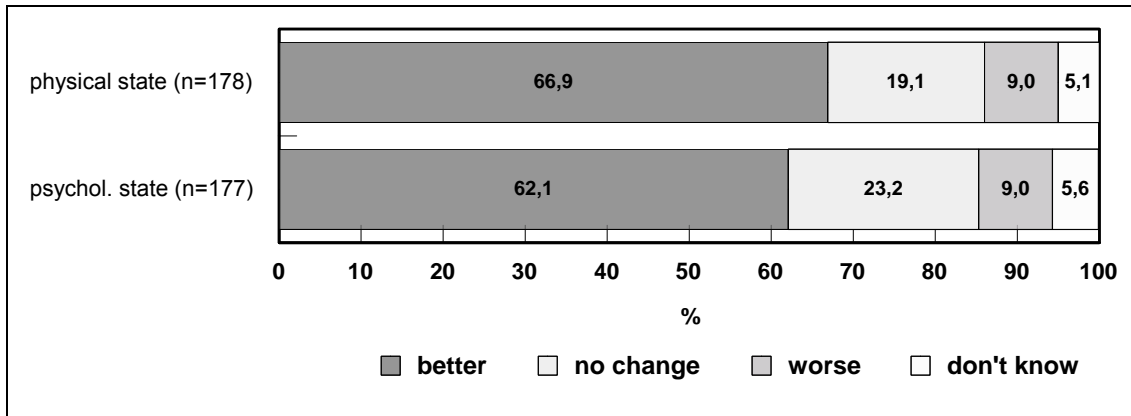
Source: AGIS-Survey Staff

WIAD 2007

Another benefit from OST in prison mentioned in the literature is the improvement of the prisoners' **health status**. When asked for changes in the health status of prisoners in treatment, the

majority of the interviewed staff indicates an obvious positive change in the prisoners' physical and psychological state. 67% indicate an improvement in the physical and 62% in the psychological health.

Chart 7: Changes in health status (staff)

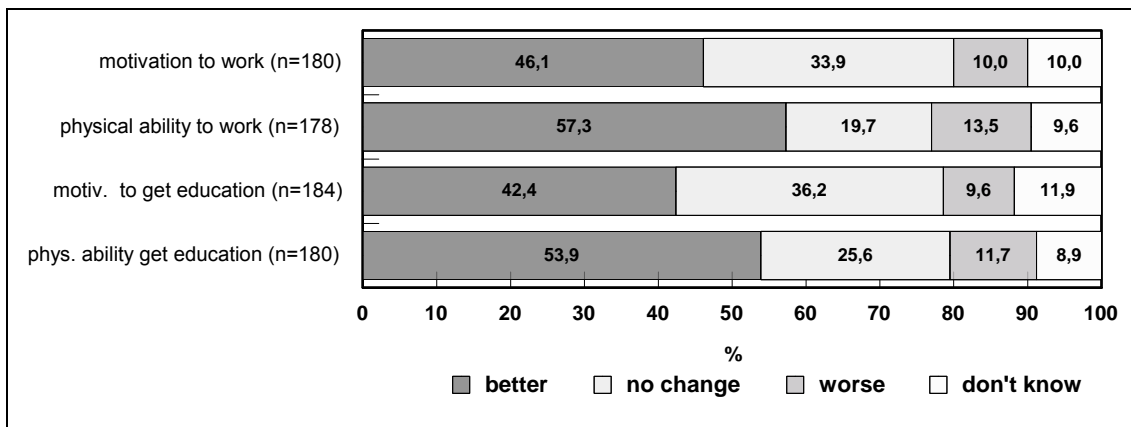


Source: AGIS-Survey Staff

WIAD 2007

Motivation and **abilities** also are assessed to have been positively influenced by OST. 46,1% of the staff see a rise in the motivation to work and 42,2% in the motivation to get education. The physical abilities to work and get education was assessed even higher: 57,3 respectively 53,9% of the staff indicate an increase in these issues.

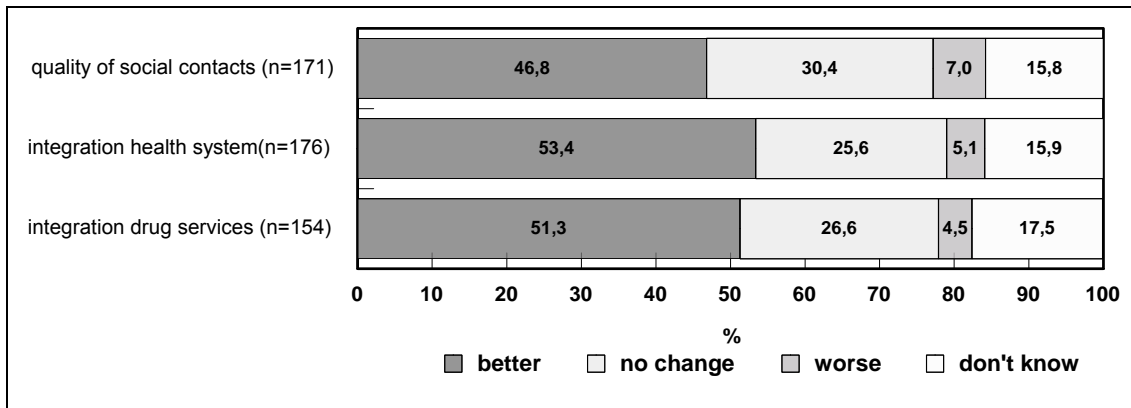
Chart 8: Changes in prisoners' behaviour, motivation and abilities (staff)



Source: AGIS-Survey Staff

WIAD 2007

Subsequently, staff was asked to indicate the extent of changes in the prisoners' social contacts and **integration**. 46,8% of the staff assess the quality of social contacts of prisoners in OST to have changed for the better. Prisoners in OST are assessed to be better integrated into the general health system (53,4%) as well as into the drug services in prison (51,3%).

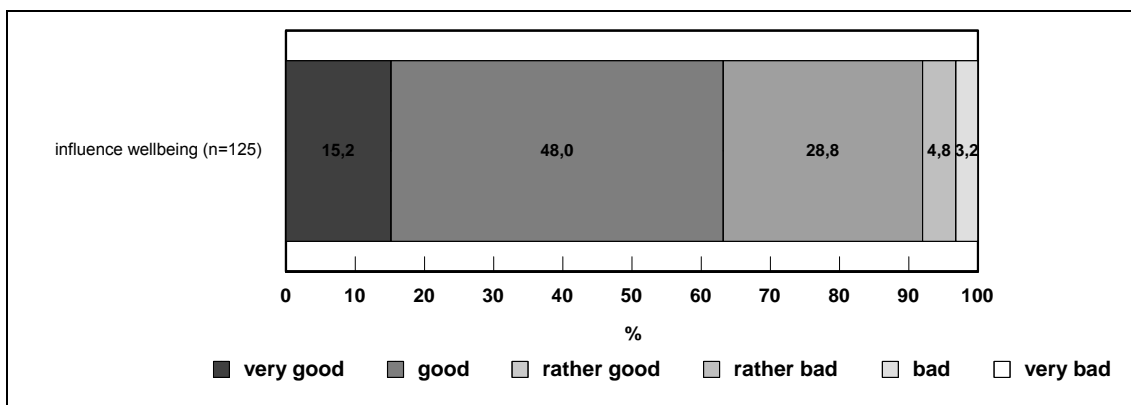
Chart 9: Changes in integration (staff)

Source: AGIS-Survey Staff

WIAD 2007

5.2.4 Psycho-social support and home leaves

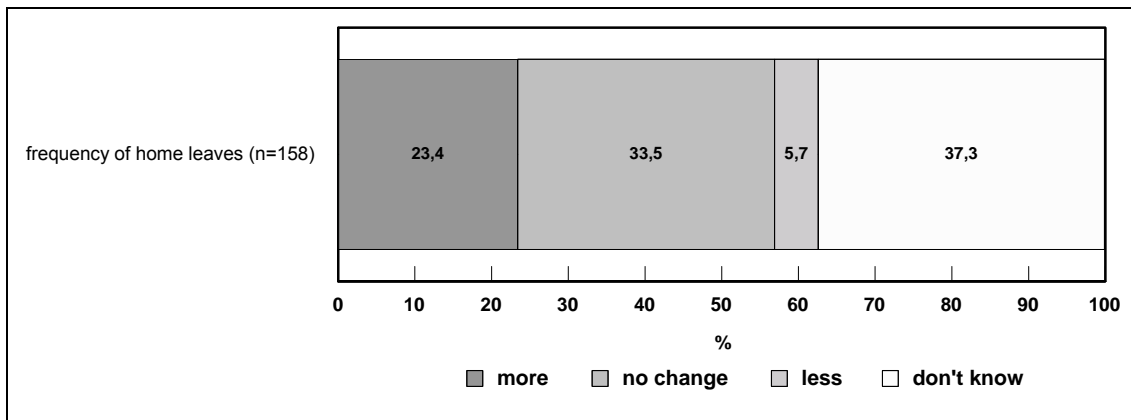
Psychological and **social support** is assessed to be an important factor for the success of opioid substitution treatment. 78,8% of the interviewed staff indicate that prisoners in OST get psychological and/or social support, accordingly 21,2% indicate that there was no such support offered. For the next question a filter was set and only participants who gave a positive answer to the question on the availability of psycho-social support for prisoners in opioid substitution treatment were analysed. Of the 130 remaining participants, 125 gave a valid answer on the assessment of the influence of psycho-social treatment: 63,2% indicate that psycho-social support for prisoners in substitution treatment has a good or very good influence on the prisoners' wellbeing, only 8% assess it to be rather bad or bad and none of the included staff assesses it to be very bad.

Chart 10: Psycho-social support (staff)

Source: AGIS-Survey Staff

WIAD 2007

When staff was asked about the changes in the frequency of **home leaves** of prisoners who started substitution treatment, a high number (37,3%) chose the category 'don't know'. Of the remaining staff 23,4% indicate a rise, 33,5% no change and 5,7% a decline in this issue.

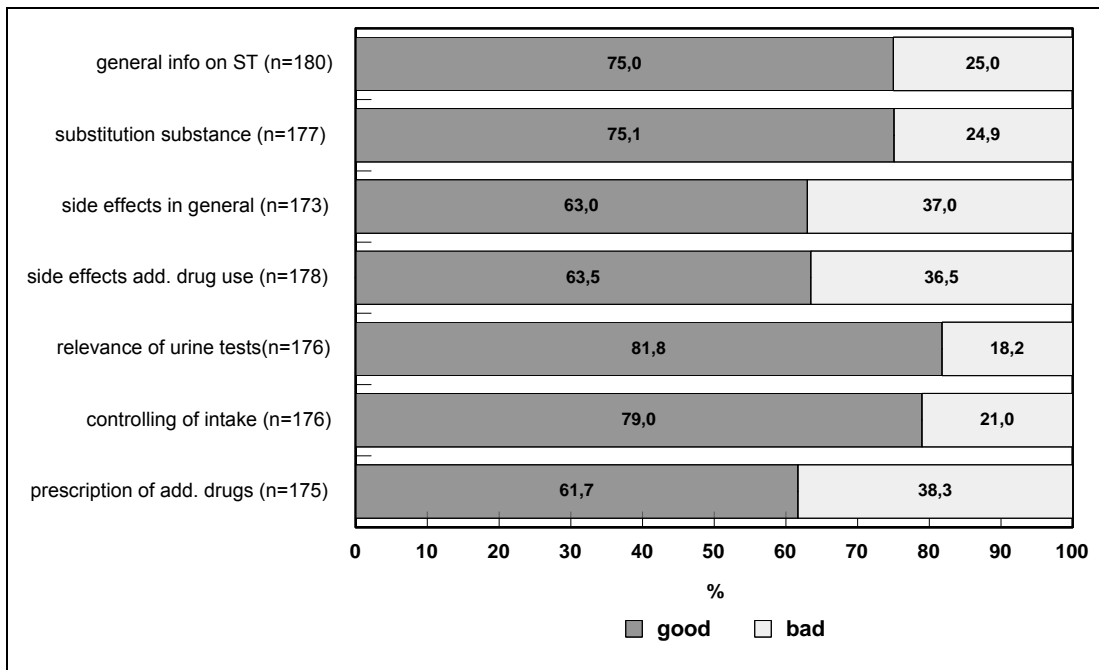
Chart 11: Frequency of home leaves (staff)

Source: AGIS-Survey Staff

WIAD 2007

5.2.5 Information level and information demand

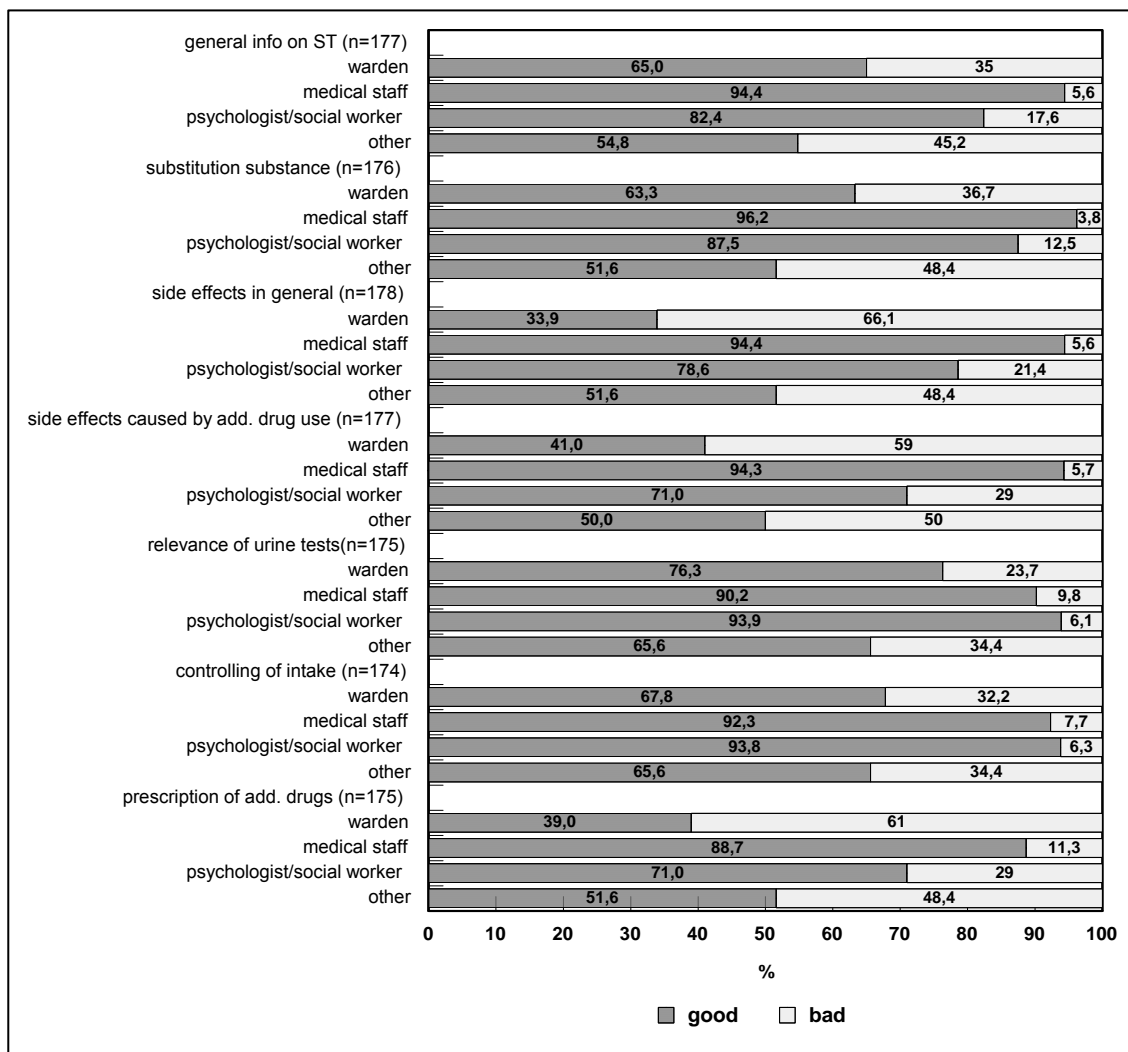
Subsequently, participants were asked about their **information level** and **information demand** on OST. As shown in chart 12, it seems that staff is - more or less - well informed about the different aspects of OST. Three quarter of the staff feel well informed about the treatment in general and the substance used as substitute. Almost 82% feel well informed about the relevance of urine tests and 79% about the controlling of the intake of the substitution substance. The medical aspects of OST, as side effects in general and side effects caused by additional drug use (in both cases 63% well informed) and the prescription of additional drugs (61,7% well informed) seem to be less well known. When differentiating in between the professional groups it is obvious that it is mostly the medical staff as well as psychologists and social workers that are well informed about the treatment (compare to chart 13). Especially concerning medical specific questions, wardens and staff that falls under the category 'other' don't feel well informed. Two thirds of the wardens don't feel well informed about general side effects, 59% feel ill-informed about side effects caused by additional drug use, and 61% feel ill-informed about the prescription of additional drugs.

Chart 12: Information level on different aspects of opioid substitution treatment (staff)

Source: AGIS-Survey Staff

WIAD 2007

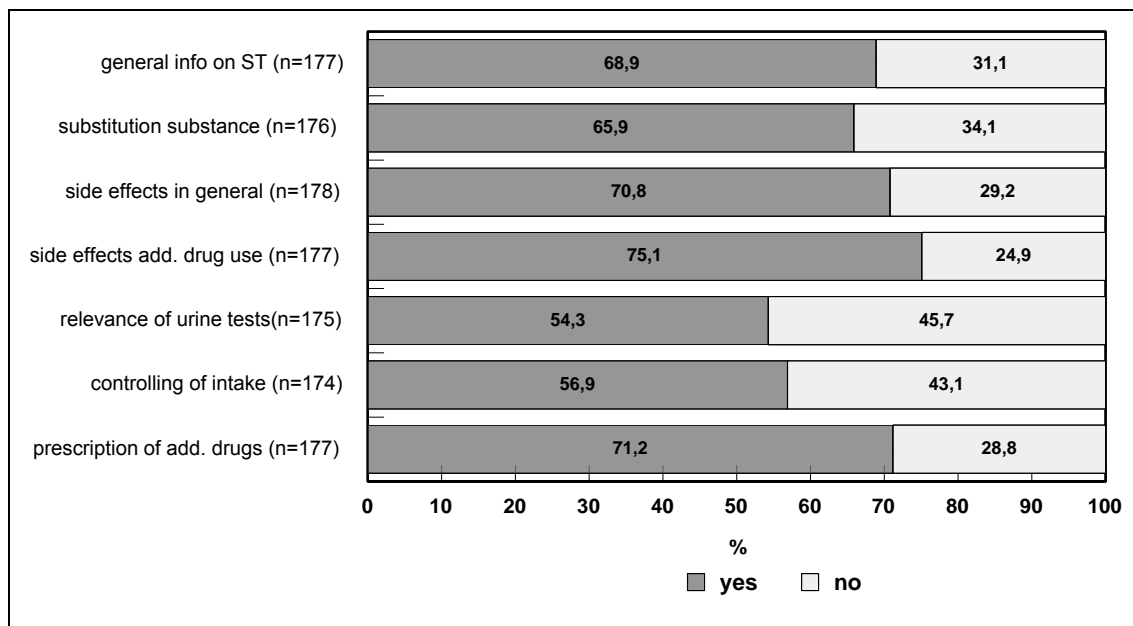
Chart 13: Information level on different aspects of substitution treatment by groups (staff)



Source: AGIS-Survey Staff

WIAD 2007

In accordance to the results mentioned above, the information demand is at highest as regards the medical specific factors of OST. Side effects in general (70,8%), caused by additional drug use (75,1%) and the prescription of drugs in addition to the substitution substance (71,2%) have the highest information demands. When differentiating between the professional groups it is again the wardens and again the interviewed staff that falls under the category 'other' that have a high information demand. As regards medical staff as well as psychologists and social workers it is always about half of the interviewed that want and half of the interviewed that do not want more information on the different aspects of OST.

Chart 14: Information demand on different aspects of OST (staff)

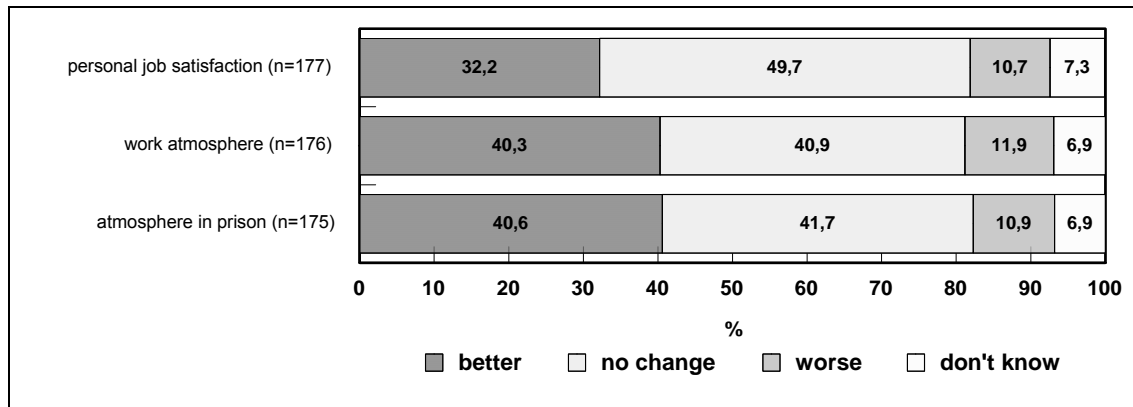
Source: AGIS-Survey Staff

WIAD 2007

5.2.6 Job satisfaction/working atmosphere

Finally, participating staff was asked about changes in their **job satisfaction** and the **atmosphere** in prison caused by the implementation of OST. One third of the interviewed staff indicates to have a higher job satisfaction since the implementation of OST, half of the staff does not see a change regarding this issue and ten percent of the staff indicate that their personal job satisfaction changed for the worse since the implementation of OST. When differentiating between the professional groups, it is obvious that the majority of wardens do not see a change in their personal job satisfaction (61,3%), also psychologist and social workers indicate this answer category (54,8%) most frequently. Medical staff indicates most frequently that their job satisfaction changed for the better (43,6%) but also has the highest number of participants that assesses it to be worse (21,8%).

The work atmosphere and the general atmosphere in prison changed for the better for about 40% of the staff, almost the same number indicates no change regarding this issue. Having a look at the different professional groups, wardens as well as psychologists and social workers most frequently see no change in the general and work atmosphere. It is again the medical staff that most frequently indicates a positive change, but in comparison to the other professional groups also has the highest percentage that indicates a negative change regarding these issues, i.e. this professional group has more polarised and explicit opinions.

Chart 15: Job satisfaction/ working atmosphere (staff)

Source: AGIS-Survey Staff

WIAD 2007

5.2.7 General assessments and further comments, remarks and information

Asked about the **effects on the prison if there was no substitution treatment**, a large group of participants answering, state first of all an increase of drug related issues or problems, i.e. more drug consumption (32) and “more drug traffic” (8). As regards consequences for the prisoners health, the risks of more overdoses (3) and more infections with diseases like Hepatitis and HIV (5) are supposed.

Beside unspecific “bad effects” for “prisoners” (11), “the prison” (5) and “the employees” (5) and the general assessment “the situation will be worse” (1) participants see a degradation of the social climate, i.e. “more violence/ aggression” (11), “more pressure” (2) or “more conflicts” (9), the problem that “medical doctors will be under the pressure of prisoners” (1), more corruptions (1) less exits (1) and less employment (1).

Few members of staff think that there will not be “any consequences” (2) and claim abstinence controlled by doctors instead of substitution (1) or accept “abstinence crisis. The assessment that there will even be a better situation “after the first crisis of drug users” can also be found (2). Moreover, some statements show definitively critical attitudes. According to these employees, many “drug users want to stop using many psychotropic substances, but they can't because in the prison they have a lot of different drugs” (1) or prisoners “are using methadone therapy just because they don't have money to buy drugs” (1). In this view OST in prison is no solution of the problem of drug addiction: “Prisoners sell methadone to get more money to buy real drugs” (1). A lack of urinary control and that inmates “are not excluded from the programme even if they take drugs” is criticized, too (1), as well as the observation that “GPs avoid conflict-loaded controls” (1).

On the other hand participants assess in some general statements OST or methadone respectively as (very) important or useful for prison (5) as well as “the only hope for prisoners” (1) which does not “cause violence” (1).

Further **comments, remarks and information** given by participants include - aside from “better conditions of work in prison” (1), “more interdisciplinarity” (1) and “more integration of prisoners” (1) - the assessments that “drug users can only work 3-4 hours” (1) and that “drug abuse” has to be avoided (1). “Different opinions about the start of OST” are observed (1) as well as “not enough information about this programme” is complained (1). While an unspecific “harder treatment” (1) and the “search for alternative programmes” (1) are claimed assessments within the framework of OST can also be found: this includes the proposal of “different substitution with other substance” (1) as well as the observation of “problems with the dosage” (1).

5.2.8 Summary of the survey among prison staff

The gender distribution in the sample is almost equal. Study participants are between 21 and 64 years old. Included staff has high educational level as concerns the performed task in prison. One third of the staff are wardens, one third medical staff, about 20% psychologists and social workers and 16% other staff. Regarding experience with opioid substitution treatment in prison, the mean working time since the implementation of OST is 8,5 years, the mean working time in the current prison 7,5 years. About half of the staff never worked in prisons without OST.

As regards changes in drug related issues most of the asked indicators are assessed to have changed for the better. 42% of the staff indicate less illicit drug use in prison, about half of the staff sees a decline in intravenous drug use. As regards finds of drugs and equipment, 30% indicate no change or less. The majority of the participants assesses drug trafficking to have stayed the same. Almost 40% of the staff indicate a decline in drug related emergencies. Many of the indicators measuring violence in prison are assessed to have positively changed. The majority of staff indicates a decline of physical violence among prisoners and among prisoners and guards, while around 29% see less psychological violence among prisoners and between prisoners and guards to have declined. As regards suicide and suicide attempts, about one third indicates a positive change, i.e. a decline in these issues. Majorities of the staff indicate positive changes in the prisoners' physical and psychological health. Four to five in ten see their motivation to work and to get education improved. The physical ability to do so was even assessed by 5 to 6 in ten to have advanced. Around half of the staff sees better social contacts and integration into the health system and drug services. About 80% of the staff state psycho-social support for prisoners in opioid substitution treatment. Around 63% indicate a good or very good influence of this support on the prisoners' wellbeing. Around a quarter sees a rise, one third no change and around 6% a decrease of home leaves.

Medical staff as well as psychologists and social workers are best informed on OST in general, whereas wardens and other staff have the highest information demand. The information level is lowest concerning medical specific questions, accordingly, information demand is highest as regards these questions. Concerning medical staff, psychologists and social workers, one half each wants more or no more information.

One third of the staff indicates a higher job satisfaction since the implementation of OST, half of the staff does not see a change and ten percent state a decline. Work atmosphere and general atmosphere in prison changed for the better for about 40%, almost the same number indicates no change. In all cases the medical staff most frequently indicates a positive as well as a negative change.

5.3 Results of the survey among prisoners

The following description of the data concerning prisoners comprises the values for the whole sample as well as national particularities for selected variables referring to the countries where the respective sub-samples of inmates interviewed are large enough, i.e. Austria, Germany, Portugal, Slovenia and Spain. The background of the prisoners interviewed in this study who are in OST while being in prison, can be described using data concerning social features, their prison and drug history, their risk behaviour and their general experience with OST in the community. The following data concerning the current substitution treatment in prisons as it was described by the prisoners interviewed comprises the form of current treatment, an assessment how easy or hard it was for the inmate to get substitution in prison, the substitution substance, some details on circumstances of substitution, confidentiality in prison, additional drug use, assessments of the results of substitution treatment concerning the prisoners' drug behaviour, their personal capacities and home leaves and changes in prison life and the general atmosphere in prison as well as assessments of effects on the inmates' health status and, finally, of social relations and influences during the treatment process. In most cases, data referring to the situation outside and inside prison can be compared.

5.3.1 Social background

As regards the social background of the inmates, almost all of them, i.e. 98,5% (n = 272), are male, because **sex** was a sampling criteria. Only 4 women (from the JVA Bremen/ Germany) have been interviewed.

Table 10: Age groups (prisoners)

Variable	Percentage
Age groups (n = 271)	
Up to 25 years	14,4
26-30 years	25,1
31-35 years	19,9
36-40 years	21,0
More than 40 years	19,6

Source: AGIS-Survey Prisoners

WIAD 2007

The **age** of the prisoners ranges between 19 and 56 years with a mean of 33,9 (n = 271). The majority of the inmates is between 26 and 40 years old (table 10). The prisoners interviewed in

Spain and *Germany* are slightly older, with a mean of 37,6 and 36,3 respectively, while inmates in *Slovenia* and *Austria* show a slightly lower average age of 30,6 and 30,7 years.

Table 11: School qualification (prisoners)

Variable	Percentage
School qualification (n = 269)	
No formal qualification	19,3
Lowest formal qualification attainable	41,3
Qualification above the lowest one but below entry requirements for universities	21,9
Entry requirements for universities	4,5
University degree completed	1,5
Other	11,5

Source: AGIS-Survey Prisoners

WIAD 2007

The **school qualification** of three of five prisoners is low, i.e. not higher than the lowest formal qualification attainable (n = 269). Almost one fifth has even no formal qualification (table 11). On the other hand, only a small group achieved the requirements to enter universities (4,5%) and only a few inmates completed a university degree (1,5%). There are considerable differences between the national groups. The prisoners interviewed in *Austria* and *Slovenia* are more qualified: 75,5% and 67,6% respectively have more than the lowest formal qualification. On the other hand, only 3,8% of the inmates in the *Portuguese* sample attained more than the lowest formal qualification and 45,3% have no formal qualification at all.

5.3.2 Prison history

As regards their **current stay**, 19,5% of the interviewed prisoners are on remand, 1,1% are in prison according to a juvenile sentence and 79,5% according to an adult sentence (n = 272).

Table 12: Prison history (prisoners)

Variable	Percentage
Total length of time ever spent in prison (n = 252)	
Up to 2 years	21,8
More than 2 years up to 5 years	30,2
More than 5 years up to 10 years	26,2
More than 10 years	21,8
Length of current stay from imprisonment until the day of the survey (n = 238)	
Up to 6 months	31,9
More than 6 months up to 1 year	18,1
More than 1 year up to 3 years	28,6
More than 3 years	21,4
Total length of current sentence (n= 211)	
Up to 1 year	23,2
More than 1 year up to 3 years	31,8
More than 3 years up to 5 years	17,5
More than 5 years	27,5

Source: AGIS-Survey Prisoners

WIAD 2007

The inmates interviewed spent between 0,1 and 30,5 **years of their whole life in prison**, i.e. on average 6,9 years (n = 252). The majority has been in prison between two and ten years (table 12). The mean is considerably higher in *Spain*, where the prisoners in the sample spent on average 10,9 years in prison, while the participants of the study in *Slovenia* with 4,4 years but also in *Austria* with 5,5 years have less experiences with prisons.

The **years of the current stay until now** range from 0,0 to 17,0 with an average of 2,1 years (n = 238). One half each of the inmates is currently up to one year or more than one year in prison (table 12). Again, the *Spanish* sample shows the highest mean with 4,1 years while the prisoners interviewed in *Austria* with 0,8 years and also in *Germany* with 1,6 are currently spending a shorter time in prison.

Finally, there is a wide range concerning the inmates' **current sentence** from 0,2 to 24,0 years. The average is 4,4 years (n = 211) while the majority of the prisoners indicate up to three years (table 12). Once more, the mean in the sample from *Spain* is considerably higher, i.e. 7,3 years, but also inmates interviewed in *Portugal* are sentenced for a longer time with a mean of 5,9 years. On the other hand, the *Austrian* sample and the *German* sample comprise inmates with clearly lower sentences, i.e. 2,2 and 2,3 years on average respectively.

5.3.3 Drug history

The prisoners were asked about the first time they used opioid drugs, the first time they injected drugs and the duration of their regular opioid drug use. Additionally, they should state if they ever injected drugs in prison and if they were in prison when they injected drugs for the first time.

Table 13: Drug history (prisoners)

Variable	Percentage
Age when first used opioid drugs (n = 267)	
Up to 15 years	28,1
16-17 years	24,0
18-20 years	23,2
More than 20 years	24,7
Age when first injected drugs (n = 208)	
Up to 16 years	29,8
17-19 years	22,6
20-24 years	25,0
More than 24 years	22,6
Duration of regular opioid drug use (n = 240)	
Up to 5 years	26,3
More than 5 years up to 10 years	28,3
More than 10 years up to 15 years	19,6
More than 15 years	25,8
Prisoners who ever injected drugs in prison (n = 267)	37,5
Prisoners who for the first time injected drugs in prison (n = 265)	12,1

The age, when the participants of the study used **opioid drugs for the first time** ranges, according to their statements, between 10 and 43 years with a mean of 18,5 years (n = 267). More than half of the inmates were less than 18 years when they used opioid drugs for the first time in their life, almost three of ten less than 16 (table 13). The prisoners of the *Spanish* sample state a lower average age of 17,2 years.

The inmates indicate that they **first injected drugs** when they were between 11 and 50. The average age is 20,5 years (n = 208). More than half of the prisoners were less than 20 and three of ten less than 17 years at that time (table 13). Again, the prisoners of the *Spanish* sample state a lower mean of 18,1 years.

The **duration of regular opioid drug use** stated by the prisoners ranges between 0,2 and 35,0 years, the mean is 11,2 years (n = 240). The majority of the inmates has up to ten years experience with this kind of drug use (table 13). Participants from *Germany* and *Portugal* show higher average values, i.e. 15,2 and 13,3 years respectively, while the mean in the sample from *Slovenia*, 6,9 years, and the sample from *Austria*, 8,9 years, is lower.

More than a third of the inmates, i.e. 37,5%, indicate, that they **injected drugs** when they were **in prison** (n = 267; table 13). The value is remarkably higher in *Austria* and *Germany*, where half of the participants state this behaviour, i.e. 54,7% and 52,8%. On the other hand, a clearly smaller group of 14,8% in the *Portuguese* sample declare, ever having injected drugs in prison⁵⁹.

Almost one of eight – 12,1% – of the participants indicate, that they **injected drugs for the first time while being in prison** (n = 265; table 13). While more prisoners in the sample of *Slovenia* – 21,1% – and in the *German* sample – 20,8% – indicate this behaviour, only a very small group of the prisoners interviewed in *Portugal*, i.e. 3,7%, declare, that they first injected in prison.

5.3.4 Risk behaviour

The participants were asked about their risk behaviour concerning drug use, i.e. the share of needles, syringes and other drug equipment like filters, spoons, water, etc., outside as well as inside prison.

⁵⁹ Some positive data from Portugal like small proportion of drug injections inside prisons might be influenced by the method (interview rather than questionnaires) and lack of trust in interviewers (confidentiality issues) and fear of repression afterwards (note by Joana Almeida/Luís Mendão, experts for Portugal).

Table 14: Risk behaviour (prisoners)

Variable	Percentage	
	Outside prison	Inside prison
Ever shared with someone else:		
Needles	31,8 (n = 245)	28,0 (n = 239)
Syringes	33,5 (n = 239)	28,0 (n = 232)
Other drug equipment (filters, spoons, water, etc.)	40,9 (n = 242)	29,3 (n = 229)

Source: AGIS-Survey Prisoners

WIAD 2007

More than three out of ten prisoners interviewed – 31,8% – indicate, that they ever **shared needles** with someone else outside prison (n = 245), a third of the inmates – 33,5% – state the **share of syringes** outside (n = 239) and four out of ten – 40,9% – the **share of other drug equipment** (n = 242). According to the inmates' statements, the respective values are lower inside prison: slightly concerning needles – 28,0% (n = 239) –, clearer for syringes – 28,0% (n = 232) – and remarkably as regards other drug equipment – 29,3% (n = 229) (table 14)⁶⁰. When comparing the national samples, significant differences can be found, especially as regards higher values in general and structures inside prison.

Outside prison there are always higher values for the participants in *Spain* – 50,0% for needles, 45,9% for syringes and 51,3% for other drug equipment – followed by *Germany*: 44,2%, 41,2% and 49,0%. Meanwhile, values below the average are stated from the inmates interviewed in *Austria* and *Slovenia* concerning needles – 20,0% and 20,6% respectively – in *Slovenia* and *Portugal* as regards syringes – 23,5% and 25,5% respectively – and finally in *Portugal* with reference to other drug equipment – 31,5%.

Inside prison the pattern is even clearer. Again prisoners from the sample in Spain and Germany state more often risk behaviour, but in reversed order: 55,3% of the interviewed *German* prisoners ever shared needles inside prison, 53,2% syringes and 43,5% other drug equipment. The respective values of the *Spanish* inmates in the study are 37,8%, 40,0% and 38,9%. On the other hand, participants from Slovenia indicate the lowest risk behaviour inside prison in all cases, followed by inmates from Portugal. 9,4% of the *Slovenian* prisoners interviewed say they shared needles, 9,1% syringes and 16,1% other drug equipment. For the *Portuguese* sample the figures are 14,3%, 12,7% and 18,5% respectively.

5.3.5 Substitution experience outside

About five out of six inmates in the study – 84,1% – ever had experiences with **OST outside prison** in the community (n = 270; table 15). The value is higher for participants from *Germany*

⁶⁰ This result, a less intensive risk behaviour inside prison compared to outside prison, is in line with findings of a large and representative survey of 1,582 prisoners in Germany in 2007, conducted by WIAD in the framework of the European Network on Drugs and Infections Prevention in Prison (ENDIPP) funded by the European Commission.

– 98,1% – and *Austria* – 94,2% – but lower for the *Slovenian* sample – 63,2% – and the *Portuguese* sample – 71,4%.

Table 15: Opioid substitution treatment in the outside community (prisoners)

Variable	Percentage
Prisoners who ever were in OST in the outside community (n = 270)	84,1
Duration of OST outside prison	
Altogether (n = 206)	
Up to 1 year	24,8
More than 1 year up to 3 years	28,2
More than 3 years up to 6 years	21,8
More than 6 years	25,2
Last treatment (n = 165)	
Up to 6 months	26,1
More than 6 months up to 18 months	24,2
More than 18 months up to 4 years	25,5
More than 4 years	24,2

Source: AGIS-Survey Prisoners

WIAD 2007

The **duration of the substitution outside altogether** for the participants ranges between 0,2 and 22,0 years, with a mean of 4,4 years (n = 206). The majority of them has up to three years experience with OST in the community (table 15). The average value is higher for the *Spanish* prisoners interviewed, i.e. 5,2 years, and lower for the *Portuguese* and the *Slovenian* sample, i.e. 2,8 and 3,6 years respectively,

Concerning the **duration of their last treatment outside** prison, the participants indicate between 0,1 and 22,0 years. In this case, the average is 3,3 years (n = 165). Almost exactly one half each of the participants were in treatment in the community up to 18 months or longer (table 15). Prisoners from the *Austrian* sample and again inmates from the *Spanish* sample state with 4,1 years a higher figure, while, once more, the values for the *Slovenian* sample and the *Portuguese* sample are lower, i.e. 2,4 and 2,5 years.

5.3.6 Form of current treatment

For the majority of the participants in the study, i.e. 57,9%, the **current treatment in prison** continues a substitution treatment which has been started in the outside community while a third – 32,6% – started a maintenance treatment inside prison. Only a small group – 9,6% – indicates a detoxification treatment (n = 261; table 16).

Table 16: Current treatment in prison (prisoners)

Variable	Percentage
Current treatment in prison (n = 261)	
Detoxification	9,6
Maintenance treatment started in prison	32,6
Continuance of OST begun in the outside community	57,9

Source: AGIS-Survey Prisoners

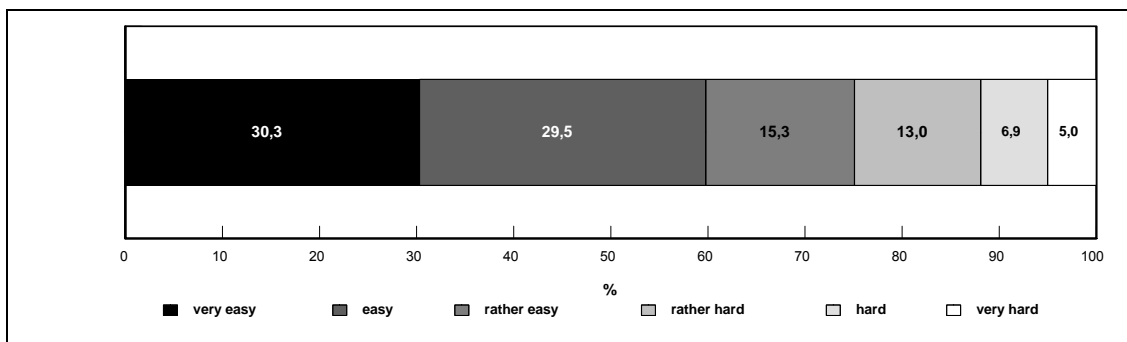
WIAD 2007

Differences concerning maintenance treatment started in prison and continuance of substitution in prison can be found for *Portugal* and *Spain*. In the Portuguese sample only 47,3% of the inmates indicate continuation of substitution but 45,5% maintenance treatment started in prison⁶¹. Inversely, only 22,2% of the prisoners interviewed in Spain state maintenance treatment but 68,9% continuance of substitution.

5.3.7 Access to substitution in prison

Asked, whether it was easy or hard to **get substitution in prison**, a clear majority of three quarter of the inmates found it easy, i.e. 30,3% very easy, 29,5% easy and 15,3% rather easy, while a minority of one out of four think it was hard, i.e. 13,0% rather hard, 6,9% hard and 5,0% very hard (n = 261, chart 16)⁶².

Chart 16: Access to substitution in prison (prisoners, n=261)



Source: AGIS-Survey Prisoners

WIAD 2007

Compared with the mean of 75,1%, prisoners interviewed in *Austria* – 88,5% – and *Spain* – 83,3% – assess more often, that they got substitution easily. Inversely, positive answers from inmates in the *German* sample – 64,2% – and in the *Portuguese* sample – 64,8% – are below the average.

5.3.8 Substances outside and inside

As regards the **substitution substances** being used inside and outside prison, a clear majority of the inmates indicate in both cases Methadone as their substitution substance outside but first of all inside prison. At the same time, a greater diversity of substances used in the community can be noticed. Table 17 shows the positive answers (“yes”). All other answers were “no” with

⁶¹ In Portugal, there are only four prisons where you can initiate methadone maintenance treatment and Oporto EP (where 35 of 56 inmates interviewed were detained) is by far the one most (80%) treatments are initiated. Therefore, there might be a bias in these results (note by Joana Almeida/Luís Mendão, experts for Portugal).

⁶² Those inmates, who state a reason, why they found it hard to get substitution treatment in prison, indicate mostly no specific reason as regards content but “long time to wait” (14). Moreover, the reasons “no substitution before imprisonment”, “too young” and “have to demonstrate the motivation” can be found (2 in each case).

the indicated exceptions of “don’t know”. 260 – 262 prisoners answered concerning the substances used during their outside treatment (“others” 246) and 264 – 268 concerning their treatment in prison (“others” 259)⁶³.

Table 17: Substitution substances being used (prisoners)

Variable	Percentage	
	Outside prison	Inside prison
Methadone	59,5 (n=262)	79,5 (n=268)
Levomethadone	6,9 (n=261)	8,6 (n=266)
Buprenorphine	11,1 (n=262)	1,1 (n=266)
Dihydrocodeine	4,2 (n=260)	0,0 (n=265)
Codeine	2,3 (n=261)	0,0** (n=266)
Slow Release Morphine	17,2 (n=261)	4,5** (n=264)
Lofexidine	0,0 (n=261)	0,0** (n=264)
Diamorphine	1,9 (n=261)	0,0** (n= 265)
Levo-alpha-acetylmethadol	1,5 (n=261)	0,4** (n=266)
Others	8,9* (n=246)	8,1*** (n=259)

* 3,3% don't know, ** 0,4% don't know, ***1,2% don't know

Source: AGIS-Survey Prisoners

WIAD 2007

Three out of five prisoners – 59,5% – have been treated with Methadone outside prison; Slow Release Morphine – 17,2% – and Buprenorphine – 11,1% – have been relevant in the community, as well. Additionally, small and very small groups indicate Levomethadone (6,9%) and Dihydrocodeine (4,2%) and 8,9% state other substances. Inside prison, Methadone is even more important: four out of five inmates – 79,5% – state this substance. Additionally, Levomethadone is of some importance with 8,6%, but Slow Release Morphine is indicated only by a very small group (4,5%), while Dihydrocodeine and Buprenorphine are not or almost not used. Finally, 8,1% of the prisoners name other substances.

5.3.9 Circumstances outside and inside

As regards details on circumstances of OST, the prisoners' answers concerning their say in choosing the substance, their experience with interruptions of treatment and the received psychosocial support inside and outside prison can be compared.

Table 18: Circumstances of opioid substitution treatment (prisoners)

Variable	Percentage	
	Outside prison	Inside prison
Say in choosing the substitution substance	65,4 (n = 234)	33,6 (n = 256)
Treatment ever been interrupted	51,3 (n = 232)	20,6 (n = 262)
Psychological and/ or social support	50,4 (n = 244)	45,3 (n = 267)

Source: AGIS-Survey Prisoners

WIAD 2007

⁶³ On the national versions of the questionnaire the commonly used names for the substances in the country were mentioned (together with the agent in brackets).

While two out of three inmates – 65,4% – indicate a **say in choosing the substitution substance** in the community (n = 234), only one out of three – 33,6% – states the same for its treatment inside prison (n = 256; table 18)⁶⁴. Inmates in the sample from *Austria* – 86,3% – followed by prisoners interviewed in *Spain*⁶⁵ – 75,6% – indicate to a higher degree having had a say in choosing the substance outside prison, while this share is very low – 14,3% – in the *Slovenian* sample. Inmates in the *Spanish* sample again state more often – 52,3% – that they had a say inside prison. In this case, the value for *Portuguese* prisoners – 11,1% – is below the average.

Slightly more than half of the prisoners – 51,3% – state that their **treatment** outside prison had been **interrupted** at least one time (n = 232)⁶⁶, but concerning treatment inside prison only a fifth of the inmates – 20,6% – indicate an interruption (n = 262; table 18). Prisoners interviewed in *Portugal* experienced less often an interruption outside, i.e. 35,1% of them, but in the *German* sample – 65,4% – and also in the *Slovenian* sample – 59,4% – the value is above the average, i.e. the latter state one more negative aspect. An interruption of treatment inside prison was less often experienced by prisoners interviewed in *Austria* – 9,4% – and, again, in *Portugal* – 12,5%. Even more similar to the structure outside prison are the values for the samples from *Slovenia* – 35,3% – and *Germany* – 34,0% – where interruption was experienced more often.

Half of the prisoners – 50,4% – received **psychological and/ or social support** during their OST in the community (n = 244), but also almost half of the prisoners – 45,3% – have this help inside prison (n = 267; table 18). Once more, prisoners interviewed in *Spain* state better experiences, when 69,8% of them indicate psychosocial support outside prison, and once more as well, the values for the *German* – 32,1% – and the *Slovenian* – 34,3% – sample are below the average. The answers concerning support inside prison show a wide range with all sub-sample above or below the average. In the first group are prisoners from *Portugal* – 79,2% – and *Austria* – 66,0% – which means another positive feature for these countries. In the second group are inmates from *Germany* – 16,7%, – *Spain* – 20,8% – and *Slovenia* – 33,3% –, i.e., with the exception of Spain, again two countries with negative values otherwise.

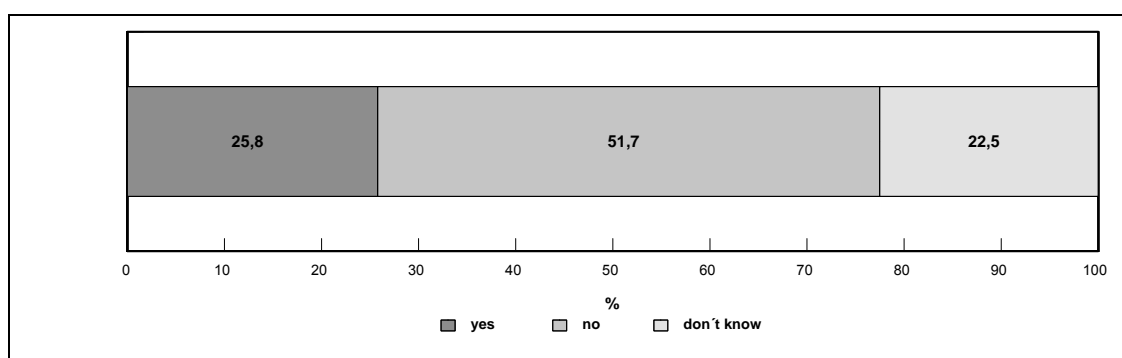
5.3.10 Confidentiality

One crucial aspect of the circumstances of OST in prison is whether this **treatment** is **kept confidential** and thereby, whether confidentiality of drug addiction is ensured. Only one out of four inmates – 25,8% – think that treatment is kept confidential while more than half of the prisoners – 51,7% – answer negatively on this question. The others – 22,5% – don't know whether substitution treatment is kept confidential in their prison (n = 267; chart 17).

⁶⁴ Additionally, inmates were asked, if they had **influence on the dose** of the substitution substance during their treatment outside prison in the community. Three out of four – 76,6% – answer "yes" (n = 239).

⁶⁵ Although there is little to choose: in Spain, there is practically only Methadone at their disposal. They may have interpreted that they could choose whether or not to take Methadone (note by Christina Visiers, expert for Spain).

⁶⁶ Besides comparatively unspecific „personal reasons“ (12) or „job and family“ (4) respectively most of the reasons for an interruption of substitution treatment outside prison stated are related to drug use or its consequences, i.e. „taking other drugs“ (17), „relapse“ (9), „withdrawal syndrome“ (7) and „detoxification“ (3). One more reason of some importance refers to the prisoners current situation: „imprisonment“ (8).

Chart 17: Confidentiality of opioid substitution treatment in prison (prisoners, n=267)

Source: AGIS-Survey Prisoners

WIAD 2007

The lowest share of positive answers, i.e. 9,4%, is to be found in the *German* sample which is due to a high share of “don’t know” answers, i.e. 35,8%. Positive answers below the average are also given by prisoners interviewed in *Spain* – 12,5% - and *Slovenia* – 17,6% - which state more often “no”, i.e. 62,5% and 67,6% respectively. Inversely, more than half of the inmates in the *Portuguese* sample – 56,4% – indicate “yes” while their share of negative answers is below the average: 29,1%.

5.3.1 Additional drug use outside and inside

Almost five out of six prisoners – 82,7% – indicate **additional drug use during their substitution treatment** outside prison in the community (n = 237). It cannot be surprising that this share is remarkably lower as regards OST in prison. Two out of five inmates – 39,2% - state that they use other drugs during their treatment inside (n = 263; table 19). Additional drug use outside prison is stated by almost all *German* prisoners interviewed, i.e. 96,1%, while the respective share in the *Slovenian* sample is with 57,6% below the average. Inside prison a higher value is to be found in the *Portuguese* sample and, again, the *German* sample with 61,1% and 47,3% respectively while *Austrian* prisoners interviewed indicate a share of 17,3%.

Table 19: Additional drug use (prisoners)

Variable	Percentage	
	Outside prison	Inside prison
Use of additional drugs	82,7 (n=237)	39,2 (n=263)
Drugs used in addition to the substitution substance		
Cannabis/hashish	61,1 (n=262)	41,3 (n=240)
Alcohol	41,2 (n=262)	5,0 (n=239)
Opiates/heroin	46,4 (n=261)	13,8 (n=239)
Tablets	42,3 (n=260)	16,5 (n=237)
Other	60,9 (n=202)	22,8 (n=158)
Consequences when additional drug use was/is discovered		
Expulsion from the programme	12,7 (n=244)	28,2 (n=241)
Reduction of the substitution substance	12,4 (n=241)	14,5 (n=241)
Other	74,4 (n=125)	49,2 (n=126)

Source: AGIS-Survey Prisoners

WIAD 2007

Cannabis/ hashish is the most often **used drug in addition to substitution treatment** outside prison. Three out of five inmates – 61,1% – give this answer. Between four out of ten and almost half of the prisoners used alcohol – 41,2% –, tablets – 42,3% – or opiates/ heroin – 46,4% – during their treatment in the community (n = 260 – 262). Other drugs are stated by three fifth – 60,9% – of the inmates (n = 202)⁶⁷. Of course, the shares of prisoners who indicate such behaviour as regards their substitution treatment inside prison are lower⁶⁸. The value is still relatively high for cannabis/ hashish which is stated by two fifth – 41,3% - of the inmates. 16,5% indicate the use of tablets and 13,8% opiates/ heroine. As regards alcohol, the largest difference between the prisoners behaviour indicated outside and inside prison is to be found, when only 5% say, they use alcohol inside prison during their substitution treatment (n = 237 – 240). 22,8% of the prisoners state the use of other drugs (n = 158; table 19).

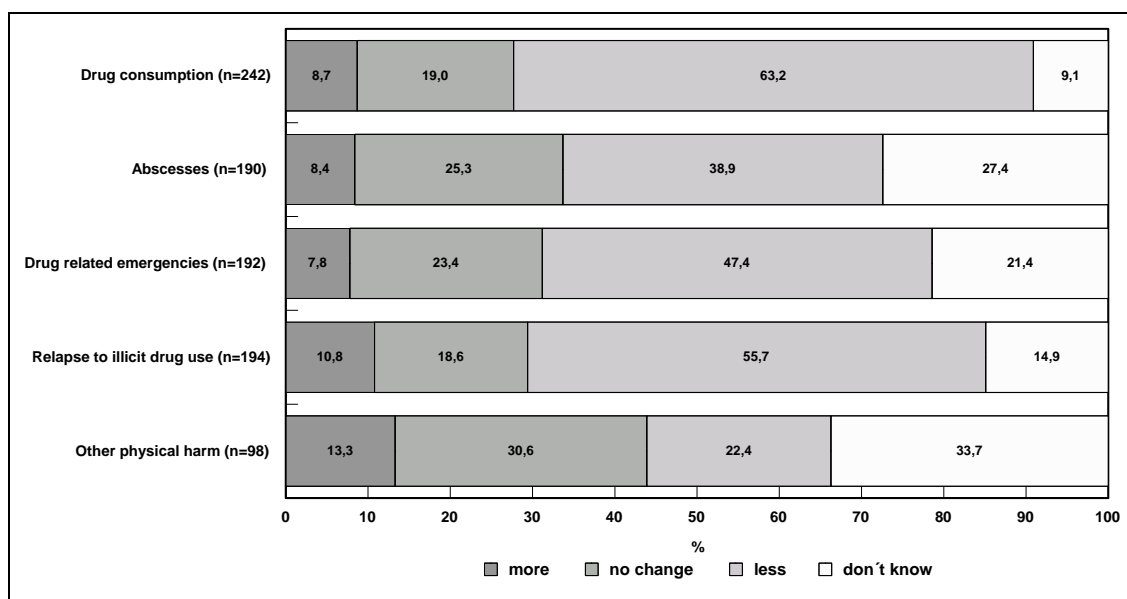
Asked about the consequences, when additional drug use was or is discovered, one out of eight prisoners – 12,7% – indicates an **expulsion from the programme** when being in opioid substitution treatment in the community (n = 244), but almost three out of ten inmates – 28,2% – states the same consequences as regards their treatment inside prison (n = 241). In contrast there is almost no difference to be found concerning **reduction of the substitution substance** as a possible consequence of additional drug use. One out of eight prisoners – 12,4% – affirms this result for treatment in the community (n = 241), while one out of seven inmates – 14,5% – states it for treatment inside prison (n = 241). Finally, 74,4% of the participants indicate **other consequences** outside (n = 125) and 49,2% inside prison (n = 126; table 19).

5.3.12 Assessments of effects and results of substitution

The participants of the study were asked to assess the effects and results of OST in prison as regards personal changes concerning drugs as well as their capacities and concerning their home leaves. Furthermore, they should estimate possible changes of different aspects of prison life and the general atmosphere as results of OST. Finally, the prisoners were asked to evaluate effects of substitution inside and outside prison on their personal health status as well as some aspects of treatment as a process, i.e. social relations and influences.

⁶⁷ 64 inmates specify this other drug as "cocaine".

⁶⁸ Whether this is due to their real behaviour or to their way to answer on such sensitive questions cannot be determined.

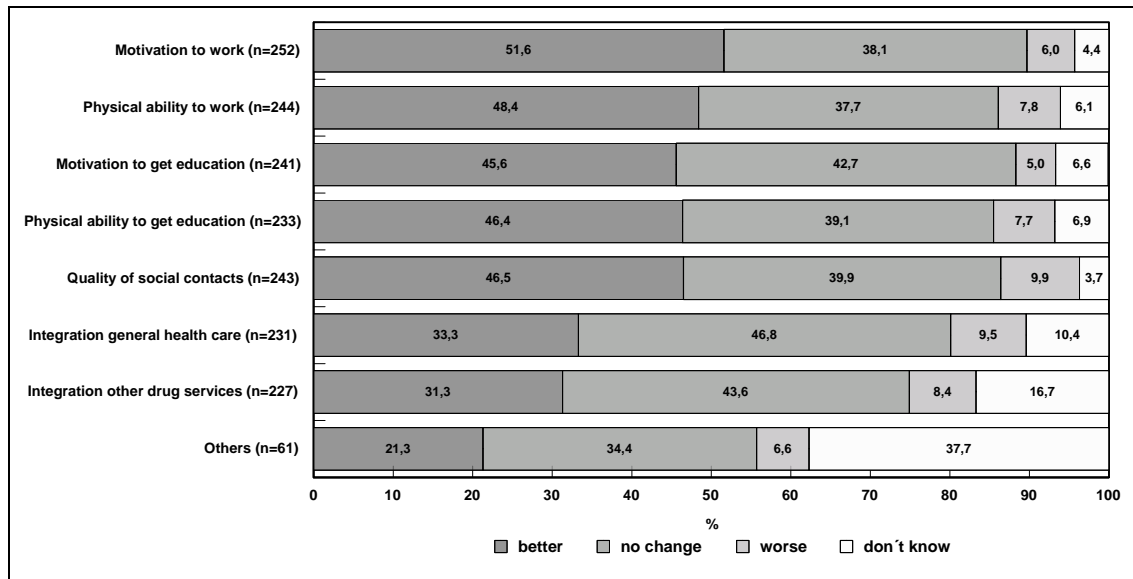
Chart 18: Personal changes concerning drugs (prisoners)

Source: AGIS-Survey Prisoners

WIAD 2007

In almost all cases absolute or relative majorities of the inmates see positive personal changes concerning drugs as a result of their substitution treatment inside prison. In all cases only small groups name negative changes. More than three out of five prisoners – 63,2% – state less **drug consumption** (n = 242), more than half of them – 55,7% – indicate less **relapses to illicit drug use** (n = 194) and almost half of them – 47,4% – less **drug related emergencies** (n = 192) and two fifth – 38,9% – say, they have less **abscesses** (n = 190). The overall assessment concerning **other physical harm** is only marginally positive and most of the inmates answering see no effect – 30,6% - or don't know – 33,7% (n = 98; chart 18).

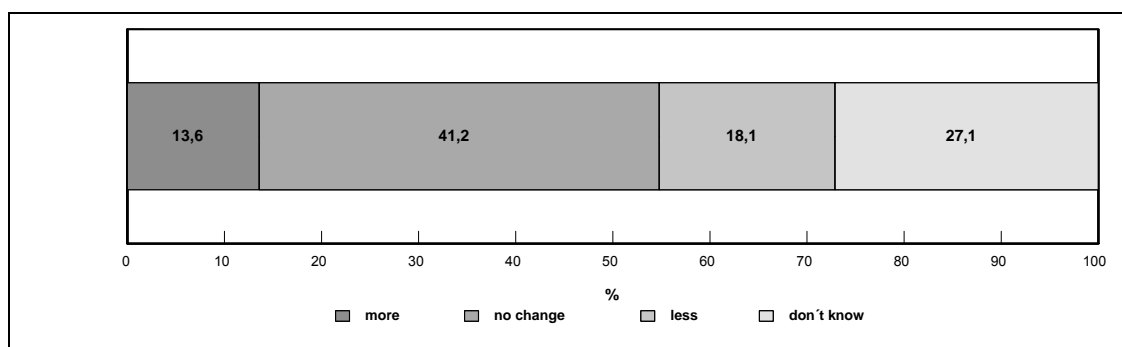
Chart 19: Personal changes concerning capacities (prisoners)



Source: AGIS-Survey Prisoners

WIAD 2007

As regards most of the variables which were investigated concerning the inmates' personal capacities absolute or relative majorities of the prisoners see positive changes resulting from substitution treatment in prison. Again, in all cases only small – and very small – groups indicate negative changes. Approximately half of the inmates state a better **motivation to work** – 51,6% – and a better **physical ability to work** – 48,4% (n = 252 and n = 244). Almost half of the prisoners think, their **motivation to get education** is better – 45,6% –, their **physical ability to get education** is better – 46,4% – and the **quality of their social contacts** is better – 46,5% – as an effect of OST inside prison (n = 241, 233 and 243 respectively). Furthermore, one third of the inmates – 33,3% – indicate a **better integration in general health care** (n = 231) and three out of ten – 31,3% – state a **better integration in other drug service** (n = 227), which are clearly higher shares than the respective negative answers, but in these cases, the largest groups see no change. Finally, one fifth – 21,3% – of the prisoners answering see **other aspects** positively changed, but most of them see “no change” – 34,4% – or “don't know” – 37,7% (n = 61; chart 19).

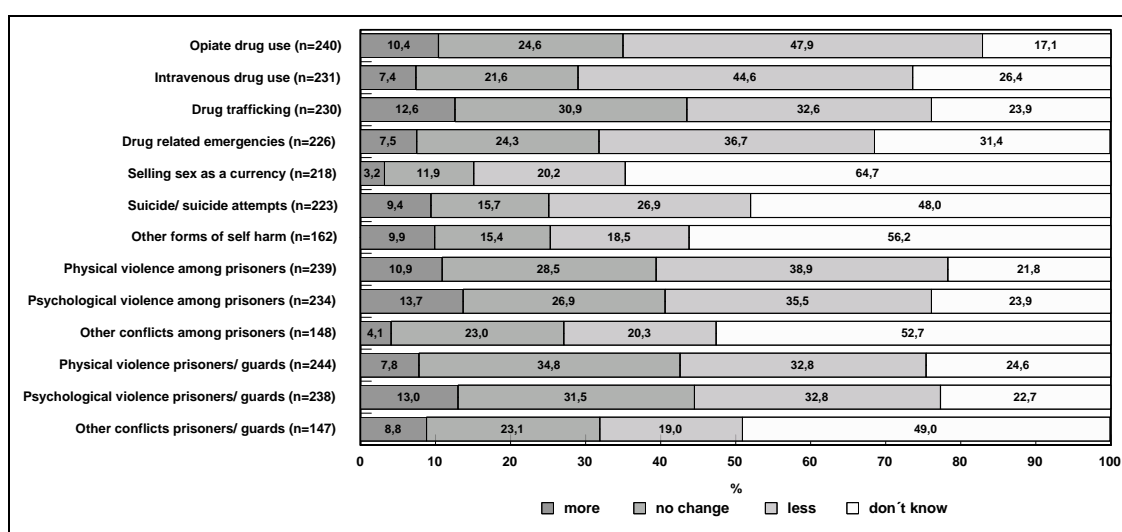
Chart 20: Home leaves (prisoners, n=199)

Source: AGIS-Survey Prisoners

WIAD 2007

Additionally, the participants were asked about changes in their **home leaves** as a result of OST in prison. In this case no positive effects are to be noted. The largest groups see “no change” – 41,2% – or “don’t know” – 27,1% – while the minority of prisoners which indicate “more” – 13,6% – is actually even smaller than the group saying “less” – 18,1% – which nevertheless is a minority as well (n = 199; chart 20).

Furthermore, the prisoners were not only asked to assess the effects of OST on their own person, but also on different aspects of **prison life**, i.e. whether characteristic problems of prison life had changed. A general feature to be noted is, that for all of these aspects, only small or very small minorities state a rise of the problem. These groups are in all cases the smallest and always smaller than the groups which indicate a decrease. Therefore, the overall assessments of the effects of OST on prison life concerning all aspects asked for are positive. Nevertheless, for some variables high shares of “don’t know”-answers are to be noted as well as remarkable shares of “no change”-answers (chart 21).

Chart 21: Changes in prison life (prisoners)

Source: AGIS-Survey Prisoners

WIAD 2007

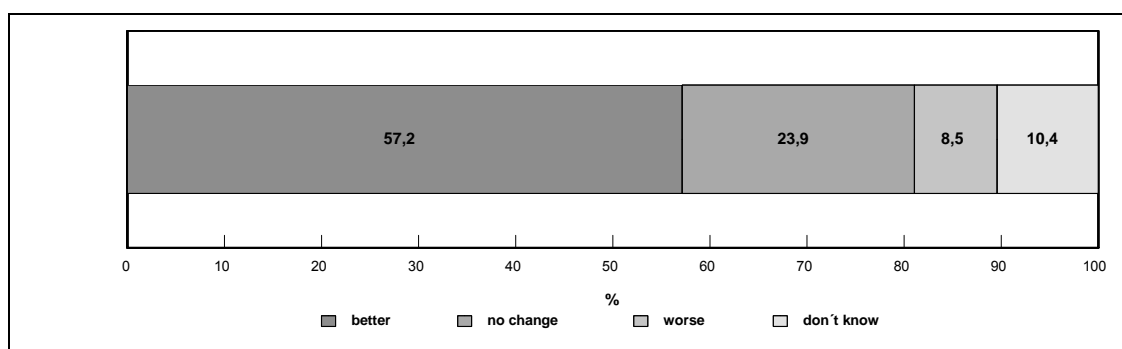
Almost half of the prisoners – 47,9% – think that OST reduces the **use of opiate drugs** (n = 240), likewise a high share of inmates, i.e. between two fifth and a half or 44,6%, sees a decrease of **intravenous drug use** (n = 231), almost two fifth – 38,9% – state less **physical violence** (fist fights, attacks with weapons) **among prisoners** (n = 239), between one third and two fifth of the inmates – 36,7% – indicate a reduction of **drug related emergencies** (n = 226) and more than a third – 35,5% – say, that **psychological violence among prisoners** (threats, bullying, intimidation) happens less often (n = 234).

One third of the prisoners perceives a decrease of **drug trafficking** – 32,6% –, **psychological violence between prisoners and guards** – 32,8% – and **physical violence between prisoners and guards** – 32,8% –, but in these cases, strong groups of inmates, i.e. three out of ten and one third respectively – 30,9%, 31,5% and 34,8% – cannot see a change of prison life as an effect of OST (n = 230, 238 and 244).

More than a quarter of the prisoners – 26,9% – state a lower frequency of **suicides or suicide attempts**, but almost half of them – 48,0% – don't know an answer (n = 223). About one out of five inmates indicates less **other conflicts between prisoners and guards** – 19,0% –, less **other conflicts among prisoners** – 20,3% – and less **selling sex as a currency** – 20,2% –, but about half of them – 49,0% and 52,7% – or even almost two third – 64,7% – answer “don't know”, the latest is the highest share of all (n = 147, 148 and 218). Finally, between one sixth and one fifth of the prisoners – 18,5% – express the opinion, that **other forms of self harm** happen less often, but more than half of them – 56,2% – don't know an answer (n = 162).

Concerning effects of OST on the prison as a whole, the inmates were asked to assess, whether the **general atmosphere in the prison** had changed. A clear absolute majority of almost three out of five – 57,2% – indicate a better general atmosphere as a result of OST, while only a small minority, i.e. one out of twelve – 8,5% –, state a degradation of the atmosphere in prison. A quarter of the prisoners – 23,9% – sees no change and one out of ten – 10,4% – does not know an answer (n = 259; chart 22)

Chart 22: General atmosphere (prisoners, n=259)



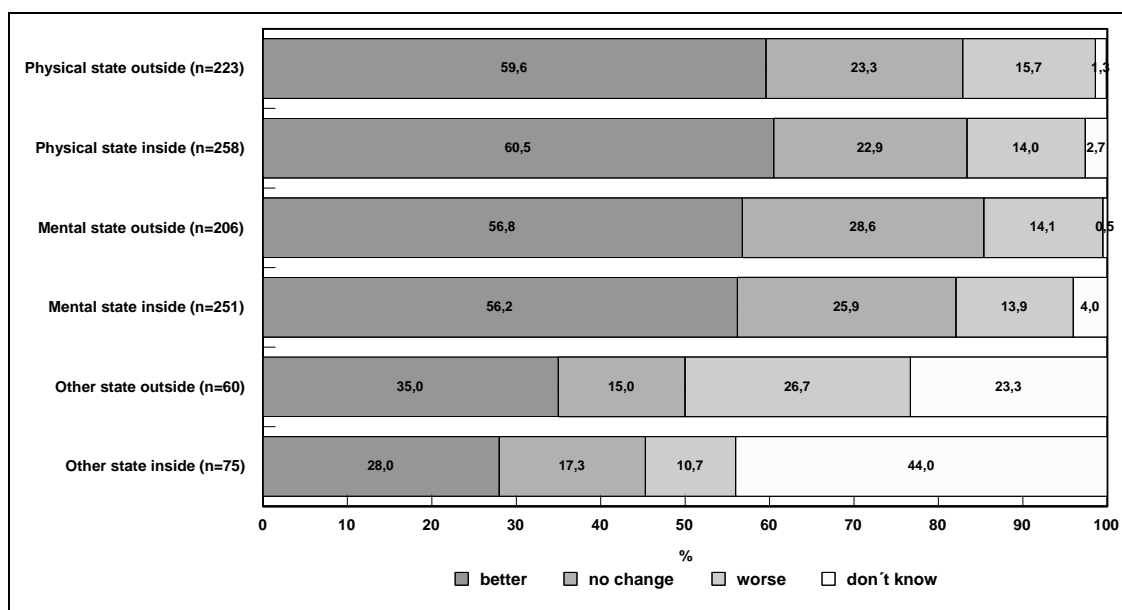
Source: AGIS-Survey Prisoners

WIAD 2007

Between three fourth and four fifth of the prisoners in the *Portuguese* sample – 77,8% – think the general atmosphere in the prison is better as an effect of OST, but only three out of ten inmates interviewed in *Slovenia* – 31,4% – can perceive an improvement.

Concerning the effects of OST on their personal **health status** the participants of the study were asked for changes of their **physical, mental and other** states as results of treatments inside and outside prison. The data show clear absolute majorities of prisoners who indicate improvements of their physical state and their mental state outside as well as inside prison while in all these cases only small groups see degradations. Three out of five inmates indicate an advancement of their physical health, 59,6 % for OST in the community and 60,5% for OST in prison, and between a half and three fifth of the prisoners state a better mental state, 56,8% outside and 56,2% inside prison (n = 223, 258, 206 and 251). Additionally, more than a third of the inmates – 35,0% – sees an improvement of other state in the community, but around a quarter in each case – 26,7% and 23,3% – sees a degradation or does not know an answer (n = 60), and almost three out of ten – 28,0% – perceive an advancement of other state inside prison, but more than two fifth – 44,0% – answer with “don’t know” (n = 75; chart 23).

Chart 23: Changes of health status (prisoners)



Source: AGIS-Survey Prisoners

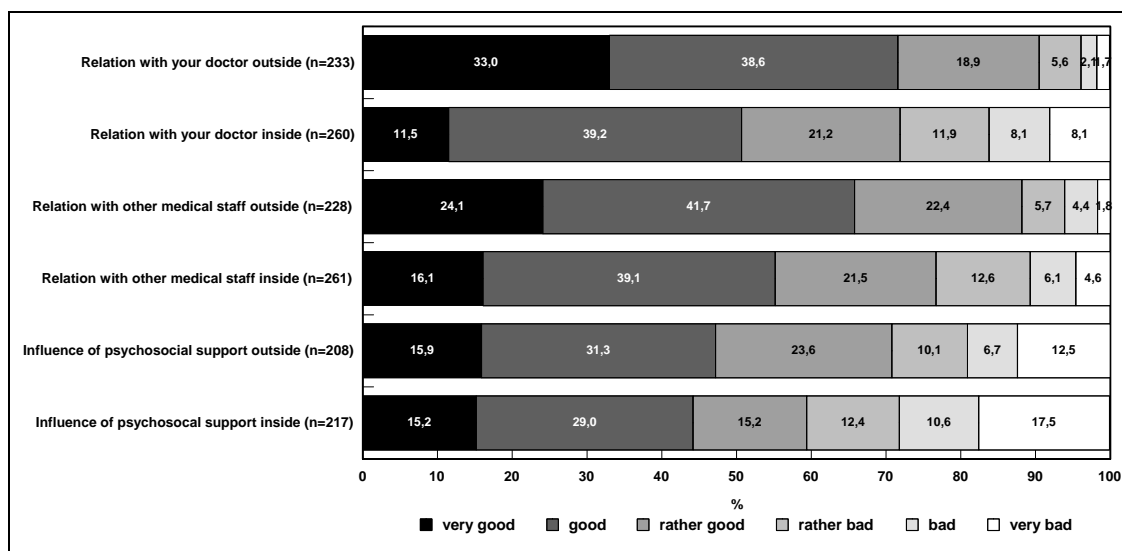
WIAD 2007

Higher shares of positive assessments are to be found for physical state as well as mental state outside and inside prison in the *Portuguese* sample which show a clear feature: three quarter – 73,7% – see an improvement of their physical state outside and even four out of five – 80,0% – inside prison, while two third – 67,6% – perceive an advancement of their mental state in the community and even three out of four – 76,4% – as a result of OST inside prison. As regards the latter aspect, inmates interviewed in *Spain* and *Germany* indicate less improvement of their mental state as an effect of OST in prison when only two fifth of them – 39,1% and 40,8% – give a positive answer.

In order to assess OST as a process, the inmates were asked to evaluate the **social relationship with their doctor** and with the **other medical staff** as well as the **influence of psychosocial support** on their general well being outside and inside prison. On the one hand, clear up to overwhelming majorities with positive answers, i.e. very good, good or rather good, are to be found in all cases, while on the other hand, there is always a definitively better assessment of the process of OST in the community compared to the situation inside prison (chart 24).

Nine out of ten prisoners – 90,6% – state positive relations with their doctor outside and slightly more than seven out of ten – 71,9% – inside prison, while the difference is mainly due to the assessment “very good”: one third of the inmates – 33,0% – perceive very good relations with their doctor in the community but only one out of nine – 11,5% – in prison, which is the largest difference of all (n = 233 and 260). Again almost nine out of ten prisoners – 88,2% – indicate a good relationship with the other medical staff in the community and slightly more than three quarter – 76,6% – in the prison. And once more as well, it is the value “very good” which makes the difference: while a quarter of the inmates – 24,1% – perceives the relation with medical staff outside as “very good”, only one of six – 16,1% – does so inside prison (n = 228 and 261). Finally, seven out of ten inmates – 70,7% – evaluate psychosocial support outside prison positive while six out of ten – 59,4% – see a positive influence inside prison. In this case, the main reasons for the difference are the shares for the value “rather good”: almost a quarter of the prisoners – 23,6% – sees a rather good influence of psychosocial support on their well being in the community, but only between a sixth and a seventh – 15,2% – evaluates the situation in prison in the same way (n = 208 and 217).

Chart 24: Assessments of social relations and influences (prisoners)



Source: AGIS-Survey Prisoners

WIAD 2007

As regards the different sub-samples of inmates interviewed in Austria, Germany, Slovenia, Spain and Portugal more or less clear features can be found. While in the *Portuguese* sample all prisoners interviewed – 100,0% – say they had a good relationship (very good, good, rather good) with their doctor during substitution treatment in the community, only three out of four

inmates in the *Slovenian* sample – 76,5% – and four out of five in the *German* sample – 81,1% – indicate the same. Concerning the relationship with the doctor inside prison, the prisoners interviewed in *Germany* show again a value below the average since only about half of them – 51,9% – see good relations.

Good relations with other medical staff outside prison are stated by all *Spanish* prisoners interviewed – 100,0% –, but again the share in the *Slovenian* sample is below the average: only seven out of ten, i.e. 70,6%, indicate a positive relationship. Inside prison as well, the participants from *Spain* evaluate their relationship with other medical staff more often positive: nine out of ten – 91,5% – say “very good”, “good” or “rather good”. And once more as well, prisoners interviewed in *Germany*, where five to six out of ten – 55,8% – indicate positive relations, and inmates in the *Slovenian* sample, where two third or 67,6% evaluate the relationship with medical staff in prison positive, show values below average.

Similar structures are to be found as regards the influence of psychosocial support in the community. In this case, inmates interviewed in *Spain*, with seven out of eight – 87,5% –, and *Portugal*, with about five out of six – 82,1% –, are again above the average, while in the *German* and the *Slovenian* sample, where around half of the inmates interviewed give positive answers, i.e. 48,8% and 51,5%, the shares are once more below average. Finally, the evaluation of psychosocial support of substitution treatment inside prison shows a wide range. For the first time, prisoners interviewed in *Austria* show a value above average, between three quarter and four fifth – 77,6% – answer positively, and in the *Portuguese* sample, where three quarter – 75,0% – see a positive influence, a high value can be found once more. In contrast, prisoners interviewed in *Germany* show again a value below the average. Between a quarter and three out of ten – 27,8% – give positive answers, this is the largest deviation of all. Additionally, only something more than two fifth of the inmates interviewed in *Spain* – 42,9% – assess psychosocial support in prison positively, which is the only negative value from these prisoners, while the share for the *Slovenian* sample, where not more than half of the prisoners interviewed – 48,5% – give positive answers, is in line with its general negative feature.

5.3.13 General assessments and further comments, remarks and information

At the end of the questionnaire, the inmates were asked with open questions to give general assessments of the consequences, if OST was not available in their prison and to add comments, remarks and information.

As regards **personal effects if opioid substitution treatment was not provided**, prisoners indicate first of all drug related issues, i.e. they assume “more consumption and more drugs” (43) as well as “relapse and withdrawal syndrome” (23). Consequently, they suppose corresponding deviant behaviour like “drug trafficking”, “smuggling” or “theft” (11, 2 and 1) and see a “need for money to buy drugs” (6). Few say, that there will be “no drug use anyway” (3) or think of “exchange injecting equipment” (2) as an alternative to OST. The second important issue is health or a degradation of health respectively. These consequences are assumed in general

terms when a “bad state of health” is indicated (31) or more specifically when “physical or psychological pains or problems” (16), “suicide” (15) or “stress/ agitation/ depression” (14) are stated. Additionally, “more infections” are supposed by some inmates (4). Moreover, inmates anticipate a decline of social relations, i.e. “more violence and more aggression” (12). Some prisoners see a “change into another prison” (4) as a personal effect if OST was not available for them in prison and some assume only “few changes” (3).

Concerning supposed **effects on the prison if opioid substitution treatment was not available**, numerous drug related statements can be found, too. The inmates anticipate “more drug use” or “more consumption” (28 and 9) as well as “relapse/ withdrawal syndrome” (3). Deviant drug related behaviour like “drug trafficking” or “smuggling” (29 and 4) is stated as well as a “need for money to buy drugs” (2). Additionally, few prisoners suppose “more syringes” (2). Again, health or the risk for health are of great importance. An unspecific “bad state of health” (16) or “physical/ psychological pains” (9) are stated as well as, more specific, “stress/ agitation/ depression” (19) and “suicide” (8). More over, some inmates anticipate “more infections” (3). Compared to the assumption of personal effects, if OST was not provided in their prison, negative effects on the social climate and social relations in the prison are more often supposed. Inmates anticipate “violence/ aggression/ conflicts” (50) and even “murder” (5) as well as “many problems” (9) in general and “escape attempts” (1). Finally, some anticipate “few changes” (2).

Asked for **comments, remarks and information**, some inmates criticize in general a “bad prison” (1) or “bad management” (1) and its “drug policy” (1) or “substitution policy” (1). As regards health issues the global assessment “bad medical care” (4) or a claim for “more medical care” (1) can be found. More specifically inmates complain that there is “no choice of the doctor” and want “more right to a say” (2).

Concerning substitution treatment, first of all other substances or a choice of substances respectively (6) are claimed by prisoners and a lack of “individual dosage” (1) is criticized. While “anonymous treatment” (1) is asked for, a comment concerning exclusion “because of the treatment” (1) might indicate the same problem. There are claims for more psycho-social or psychological care (3) or just “more understanding” (1) to be found and a lack of “rehabilitation” is complained.

While on the one hand critical statements claim a “better control of who gets methadone” (1), complain about the use of “other hard drugs” (1) and an “abuse of the treatment” (1) or assume less users “without OST” (1), on the other hand several positive statements favour OST in prison, especially as a help for better life, or claim more of it (5).

5.3.14 National particularities

The following tables and texts recapitulate national particularities according to the samples of prisoners interviewed in Austria, Germany, Portugal, Slovenia and Spain (table 20 and 21).

Table 20: National particularities: Background of Substitution (prisoners)

Variable	Country (+ = above average/ - = below average)				
	Austria	Germany	Portugal	Slovenia	Spain
<i>Social background</i>					
Age	-	+		-	+
School qualification	+		-	+	
<i>Prison history</i>					
Years spent in prison whole life	-			-	+
Years of current stay until now	-	-			+
Current sentence	-	-	+		+
<i>Drug history</i>					
First used drugs					-
First injected					-
Time using drugs	-	+	+	-	
Ever injecting in prison	+	+	-		
First time injecting in prison		+	-	+	
<i>Risk behaviour</i>					
Shared needles outside	-	+		-	+
Shared syringes outside		+	-	-	+
Shared other drug equipment outside		+	-		+
Shared needles inside		+	-	-	+
Shared syringes inside		+	-	-	+
Shared other drug equipment inside		+	-	-	+
<i>Substitution experience outside</i>					
Ever in substitution outside	+	+	-	-	
Substitution time outside altogether			-	-	+
Substitution time outside last treatment	+		-	-	+

Source: AGIS-Survey Prisoners

WIAD 2007

Prisoners interviewed in the *Austrian* sample are younger than the average and have higher school qualification. They have spent less time of their whole life in prison, have been a shorter period in prison at the time of the study and have a sentence below average. They have used drugs for a shorter time but injected more often inside prison. Needle sharing outside prison is less frequent in this group. They participated more often in substitution outside and for a longer time during their last treatment.

The *German* sample is characterised by a higher age of the inmates interviewed and a lower current stay in prison as well as a lower sentence. These prisoners have used drugs for a longer time, injected more often in prison and more frequently for the first time in prison. All kinds of risk behaviour asked for are above average, i.e. sharing of needles, syringes and other drug equipment outside as well as inside prison. In the sample, there are more prisoners with experience in OST in the community.

The inmates interviewed in *Portugal* have lower school qualification and higher sentences. They have used drugs for a longer time than average, but injected less often in prison or for the first time in prison. With the exception of needle sharing outside prison, their risk behaviour is below

average. They also have less experience with substitution outside and their time of substitution in the community altogether as well as for the last time is below average.

The prisoners in the *Slovenian* sample are younger and have higher school qualification than average. They have spent less time of their whole life in prison and have used drugs for a shorter time, but injected more often for the first time in prison. With the exception of sharing of other drug equipment outside prison, their risk behaviour is below average. They participated less frequently in substitution outside, for less time, altogether as well as for the last treatment.

The prisoners interviewed in *Spain* are older than average, have spent more time of their life in prison, have a longer current stay and a longer sentence. They were younger when they used drugs for the first time as well as when they injected for the first time. For all kinds of risk behaviour, they show higher values. They spent more time in substitution treatment outside, altogether as well as for the last time.

Table 21: National particularities: Substitution outside and inside prison (prisoners)

Variable	Country (+ = above average/ - = below average)				
	Austria	Germany	Portugal	Slovenia	Spain
<i>Form in prison</i>					
Maintenance started in prison			+		-
Continuance of treatment in prison			-		+
<i>Circumstances</i>					
Get substitution in prison easily	+	-	-		+
Say in choosing the substance outside	+			-	+
Treatment interrupted outside	+		-	+	
Psychosocial support outside		-		-	+
Say in choosing the substance inside			-		+
Treatment interrupted inside	-	+	-	+	
Psychosocial support inside	+	-	+	-	-
Confidentiality		-	+	-	-
<i>Additional drug use</i>					
Use of additional drugs outside		+		-	
Use of additional drugs inside	-	+	+		
<i>Effects</i>					
General atmosphere in prison better			+	-	
Physical state better outside			+		
Mental state better outside			+		
Physical state better inside			+		
Mental state better inside		-	+		-
<i>Treatment process:</i>					
<i>social relations and influences</i>					
Good relation with doctor outside		-	+	-	
Good relation with medical staff outside				-	+
Good psychosocial support outside			+	-	+
Good relation with doctor inside		-			
Good relation with medical staff inside		-		-	+
Good psychosocial support inside	+	-	+	-	-

Source: AGIS-Survey Prisoners

WIAD 2007

Prisoners in the *Austrian* sample say more frequently that it was easy to get substitution in prison. They had more often a say in choosing the substance outside, but experienced more often an interruption of treatment in the community, too. Inside prison, their value for interruption

is below average and they got more often psychosocial support. They use less often additional drugs during substitution in prison and indicate more frequently a positive influence of psychosocial support inside.

Inmates interviewed in *Germany* state less often that it was easy to get substitution in prison. They also had less frequently psychosocial support in the community. Inside prison, their treatment was more often interrupted, they have less psychosocial support and perceive less often, that confidentiality is ensured. While their use of additional drugs is higher outside as well as inside prison, they state less often an improvement of their mental state as an effect of OST inside prison. Their assessments of the treatment process concerning social relations and influences is almost always below average with the only exception of relations with medical staff outside.

Prisoners from *Portugal* participating in the study have more frequently started maintenance treatment in prison and, inversely, continue less often a treatment started in the community. They think less often than average, that getting treatment in prison was easy. Outside, their experience with interruptions of treatment is below average. Inside prison, they had less often a say in choosing the substance. Their value for interruption inside is lower than average, while they state more frequently having psychosocial support and assess confidentiality higher. They use additional drugs inside prison above average. Positive effects of OST on the general atmosphere are perceived more frequently as well as improvements of their physical and mental state outside and inside prison. Larger shares indicate positive relations with their doctor in the community and a positive influence of psychosocial support outside as well as inside prison.

The *Slovenian* prisoners interviewed concerning substitution indicate, outside less often that they had a say in choosing the substance, more often an interruption of treatment and psychosocial support below average. Inside prison, their treatment was more often interrupted, while they have less frequently psychosocial support and assess confidentiality below average. Outside, they use less often additional drugs. An advancement of the general atmosphere in the prison due to OST is indicated below average. With the exception of relations with their doctor inside prison their assessments of the treatment process concerning social relations and influences is always below average.

In the *Spanish* sample a lower share started maintenance treatment in prison while a higher share continued the treatment started outside. The assessment, getting substitution treatment in prison were easy, is above average as well as the possibility to have a say in choosing the substance outside as well as inside prison. While they had more often psychosocial support outside, the value for inside prison is below average, as well as the value for confidentiality. They see less often an improvement of their mental state inside. Relations with medical staff are more often evaluated positively outside as well as inside prison. While the positive assessment of psychosocial support outside is above average as well, the estimation of psychosocial support inside is below average.

5.3.15 Summary of the survey among prisoners

The majority of the prisoners is between 26 and 40 years old, the school qualification of three of five of them is not higher than the lowest formal qualification attainable. The majority has spent between two and ten years of their life in prison and one half each of the inmates are currently up to one year or more in prison. The majority indicate up to three years as current sentence.

More than half of the inmates were less than 18 years when they used opioid drugs for the first time and also more than half less than 20 when they first injected drugs. The majority has up to ten years experience with regular opioid drug use. More than a third indicate they injected drugs while being in prison and almost one of eight state they first injected in prison. More than three out of ten prisoners state they ever shared needles with someone else, a third indicate the share of syringes and four out of ten the share of other drug equipment outside prison. According to the inmates, the respective values are lower inside prison: slightly concerning needles, clearer for syringes and remarkably as regards other drug equipment.

About five out of six inmates had experiences with OST in the community, the majority up to three years. Almost exactly one half each were in treatment outside for the last time up to 18 months or longer. The majority continue a substitution treatment which has been started in the outside community while a third started a maintenance treatment inside prison. Only a small group indicate a detoxification treatment.

A clear majority of three quarter found it easy to get OST in prison and again a clear majority indicate Methadone as their substitution substance outside but first of all inside prison, while a greater diversity of substances used in the community can be noticed. While two out of three inmates indicate a say in choosing the substitution substance outside, only one out of three do so for their treatment inside. For slightly more than half of the prisoners treatment outside prison had been interrupted at least one time, but only a fifth indicate an interruption inside prison. Half of the prisoners received psychological and/ or social support during substitution outside, but almost half of the prisoners have this help in prison, too. Only one out of four sees confidentiality of treatment ensured, while more than half of the inmates deny the question.

Almost five out of six inmates indicate additional drug use during OST outside. This share is remarkably lower – two out of five – inside prison. Outside prison, three out of five prisoners use cannabis/ hashish, between four out of ten and almost half of the inmates alcohol, tablets or opiates/ heroin. Other drugs are stated by three fifth. The shares for inside are lower, but the value is still relatively high for cannabis/ hashish which state two fifth. One out of eight prisoners indicates expulsion from the programme for discovering of additional drug use outside prison, but almost three out of ten states the same consequence as regards inside prison, while there is almost no difference concerning reduction of the substitution substance: one out of eight prisoners affirms this for outside and one out of seven for inside prison.

In almost all cases absolute or relative majorities of the inmates see positive personal changes as regards drugs due to substitution inside prison, only small groups negative changes. More

than three out of five state less drug consumption, more than half of them indicate less relapses to illicit drug use and almost half of them less drug related emergencies. Two fifth say, they have less abscesses. The assessment of other physical harm is only marginally positive. Concerning most of the aspects of the inmates' personal capacities absolute or relative majorities see positive changes. Again, only small or very small groups indicate negative changes. About half of the inmates state better motivation and better physical ability to work. Almost half of them think, their motivation and their physical ability to get education and the quality of social contacts are better. One third indicate better integration in general health care, three out of ten better integration in other drug service. Changes of home leaves are not positively affected.

Only small or very small minorities state a rise of problems in prison life. Because the groups which indicate a decrease are always larger, the overall assessments are positive. Almost half of the prisoners think OST reduces the use of opiate drugs, between two fifth and a half see a decrease of intravenous drug use, almost two fifth state less physical violence among prisoners, between one third and two fifth indicate a reduction of drug related emergencies and more than a third say psychological violence among prisoners happens less often. One third perceive a decrease of drug trafficking, psychological violence between prisoners and guards and physical violence between prisoners and guards. More than a quarter state a lower frequency of suicides or suicide attempts. About one out of five indicates less other conflicts between prisoners and guards, less other conflicts among prisoners and less selling sex as a currency. Between one sixth and one fifth think other forms of self harm happen less often. A clear absolute majority of almost three out of five indicate a better general atmosphere.

Clear absolute majorities indicate improvements of their physical state and their mental state outside as well as inside prison while only small groups see degradations. Three out of five inmates state an advancement of their physical health and between a half and three fifth a better mental state outside and inside. As regards the social relationship with their doctor and with other medical staff as well as the influence of psychosocial support overwhelming majorities of positive answers are to be found, but there is always a definitively better assessment of the process of OST outside compared to inside prison. Nine out of ten state positive relations with their doctor outside, slightly more than seven out of ten inside. Almost nine out of ten indicate a positive relations with the medical staff outside, slightly more than three quarter inside. Seven out of ten evaluate psychosocial support outside positive, six out of ten inside.

6. Summary

The results of the international and multi-method research project on the “Reduction of drug-related crime in Prison: The impact of substitution treatment on the manageability of opioid dependent prisoners” carried out in 7 European countries, demonstrate that Opioid Substitution Treatment (OST) plays a more and more prominent role in tackling drug use and its negative consequences and in particular opioid-related security and health problems in European prisons. The more the number of patients in OST increases in the community, as it is the case in Europe (compare to chart 1)⁶⁹, the more treatment uptake and/or continuation of OST becomes a widely accepted and successful treatment option in prisons. This study focuses on the impact OST has for prisoners, for staff and for the whole institution and looks after health related impacts for prisoners with regard to opioid addiction and related diseases. Staff's attitude, perception and experiences with OST as well as prisoners health needs, experiences, and demands are analysed. Both groups have been asked about their views on the role of OST for the manageability of drug dependence within the prison setting.

The **literature review** revealed that prison-based substitution treatment is effective in reducing re-incarceration rates and crime rates as well as mortality and HIV infections. The frequency of injecting was reduced in long-term OST with a sufficient dosage. There is evidence for the feasibility in a range of prison settings. OST can have positive effects on prison safety as drug-seeking behaviour decreases. Health benefits are likely, OST increases for instance the access to antiretroviral therapies. An important effect of prison-based OST is an increased treatment entry and retention. There is a positive impact on safety and crime issues in penal institutions and no security or safety problems were found.

The **interviews with experts in the 7 countries** demonstrated that the number of prisoners receiving substitution treatment has steadily increased in recent years (e.g. in Austria) and many patients receive substitution treatment for the first time whilst in prison.

A prerequisite for successful implementation and steady developments of OST in custodial settings are political commitment and leadership combined with financial allocations.

The Austrian example demonstrates that a decree from the Ministry of Justice regarding substitution treatment as a standard procedure in prisons is on the one hand clarifying the relevance, the impact and treatment modalities of OST, and on the other hand the importance of OST for every prison.

However, despite a common ministerial decree, heterogeneous policies and practices regarding substitution drugs (e.g. duration of prescription ranging from expected 6-12 months sentence in one prison to indefinite durations in others, disparities in urine testing in Germany; different perception of the eligibility of slow release morphine in Austria) indicate a need for an ongoing and countrywide discussion of OST.

⁶⁹ <http://www.emcdda.europa.eu/html.cfm/index41523EN.html>

The experiences in England and Wales show that political and professional leadership, a shift of responsibility for health care delivery from the Home Office to the National Health Service, and a massive investment in training and education for doctors, nurses and staff in prisons are significant prerequisites for the enormous increase in the number of patients in prison-based OST in a considerably short period of time.

On the contrary the lack of political commitment, resources and efforts to train doctors, nurses and staff leads to the fact that the whole potential of OST is not yet fully exploited. The German experiences demonstrate that these limiting factors lead to a low number of patients in OST (approx. 500 out of approx. 20-25,000 opioid experienced prisoners) with extremely heterogeneous access and treatment modalities. The 16 German 'Länder' have their own prison jurisdictions, which furthermore leads to different practices and policies across the country.

The pivotal role of NGOS to be involved in prison-based OST becomes obvious in the structures in place particularly in Portugal and Italy. The CAT centres are external centres, specialised in drug treatment, that play a key role in the provision of substitution treatment in and out of prisons, and thus guarantee a seamless provision of OST from the community to the prison setting and back to the community all over the country.

We also observed a change in the variety of substitution drugs available in the community to a reduced offer in custodial settings. Slow release morphine or buprenorphine are prescribed in the community, but to a large extent they are replaced by methadone in prisons. The reason is that methadone often is seen as pharmacologically superior and easier to handle in terms of control and supervision of intake. Furthermore, it is much cheaper compared to slow release morphine.

Treatment provision modalities in Slovenia demonstrate the importance of team's decision on OST. The members of the teams are: nurses, medical doctors, psychiatrist (GP/psychiatrist is often the same as the one in community treatment center). There is a strong connection and collaboration between treatment teams in prisons and community treatment centers.

An acknowledgement and integration of the patient's views and expertise contributes to successful accomplishment and outcome of OST. Individual negotiations about dosage are part of the doctor-patient relationship and important to adjust treatment possibilities to individual health needs. Experiences show that clear orientations towards the patients needs are feasible and lead to a higher satisfaction and retention rates in OST (e.g. Austria).

Although OST is becoming more and more accepted in almost all countries of the EU, there is still resistance against it based on the widespread drug-free orientation regarding problem drug users. This resistance is predominant in the prison setting, where new approaches in drug services (e.g. harm reduction approaches) usually reach custodial health care settings with a time lag of 10-15 years.

The main positive outcomes of OST in prisons is the process of normalisation of drug treatment in general. Still stigmatised in some ways, drug users in treatment are now better accepted by other prisoners and are less stigmatised by the staff.

The massive coverage of OST needs of prisoners in Spain is combined with psychosocial support, which is seen as an important factor for the success of the treatment. Further characteristics of OST in Spain are:

- Same inclusion criteria than outside in the community.
- No waiting list.
- Smooth transition from prison-based programme to outside programmes.
- Integral part of a comprehensive drug strategy including drug free treatment, needle exchange, access to HAART and anti-viral therapies..
- No exclusion with other programmes (except drug free Therapeutic Communities).

The evaluation of the impact of substitution treatment on opioid dependent prisoners revealed the following:

- *Experiences:* About five out of six inmates had experiences with substitution treatment in the community, most of them up to three years. The majority continues a substitution treatment which has been started in the community while one third started a maintenance treatment inside prison.
- *Violence, suicides, self harm and conflicts:* One third perceives a decrease of psychological violence between prisoners and guards and physical violence between prisoners and guards More than a quarter state a lower frequency of suicides or suicide attempts. About one out of five indicates less other conflicts between prisoners and guards, less other conflicts among prisoners and less selling sex as a currency. Between one sixth and one fifth think other forms of self harm happen less often. A clear absolute majority of almost three out of five indicate a better general atmosphere.
- *Drug use, trafficking and risk behaviour:* Almost half of the prisoners think substitution treatment reduces the use of opiate drugs, between two fifth and a half see a decrease of intravenous drug use, almost two fifth state less physical violence among prisoners, between one third and two fifth indicate a reduction of drug related emergencies and more than a third say psychological violence among prisoners happens less often. One third perceive a decrease of drug trafficking.
- *Physical and mental state:* Clear absolute majorities indicate improvements of their physical state and their mental state outside as well as inside: Three out of five inmates state an advancement of their physical health and between a half and three fifth a better mental state outside and inside prisons. As regards the social relationship with their doctor and with other medical staff as well as the influence of psychosocial support overwhelming majorities of positive answers are to be found. However, there is always

a definitively better assessment of the process of substitution treatment outside compared to inside prison. Nine out of ten state positive relations with their doctor outside, slightly more than seven out of ten inside. Almost nine out of ten indicate a positive relation with the medical staff outside, slightly more than three quarter inside. Seven out of ten evaluate psychosocial support outside positive, six out of ten inside.

- *Access:* A clear majority of three quarter found it easy to get substitution treatment in prison and again a clear majority indicate Methadone as their substitution substance outside but first of all inside prison, while a greater diversity of substances used in the community can be noticed.
- *Choice of substitution substance:* While two out of three inmates indicate a say in choosing the substitution substance outside, only one out of three do so for their treatment inside.
- *Additional drug use:* Almost five out of six inmates indicate additional drug use during substitution treatment outside. This share is remarkably lower (two out of five) inside prison.
- *Expulsion from OST programme:* One out of eight prisoners indicates expulsion from the programme due to additional drug use outside prison, but almost three out of ten states the same consequence inside prison.
- *Personal changes:* In almost all cases absolute or relative majorities of the inmates see positive personal changes as regards drug use due to substitution inside prison. More than three out of five state less drug consumption, more than half of them indicate less relapses to illicit drug use and almost half of them less drug related emergencies. Two fifth say they have less abscesses.
- *Personal capacities:* Concerning most of the aspects of the inmates' personal capacities absolute or relative majorities see positive changes. About half of the inmates state better motivation and better physical ability to work. Almost half of them think, their motivation and their physical ability to get education and the quality of social contacts are better. One third indicate better integration in general health care, three out of ten better integration in other drug service.

The evaluation of the impact of substitution treatment on the manageability of opioid dependent prisoners revealed that staff perceives OST as follows:

- *Violence, suicides, self harm and conflicts:* Many of the indicators measuring violence in prison are assessed to have positively changed. The majority of staff indicates a decline of physical violence among prisoners and among prisoners and guards, while around 29% see less psychological violence among prisoners and between prisoners and guards to have declined. As regards suicide and suicide attempts, about one third indicates a positive change, i.e. a decline in these incidences.
- *Drug use, trafficking and risk behaviour:* As regards changes in drug related issues most of our indicators are assessed to have changed for the better. 42% of the staff in-

dicating less illicit drug use in prison and about half of the staff sees a decline in intravenous drug use. Almost 40% of the staff indicate a decline in drug related emergencies.

- *Physical and mental state:* Majorities of the staff indicate positive changes in the prisoners' physical and psychological health. Four to five in ten see their motivation to work and to get education improved. The physical ability to do so was even assessed by 5 to 6 in ten to have advanced. Around half of the staff sees better social contacts and integration into the health system and drug services. About 80% of the staff state psycho-social support for prisoners under substitution treatment. Around 63% indicate a good or very good influence of this support on the prisoners' wellbeing. Around a quarter sees a rise, one third no change and around 6% a decrease of home leaves.
- *Information on OST:* Medical staff as well as psychologists and social workers are best informed on substitution treatment in general, whereas wardens and other staff have the highest information demand. The information level is lowest concerning medical specific questions; accordingly, information demand is highest as regards these questions. Concerning medical staff, psychologists and social workers, one half each wants more or no more information.
- One third of the staff indicates a higher job satisfaction since the implementation of substitution treatment, half of the staff does not see a change and ten percent state a decline. Work atmosphere and general atmosphere in prison changed for the better for about 40%, almost the same number indicates no change. In all cases the medical staff most frequently indicates a positive change as well as a negative.

These results clearly demonstrate the benefits of OST inside prisons both for prisoners and for staff and subsequently for the institution.

7. Recommendations

Meanwhile there is a body of scientific evidence and positive practical experiences in providing OST to opioid dependent prisoners throughout the world. This was the basis for many international guidelines to explicitly recommend OST as an efficient and successful method to tackle opioid dependency, drug use related problems, to facilitate ongoing treatments of other diseases (e.g. antiretroviral treatment) and to manage problems related to opiate use like trafficking, violence etc. These findings have been published in manuals to assist medical doctors, nurses, social workers and psychologists working inside prisons. This evidence and the importance of providing care and treatment in prisons equivalent to that available in the community provides compelling reasons for prison systems to introduce substitution treatment. On this basis the positive results for prisoners, staff and the whole institution should be more intensively communicated with politicians in charge and stakeholders responsible for health care in prisons (doctors, governors etc.).

This study revealed benefits of OST not only for the individual prisoner, but also for the institution. A number of health benefits for the prisoners have been identified. These are in line with what has been analysed by other studies. What is demonstrated by this study are the benefits for the general atmosphere in the prison stated both by prisoners and prison staff (i) decrease of violence between prisoners and guards, less conflicts; (ii) reduction of illicit drug use, trafficking and risk behaviour), (iii) improvements in prisoners' physical, psychological health and wellbeing (iv) improvement of job satisfaction, work and general atmosphere. These results should be taken as arguments for either introducing or scaling up of OST until demands of opioid dependent prisoners for such a treatment are covered.

The massive drug and other health problems prisoners are facing demand urgently a massive health policy response on the basis of political leadership and professional commitment, and a massive investment in training and education of doctors, nurses and staff in prisons. Making use of OST as a proven and effective strategy to successfully fight HIV/AIDS and hepatitis among injecting drug users and to stabilise patients, and to make drugs problem better manageable in the institution means that a coordinated and concerted strategy is needed nationally, regionally and locally.

Education, information and training should be provided on the concrete treatment modalities as well as on the general impact of OST to tackle opioid dependency and drug related problems (drug use, trafficking, violence, prostitution etc.) in prisons adequately for all levels of staff: health care staff (doctors, nurses), managers and guards. The study showed that guards formulate the highest information demand.

OST should be integrated into existing drug and/or infectious diseases prevention, treatment, care and support strategies of the prisons/regions/countries in order to make OST part of a comprehensive approach of health provision. Within this context it becomes an understandable and transparent form of treatment that will not produce any misunderstandings, absorb envy, and will help to correct misconceptions about addiction and treatment.

In order to be effective, opioid substitution treatment should be:

- based on the individual condition and needs of prisoners, acknowledging their experiences and knowledge
- best organised in a multidisciplinary team to discuss strategy, everyday practice, problems, and perspectives jointly
- provided for the right period of time and at the right dosage required by the individual prisoner;
- provided with the same substitution agents prescribed also in the community, if required
- provided with continuity, upon imprisonment and also following release
- accompanied by psycho-social care, or self help groups and the support of NGOs
- aware of security risks in the situation of uptake, being more relevant for certain substances (slow release morphine, buprenorphine) than for others (methadone).

To guarantee transparency for all involved, clear protocols and guidelines with understandable rules are needed to regulate entry into and conduction of substitution programmes in prison. This is also necessary for existing and transferring patients to community based programmes. Protocols and guidelines offer valuable information on the feasibility and practices of prison-based substitution treatment. They are also an attempt to harmonise different approaches and work on a common understanding of OST and drug addiction.

Substitution treatment is causing daily contacts between health care service professionals and patient, a relationship that can serve as a basis for raising further health issues and a linkage with other infectious diseases prophylaxis and treatment strategy matters.

Treatment risks like additional drug use should not lead to exclusion form OST. As this study shows the level of additional drug use in prisons drops substantially compared with drug use in the community, and problems arising from that are manageable by strict rules and the implementation of control measures (urine controls etc.).

8. Models of good practice

8.1 Definition

Good practice is a positive action that must be successful, innovative, understandable, and sustainable, which then leads to multiplying effects. Innovative means providing a new or different solution to existing ones in the territory or sector. The multiplying effect is expressed by the fact that good practice (i) on the horizontal level is visible, communicable, shareable (dissemination) and/or (ii) on the vertical level is integrated and applicable to systems and regulations.⁷⁰

8.2 Methodology

In order to identify elements of best practice, interviews with experts from the seven participating countries were conducted (see annexed questionnaire). Results of the interviews were processed according to the **methodological principles of qualitative interpretation**. First, in every single interview all different issues and elements were separated and their contents determined. In the next step, these contents and the respective parts of the texts were arranged according to their emerging structure of superior and inferior categories which were denominated with abstract terms referring to the given empirical data. Finally, the whole material was synthesized according to the same principles, i.e. from all interviews the abstract categories and the empirical data belonging to them were combined in order to identify a more complex structure of main- and subcategories on the one hand and denser descriptions of their contents on the other hand. Most elements of good practice mentioned by the interviewed experts rather relate to health aspects than to the manageability of opioid dependent drug users in prison.

8.3 General Principles

According to views of experts interviewed in the framework of this study, good practice of OST in custodial settings should fully acknowledge the key problem of health care in prisons: to deliver health care in the same standard and quality equivalent to that in the community (e.g. inclusion criteria, individual dosage, variety of substitution drugs etc.). Consequently, a component of the **principle of equivalence** would be a **close cooperation and close professional relationships with community based programmes** and treatment services and collaboration with drug therapist in the society. Thus any medical treatment should reflect the importance of throughcare and seamless provision of treatment services.

Experts also emphasise the necessity of the **independence of health care in prison from custodial demands** and attempts to functionalise medical treatment for other than medical purposes.

⁷⁰ In adaptation of equalhungary.hu: <http://www.kezenfogva.hu/equalset/index.php?q=en/node/85>; accessed 14 March 2008

In order to get acceptance and endorsement for health care measures, in particular for those treatments which are controversially discussed like OST, it is necessary to **adjust the programme to the prison-specific needs**, without breaching the outlined requirements.

OST should not be seen as a single and isolated treatment, but should better be **integrated into other health care services** and offers. **OST is part of a comprehensive approach** to tackle opioid dependence and related problems. It is neither the silver bullet, nor eligible for all opioid dependent inmates. It is a substantial part of a comprehensive approach, and should be linked to other disciplines and professions. OST has medical, psycho-social, and security dimensions, which should be combined with and linked to outside professions for the improvement of the patient's health and the security of the institution.

The doctor/nurse-patient-relationship is of pivotal importance for the success of the treatment. This includes **integration of the patient's views and experiences**, the dialogue on suitable substitution drug, dosage, adjustments, definition of treatment goals in a treatment plan, psycho-social care and support, and on rules and regulation, where mutual expectations, should be reflected. Part of this process is the information on OST, and the close cooperation among professionals on the basis of **informed consent**. **Confidentiality** has to be respected. OST is not a 'one-size-fits-all' treatment but like every other medical treatment to be adapted to individual needs, abilities, and resources.

There should be **no waiting list** for prisoners who wish to start OST, and there should be **no exclusion with other drug programmes**.

In the following some examples of good practice of OST are presented:

8.4 Substitution guidelines for penal institutions in Austria

The substitution guidelines for penal institutions in Austria are stating very clearly for every prison doctor in the whole country the purpose, strategy, indications, ethical basis of substitution treatment and possible drug interactions (adapted from Pont J, Spitzer B, Resinger E, 2005⁷¹)

Purpose of substitution

1. Emotional and physical stabilisation of severely opiate addicted individuals
2. Minimisation of drug related crime and debt
3. Reduction of intravenous opiate consumption and of transmissible diseases (hepatitis B/C and HIV/AIDS).

Substitution strategies

- A) Long-term substitution: for months, years or for life-time
- B) Interim substitution: substitution on temporary basis until a well planned treatment and withdrawal.

⁷¹ Published in Kastelic/Pont/Stöver et al. 2008

C) Reduction substitution: substitution medication is carefully reduced step by step.

Substitution medication: use only drugs that are effective for at least 24 hours and are administered orally once a day:

Methadone is prepared and administered “magistraliter” as a syrup in order to make intravenous usage more difficult. The dependence potential is very high. The average oral maintenance dosage is around 40-100mg a day. A dose exceeding 120mg is not recommendable. Introductory dose: 30-40mg daily, boosting by approx. 10mg per week; tapering by 5-10mg per week.

Buprenorphine is a partial opiate agonist and antagonist to be administered sublingually once a day. Daily dose ranges between 8mg and 32mg. In contrast to other substitution drugs, patients remain rather lucid. This creates problems for those patients who clear-minded cannot stand themselves due to their psychosocial co-morbidity. The major reported side-effect is headache. When switching from pure opiate agonists to buprenorphine, it is important to stop the agonist for one day before starting buprenorphine, in order not to cause acute opiate withdrawal symptoms.

Slow release morphine is administered as tablets or capsules. The average morphine dose is around 600mg per day, the highest recommended dose being approx. 800 mg. Patients on anti-retroviral therapy sometimes require a dose of up to 1200mg due to drug interactions. The introductory dose is 200mg, boosted or tapered by 30-60mg per week. The range of side effects attributable to retarded morphine is less than with methadone (less depression, less apathy, less increase in weight).

Drug interactions

With all opiate medications, interactions must be taken into consideration, in particular those due to competitive inhibition or induction of cytochrome P 450: The antibiotics ciprofloxacin, erythromycin, clarithromycin, oral contraceptives and SSRI (especially fluvoxamin) increase the opioid effect, while the HIV virostatics nevirapine, efavirenz, nelfinavir/ritonavir and zalcitabine decrease it.

Obligatory agreements with the patient

- Declaration of consent and registration at the addictive drug monitoring department
- Visual monitoring of the administration
- Consumption control by means of urinalysis
- Regular care support by treatment consultants
- Exact information about substitution medication and the dangers of misuse and of accompanying consumption of other drugs

Indications for substitution

- The patient is already on substitution treatment when entering the penal institution
- The patient has been dependent on opiates prior to imprisonment, and cannot withdraw inside the penal institution

- The patient became dependent on opiates during imprisonment, and in spite of several withdrawal therapies, has not succeeded in becoming clean.

Security measures

- Exact control of administration of the substitution medication by medical staff
- Obligatory random urine tests by medical staff.

Ethical basics of substitution

Addiction is a chronic recurring illness. The optimal goal of therapy, cure, hardly ever is achieved. Modern addiction therapy is increasingly based upon the term harm reduction, i.e. reducing suffering, completed by precise clarification and treatment of psychosocial comorbidities. When choosing substitution medication, cost awareness is of course an issue, i.e. methadone is the first choice. In case of severe side-effects of methadone, a switch to another better tolerated medication is to be considered. Patients successfully on substitution before imprisonment should continue the same medication in prison. Relapses should not lead to termination of substitution treatment as relapses are inherent in addiction. Instead, they should lead to a reassessment whether the treatment can be optimized. In particular, it should be clarified whether the medication dosage is sufficient. If relapses continue to occur in spite of a higher dosage, it might be necessary to switch to a different substitution drug. However, if a patient repeatedly misuses or diverts the prescribed substitution drugs he should be gradually withdrawn from the substitution program as obviously he is lacking the necessary motivation and discipline.

8.5 OST practice in Spanish prisons

Substitution treatment is a generalised drug treatment programme in all 85 Spanish prisons which started 15 years ago. Protocols have long been established. Continuous training on methadone ST is ensured for prison health teams, NGO participate in psychosocial interventions, the target population also participate in the programmes. There are few differences between prisons, even though prisons differ among them

Background information on the prison

Madrid VI Aranjuez is a closed institution with 1.578 adult inmates (1522 male, 56 females), currently 315 of them in substitution treatment. The treatment is organised by the medical department of the prison which comprises a health team with 1 medical subdirector, 7 doctors, 13 nurses and 11 aide-nurses, while psychosocial support is provided by the outside organization "Grupo Interdisciplinar sobre Drogas (GID)" which is in charge of the psychosocial intervention and pre-release activity included in the programme, but not of ST in itself. There exists no separate unit for prisoners who undergo substitution treatment.

Main characteristics of the example

All opiate drug users in prison have access to OST, at any time during their sentence and as long as necessary, with no restrictions. Opiate dependence diagnosis is the only inclusion criteria for OST programmes.

Achievements:

Standardised methadone treatment includes early detection and treatment interventions such as detection, quimioprofylaxis and treatment of TB, VCT and HIV/AIDS treatment, STI detection and treatment, HCV diagnosis and treatment, diagnosis and treatment of mental disorders, as well as HBV immunisation, health education, provision of bleach and condoms and social reintegration programmes inside prison and through community referral.

Who was involved?

The prison health team is responsible for the programme, nurses dispense daily and only the social reintegration programmes are held with NGOs. Inmates participate in dosage co-decision with doctors. Each doctor is responsible for a number of drug dependent patients and can prescribe ST. A nurse is nominated responsible for the methadone programme and prepares daily all methadone solution individual doses adequately identified with the inmates name and module. All methadone is administered at the same time, with different nurses taking them to each module.

Time frame:

All opiate drug users in prison have access to MMT, at any time during their sentence and as long as necessary, with no restrictions. If the patient was following ST before entering the prison, it is continued and before release continuity of treatment is ensured through previous agreements with out-of-prison drug dependence treatment centres.

All the previous characteristics are common to most other ST programmes in Spanish prisons. What has reached further development in Madrid VI-Aranjuez is

- a) health education pre-ST treatment and
 - b) psychosocial intervention and preparation for release.
- a) Every month, the inmates that are following or starting ST will follow a 3-day health education course with the nurse in charge of the ST programme. Contents include information on substances, drug abuse, risks of injection, common infectious diseases associated to drug use, methadone, interactions, especially alcohol and benzodiazepines, secondary effects, overdose prevention and management, pregnancy and breast-feeding etc.
 - b) A psychologist and a health educator from an experienced NGO are responsible for psychosocial intervention and preparation for release. 20% of patients in ST are covered by behavioural interventions, which includes individual evaluation, follow-up and support interviews, group psychological and social support (10-12 participants twice a week) working

self-esteem, functional behaviour analysis, social skills, relapse prevention, emotional control. Participation in health groups is also offered, dealing with healthy lifestyles, dental health, nutrition, communicable diseases, treatment adherence, drug addiction, sexual and injection risk reduction, sexuality, tattoos, family and social support. Participation of inmates in behavioural, sports, social, training and occupational activities is enhanced. Co-ordination with community treatment centres and families is ensured. A minimum of 6 preparation for release workshops are attended by prisoners, including information on community resources, work market, family relations, social networks, social skills, drugs and self-esteem. Finally, sweat collection patches for drug analysis and control are used.

8.6 Scaling-Up OST services in England & Wales

The number of prisoners in substitution treatment in England and Wales increased significantly in a very short period of time. The prerequisite for this development is the political will to massively respond to the health needs of many prisoners. This scaling up process is (apart from shifting health care responsibilities to the National Health Service and published guidelines) the result of massive investment in training for doctors, nurses and staff. Approx. 1 Mio Euros have been spent in one year for vocational training of medical staff in prisons in order to adjust the quality of health care delivery outside and inside prisons and to improve the ability and skills to prescribe substitution agents, increase patients safety and initiate attitude changes.

Offender Health and the Royal College of General Practitioners have jointly developed IDTS clinical training. The training has three levels:

- Level I: A generalist course that comprises e-learning and a day's face-to-face training
- Level II: This is a course of five single-day training events, specialist mentorship and a practice development project. It is designed to move practitioners towards clinical specialist status
- Level III: Advanced Secure Environments Module: This is an intensive two-day course that concentrates wholly on practice in prisons and police custody.

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ANNEX

Table 22:
List of Experts interviewed

List of Experts interviewed

Country	Name	Position
Austria	Dr. Bernhard Spitzer	Medical doctor in several prisons
Austria	Prof. Dr. Jörg Pont	Consultant to the Min. of Justice
Austria	Walter Kahl	Min. of Justice
Austria	Magistra Regina Agostini	Psycho-therapist, Schweizerhaus Hadersdorf, Vienna/Austria
England/Wales	Dr. Michael Farrell	Senior Lecturer , National Addiction Center, Institute of Psychiatry, London/UK xy
England/Wales	David Marteau	Senior Advisor Offender Health/England and Wales
Germany	Dr. Karlheinz Keppler	JVA für Frauen in Vechta/Lower-Saxony
Germany	Bärbel Knorr	Deutsche AIDS-Hilfe, Berlin
Italy	Dr. Daniele Berto	Osservatorio Regionale Carcere - ULSS 16 Padova
Portugal	Luis Mendao	G.A.T. Grupo de Activistas VIH/SIDA, Lisbon/Portugal
Slovenia	Andrej Kastelic	Medical doctor, Center for Treatment of Drug Addiction, Ljubljana/Slovenia
Spain	Andres Marco	Barcelona

Table 23:
Prisons participating in the study

Prisons participating in the study

Country	Prison name	Location of prison	No. of prisoners	No. of prisoners in OST	No. of staff	No. of medical staff
Austria	JA Favoriten	Vienna	130	100	80	6
	JA Josefstadt	Vienna	1200	130	550	41
	JA Simmering	Vienna	462	36	182	9
Germany	JVA Bielefeld - Brackwede I	Bielefeld	527	7	331	13
	JVA Bremen	Bremen	660	90	350	17
	JVA Rheinbach	Rheinbach	550	12	250	10
England	HMP Leeds	Leeds	1000	140	450	7
Italy	Casa Circondariale San Vittore	Milano	1300	80	1800	82
	Casa di reclusione Milano Bollate	Milano	500	80	300	25
Portugal	EP Linho	Cascais	481	6	159	15
	EP Porto	Leca do Balio	922	129	297	26
	EP Sintra	Sintra	698	35	224	9
Slovenia	ZPMZKZ Celje	Celje	105	12	88	1
	ZPKZ Dob	Dob	458	44	207	3
	ZPKZ Ljubljana	Ljubljana	257	52	134	2
	ZPKZ Maribor	Maribor	176	17	118	4
Spain	CP d'Homes de Barcelona	Barcelona	2100	300	540	50
	CP Quatre Camins	La Roca del Valles	1820	285	810	45

Source: AGIS-Survey Staff/ Prisoners

WIAD 2007

Questionnaire prison



Anonymous study on substitution treatment in prison

Information sheet for interviewers

Background information on individual prisons

1. Name of prison _____
2. Location of prison _____
3. Total number of prisoners _____
4. Number of prisoners, who currently undergo substitution treatment in this prison

5. Total number of staff _____
6. Number of medical staff _____
7. Is this prison
 - an open institution
 - including closed and open units
 - a closed institution
8. Is it a prison for
 - female
 - male
 - both
9. Are the inmates
 - adolescent or juveniles
 - adult
 - both
10. Is this prison
 - a public institution
 - a private institution
 - a public private partnership
11. How is substitution treatment organised in this prison?
 - substitution treatment is organised by the medical department of the prison
 - substitution treatment is organised by an outside organisation

12. **If substitution treatment is organised by an outside organisation, please name this organisation:** _____

13. **Is there any kind of psycho-social support offered in this prison for prisoners who undergo substitution treatment?**

	<i>yes</i>	<i>no</i>
psycho-social support by prison staff	<input type="checkbox"/>	<input type="checkbox"/>
psycho-social support by outside organisation	<input type="checkbox"/>	<input type="checkbox"/>

14. **If there is psycho-social support offered from an outside organisation please name this organisation:** _____

15. **Does this prison have a separate unit for prisoners who undergo substitution treatment?**

yes no

Questionnaire staff



Anonymous study on substitution treatment in prison

On behalf of the European Commission the University of Bremen and WIAD (Scientific Institute of the German Medical Association) together with partner organizations in 7 European countries are conducting a study on drug substitution treatment in prisons. In **COUNTRY** the study is carried out by **ORGANIZATION**. The objective of this survey is to investigate the **impact of substitution treatment both for opiate dependent prisoners, prison staff and the organisation of the prison**. This study is strictly voluntary and anonymous. Your personal results will not be made available to anybody else.

Thank you in advance for your kind participation in this study.

1. How old are you? _____ years
2. Are you ... male female
3. Please indicate your current educational level regarding the task you perform in this prison.
 - unskilled
 - semi-skilled (small introduction)
 - trained/skilled (i.e. certificate as warden)
 - college/university degree (i.e. lawyer, doctor)
 - other, please name _____
4. What is your current professional rank?
 - administrative official
 - warden
 - psychologist
 - social worker
 - nursing staff
 - physician
 - other, please name _____

*The following questions concern **SUBSTITUTION MAINTENANCE TREATMENT** (not detoxification) which means **medically assisted treatment for opioid drug dependent persons with substitution substances** such as methadone, buprenorphine etc. in relatively stable doses over a long period of time*

5. How long have you had experience with substitution treatment in prisons (this or other prisons)?
_____ years / _____ months
6. For how long did you work in prisons (this or other prisons) where there was no substitution treatment?
_____ years / _____ months

7. For how long have you worked in this prison since the implementation of substitution treatment?

_____ years / _____ months

*From now on the questionnaire is focussing on **the effects of substitution maintenance treatment** on prisoners in these kind of programmes and the prison system.*

8. Please assess the impact of the change of the following after the implementation of substitution treatment.

	<i>more</i>	<i>no change</i>	<i>less</i>	<i>don't know</i>
the frequency of illicit drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the frequency of intravenous drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
finds of drugs and equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
drug trafficking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
drug-related emergencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
others, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physical violence among prisoners (fist fights, attacks with weapons)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physical violence among prisoners and guards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychological violence among prisoners (threats, bullying, intimidation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychological violence among prisoners and guards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other conflicts among prisoners _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other conflicts among prisoners and guards _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other physical self harm, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. How do you assess the change in the health status of prisoners who undergo a substitution treatment after the implementation of this treatment?

	<i>better</i>	<i>no change</i>	<i>worse</i>	<i>don't know</i>
physical state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychological/ mental state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. How do you assess the change in prisoners' behaviour, motivation and abilities after the implementation of substitution treatment?

	<i>better</i>	<i>no change</i>	<i>worse</i>	<i>don't know</i>
motivation to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physical ability to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
motivation to get education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physical ability to get education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
quality of social contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other, please name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>				
integration into the general health care in prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
integration into other drug services in prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Do prisoners who undergo substitution treatment get any kind of psychological or social support (e.g. from a psychologist or a social worker)?

yes no

12. How do you assess the influence of the psycho-social support on the prisoners' general wellbeing during substitution treatment?

very good good rather good rather bad bad very bad

13. Did the frequency of the home leaves of the prisoners who started a substitution treatment change?

more no change less don't know

14. How well informed do you feel about the following aspects of the substitution programme offered in your prison?

	<i>very good</i>	<i>good</i>	<i>rather good</i>	<i>rather bad</i>	<i>bad</i>	<i>very bad</i>
general information about the programme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the substances used as substitute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the possible side effects in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the possible side effects caused by additional illegal drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the relevance of urine tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the controlling of the intake of the substitution substance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the prescription of other additional drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Do you want more information about substitution treatment in your prison?

	<i>yes</i>	<i>no</i>
general information about the programme	<input type="checkbox"/>	<input type="checkbox"/>
the substances used as substitute	<input type="checkbox"/>	<input type="checkbox"/>
the possible side effects in general	<input type="checkbox"/>	<input type="checkbox"/>
the possible side effects caused by additional illegal drug use	<input type="checkbox"/>	<input type="checkbox"/>
the relevance of urine tests	<input type="checkbox"/>	<input type="checkbox"/>
the controlling of the intake of the substitution substance	<input type="checkbox"/>	<input type="checkbox"/>
the prescription of other additional drugs	<input type="checkbox"/>	<input type="checkbox"/>

Questionnaire prisoners



Anonymous study on substitution treatment in prison

On behalf of the European Commission the University of Bremen and WIAD (Scientific Institute of the German Medical Association) together with partner organizations in 7 European countries are conducting a study on drug substitution treatment in prisons. In **COUNTRY** the study is carried out by **ORGANIZATION**. The objective of this survey is to investigate the **impact of substitution treatment for opiate dependent prisoners, prison staff and the prison organisation**. This study is strictly voluntary and anonymous. Your personal results will not be made available to anyone else.

Thank you in advance for your kind participation in this study.

1. **How old are you?** _____ years
2. **Are you ...** male female
3. **What is your school qualification** (*country specific*)?
 - no formal qualification
 - lowest formal qualification attainable
 - Qualification which are above the lowest qualification, but below the usual entry requirement for universities
 - entry requirement for universities (Abitur, Bac etc.)
 - University degree completed
 - other, please name _____
4. **Your current stay in prison is a ...**
 - remand
 - juvenile sentence
 - adult sentence
5. **How long have you been in prison altogether IN YOUR WHOLE LIFE?**
_____ years / _____ months
6. **How long is your current stay in prison FROM THE FIRST DAY OF IMPRISONMENT UNTIL NOW (including transfer from other prisons)?**
_____ years / _____ months
7. **What is the TOTAL LENGTH of your CURRENT SENTENCE?**
_____ years / _____ months current stay is a remand
8. **How old were you the FIRST time you ever used opioid drugs?** _____ years
9. **How old were you when you first ever INJECTED drugs?** _____ years

10. How long have you been regularly been using opioid drugs (on a daily base)?

for _____ years / _____ months

11. While IN PRISON have you ever INJECTED drugs? yes no

12. Were you in prison the FIRST time you ever INJECTED drugs? yes no

13. Have you EVER shared any of the following with someone else?

	inside prison		outside prison	
	yes	no	yes	no
needles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
syringes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other drug equipment as filters, spoons, water etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions concern **SUBSTITUTION MAINTENANCE TREATMENT** (not detoxification) which means **medically assisted treatment for opioid drug dependent persons with substitution substances** such as methadone, buprenorphine and the like in relatively stable doses over a long period of time

14. Have you ever undergone a medically assisted substitution treatment OUTSIDE prison?

yes no

15. How long have you been under substitution treatment OUTSIDE prison?

ALTOGETHER _____ years / _____ months

on your LAST treatment _____ years / _____ months

does not apply to me

The following questions concern your LAST substitution treatment in the OUTSIDE COMMUNITY.

16. Please indicate the substance being used in your LAST substitution treatment in the OUTSIDE COMMUNITY. (country specific)

	yes	no	don't know
Metasedin® (Methadone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L-Polamidon® (Levomethadone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subutex® (Buprenorphine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DHC®, Remedacen® (Dihydrocodeine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mundidol®, Substitol® (Slow Release Morphine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BritLofex® (Lofexidine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin® (Diamorphine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orlaam® (Levo-alpha-acetylmethadol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

does not apply to me

17. How do you assess the relationship between you and your doctor concerning your LAST substitution treatment in the OUTSIDE COMMUNITY, was it ...

- very good
 good
 rather good
 rather bad
 bad
 very bad
 does not apply to me

18. How do you assess the relationship between you and the other medical staff concerning your LAST substitution treatment in the OUTSIDE COMMUNITY, was it ...

- very good
 good
 rather good
 rather bad
 bad
 very bad
 does not apply to me

19. Did you have a say in choosing the type of substitution drug?

- yes
 no
 does not apply to me

20. Did you have a certain influence on the dose of the substitution substance?

- yes
 no
 does not apply to me

21. Has your substitution treatment in the outside community ever been interrupted?

- yes
 no
 does not apply to me

22. If your substitution treatment in the outside community has ever been interrupted, please indicate why:

- does not apply to me

23. While you were in treatment in the outside community, did you use any other drugs in addition to your substitution substance?

- yes
 no
 does not apply to me

24. If you used other drugs in addition to your substitution substance, what kind of drugs were these?

	<i>yes</i>	<i>no</i>
cannabis/hashish	<input type="checkbox"/>	<input type="checkbox"/>
alcohol	<input type="checkbox"/>	<input type="checkbox"/>
opiates/ heroin	<input type="checkbox"/>	<input type="checkbox"/>
tablets	<input type="checkbox"/>	<input type="checkbox"/>
other, please name _____	<input type="checkbox"/>	<input type="checkbox"/>

- does not apply to me

25. What happened when the doctor or someone else found out that you used other drugs on top of your substitution drug?

	<i>yes</i>	<i>no</i>
expulsion from the substitution programme	<input type="checkbox"/>	<input type="checkbox"/>
reduction of the substitution substance	<input type="checkbox"/>	<input type="checkbox"/>
other, please name _____	<input type="checkbox"/>	<input type="checkbox"/>

- does not apply to me

26. Did you get any kind of psychological and/ or social support in your substitution treatment in the outside community (e.g. from a psychologist or a social worker)?

yes no

27. How did you assess the influence of the psycho-social support on your general wellbeing under substitution treatment at that time?

very good good rather good rather bad bad very bad

28. How do you assess the change of your health status within the substitution treatment in the community?

	<i>better</i>	<i>no change</i>	<i>worse</i>	<i>don't know</i>
physical state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychological/ mental state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
others, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

does not apply to me

The following questions concern the substitution treatment you CURRENTLY undergo IN THIS PRISON.

29. What kind of substitution treatment do you CURRENTLY undergo inside this prison?

detoxification (detox in a few days/weeks)

maintenance started in prison (daily doses for a longer period over 30 days)

continuance of substitution treatment already begun in the community

30. Please indicate the substitution substance you are CURRENTLY taking. (country specific)

	<i>yes</i>	<i>no</i>	<i>don't know</i>
Metasedin® (Methadone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L-Polamidon® (Levomethadone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subutex® (Buprenorphine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DHC®, Remedacen® (Dihydrocodeine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mundidol®, Substitol® (Slow Release Morphine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BritLofex® (Lofexidine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin® (Diamorphine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orlaam®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Levo-alpha-acetylmethadol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
others, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

does not apply to me

31. How hard or easy was it for you to get access to substitution treatment in this prison?

very easy easy rather easy rather hard hard very hard

32. If it was hard to take part in the substitution programme, please indicate why:

does not apply to me

33. How do you assess the relationship between you and your doctor concerning your current substitution treatment in prison, is it ...

very good good rather good rather bad bad very bad

34. How do you assess the relationship between you and the other medical staff concerning your current substitution treatment, is it ...

very good good rather good rather bad bad very bad

35. Do you have a say in choosing the type of substitution drug? yes no

36. Has your substitution treatment in this prison ever been interrupted?

yes no

37. If your substitution treatment in this prison has ever been interrupted, please indicate why:

does not apply to me

38. Do you use any other drugs in addition to your substitution substance?

yes no

39. If you use other drugs in addition to your substitution substance, what kind of drugs are these?

	yes	no
cannabis/hashish	<input type="checkbox"/>	<input type="checkbox"/>
alcohol	<input type="checkbox"/>	<input type="checkbox"/>
opiates/ heroin	<input type="checkbox"/>	<input type="checkbox"/>
tablets	<input type="checkbox"/>	<input type="checkbox"/>
other, please name _____	<input type="checkbox"/>	<input type="checkbox"/>

does not apply to me

40. What happens when the doctor or someone else finds out that you use other drugs?

	yes	no
expulsion from the substitution programme	<input type="checkbox"/>	<input type="checkbox"/>
reduction of the substitution substance	<input type="checkbox"/>	<input type="checkbox"/>
other, please name _____	<input type="checkbox"/>	<input type="checkbox"/>

does not apply to me

41. Do you currently get any kind of psychological and/ or social support in your substitution treatment (e.g. from a psychologist or a social worker)?

yes no

42. How do you assess the influence of the psycho-social support on your general wellbeing during your substitution treatment?

very good good rather good rather bad bad very bad

43. Is the fact that you undergo a substitution treatment in prison kept confidential?

yes no don't know

44. For YOU PERSONALLY, how did your substitution treatment in prison change the frequency of the following issues?

	<i>more</i>	<i>no change</i>	<i>less</i>	<i>don't know</i>
drug consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
abscesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
drug-related emergencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
relapses to illicit drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other physical harm, please name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45. How did your participation in the substitution treatment in prison change

	<i>better</i>	<i>no change</i>	<i>worse</i>	<i>don't know</i>
your motivation to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your physical ability to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your motivation to get education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your physical ability to get education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the quality of your social contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your integration into the general health care in prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your integration into other drug services in prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
others, please name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. Do you think that the substitution treatment has any influence on the following behaviors of the INMATES IN YOUR PRISON? Please indicate the impact of the change.

	<i>more</i>	<i>no change</i>	<i>less</i>	<i>don't know</i>
the frequency of opiate drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the frequency of intravenous drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
drug trafficking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
drug related emergencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physical violence among prisoners (fist fights, attacks with weapons)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychological violence among prisoners (threats, bullying, intimidation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other conflicts among prisoners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
selling sex as a currency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
suicide/ suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other forms of self harm, please name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

47. Do you think that the substitution treatment has any influence on the relationship between prisoners and guards? Please indicate the impact of the change.

	<i>more</i>	<i>no change</i>	<i>less</i>	<i>don't know</i>
physical violence (fist fights, attacks with weapons)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychological violence (threats, bullying, intimidation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other conflicts, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. How do you assess the change in your health status after the implementation of the substitution treatment in prison?

	<i>better</i>	<i>no change</i>	<i>worse</i>	<i>don't know</i>
physical state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychological/mental state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
others, please name _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

49. How do you assess the impact of the substitution treatment on the general atmosphere in your prison? Is it ...

- better no change worse don't know

50. Did the frequency of your home leaves change after starting your substitution treatment?

- more no change less don't know

51. What do you think would be the effects on YOU PERSONALLY, if your prison didn't offer substitution treatment?

52. What do you think would be the effects on THE PRISON if there was no substitution treatment?

Thank you very much for your help!

Questionnaire expert interviews



INTERVIEWS OF
EXPERTS ON SUBSTITUTION
TREATMENT IN PRISON

Please feel free to write on additional themes and pages.

- 1. Please describe the process of the implementation of ST (with starting date) in your country in general AND in the prison setting including the political situation concerning ST.**

- 2. What are the main differences between the outside community and the prison setting regarding ST?**

- 3. Substitution treatment in prison can be realised in different ways. Please describe the current situation of substitution treatment in prison in your country.**

4. How do you assess the significance of ST in prison in comparison to other drug related treatment (e.g. brief detoxification)?

5. Please give information on the medical rules (formal and informal) as regards ST in prison (e.g. who takes part in the programme, substitution substance, dosing, etc.).

6. Are there differences in the realisation of ST between the outside community and the prison setting as regards medical rules? Please specify the differences.

7. How would you assess the main changes in the health status (physical and psychological health) of prisoners who undergo a ST?

We thank you for your support.

Questionnaire best practice



Questionnaire on best practice of substitution treatment in prison

Please feel free to write on additional themes and pages.

14. Please define your criteria of „best practice” of ST in prison (general rules and specific aspects of practice).

15. In the light of your criteria, are there examples of best practice in ?

Please describe them:

- Please fill the form again for each new example!-

Title of example of best practice in substitution treatment in prison in:

Please describe the main characteristics of the example of best practice (general objective, target groups, achievements, who was involved, time frame, etc.):

Please give details concerning the following aspects:

Which medical rules (formal and informal) are applied in this case (e.g. who takes part in the programme, substitution substance, dosing, confidentiality, consent of prisoners, etc.)?

Are the impacts on the health status (physical and psychological health) of prisoners who undergo the ST assessed?

Are the impacts of ST on the manageability and control of prisoners (e.g. as regards drug related issues, violence, self harm, prisoners' motivation and behaviour etc.) assessed?

Please give some background information on the prison, as far as available:

1. **Name of prison:** _____

2. **Location of prison:** _____

3. **Total number of prisoners:** _____

4. **Number of prisoners, who currently undergo substitution treatment in this prison** _____

5. **Total number of staff:** _____

6. **Number of medical staff:** _____

7. **Is this prison ...**

- an open institution
- including closed and open units
- a closed institution

8. **Is it a prison for ...**

- female
- male
- both

9. **Are the inmates ...**

- adolescent or juveniles
- adult
- both

10. **Is this prison ...**

- a public institution
- a private institution
- a public private partnership

11. **How is substitution treatment organised in this prison?**

- substitution treatment is organised by the medical department of the prison
- substitution treatment is organised by an outside organisation

12. **If substitution treatment is organised by an outside organisation, please name this organisation:**

13. **Is there any kind of psycho-social support offered in this prison for prisoners who undergo substitution treatment?**

	<i>yes</i>	<i>no</i>
psycho-social support by prison staff	<input type="checkbox"/>	<input type="checkbox"/>
psycho-social support by outside organisation	<input type="checkbox"/>	<input type="checkbox"/>

14. **If there is psycho-social support offered from an outside organisation please name this organisation:**

15. **Does this prison have a separate unit for prisoners who undergo substitution treatment?**

yes *no*

Please give contact details of the person who managed the measure of best practice:

Name:

Profession:

Address:

Email:

Tel No.:

Fax No.:

We thank you very much for your support!