



Status Paper on Prisons, Drugs and Harm Reduction

May 2005



ABSTRACT

The Status Paper on Prisons, Drugs and Harm Reduction was adopted at the WHO International Meeting on Prisons and Health in De Leeuwenhorst, the Netherlands on 22 October 2004. The meeting was organized in cooperation with the National Agency of Correctional Services, the Ministry of Justice, the Netherlands and the Pompidou Group of the Council of Europe. The meeting was co-sponsored by the WHO Collaborating Centre on Prison Health, Department of Health, England and Wales, Ministry of Health, the Netherlands, KNCV Tuberculosis Foundation, Aids Foundation/SOA Aids Nederland, Cranstoun Drug Services and European Monitoring Centre for Drugs and Drug Addiction.

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Foreword

This Status Paper on Prisons, Drugs and Harm Reduction summarizes the evidence on harm reduction in prisons and aims to provide evidence for action that will reduce the health-related harm associated with drug dependence within the overall objectives of the WHO Health in Prisons Project to protect and promote the health of those imprisoned in the interest of public health.

The Status Paper is the result of research evidence and expert opinion derived from various expert sources and from the conclusions of:

- an expert discussion and a dedicated round-table session at the 7th European Conference on Drug and HIV/AIDS Services in Prison: Prison, Drugs and Society in the Enlarged Europe: Looking for the Right Direction held in Prague, Czech Republic on 25–27 March 2004;
- a discussion at a Task Force meeting of the WHO Health in Prisons Project held by the Pompidou Group of Council of Europe in Strasbourg on 13–14 May 2004;
- a special session at the WHO Health in Prisons Project annual conference held in De Leeuwenhorst, the Netherlands on 21 October 2004.

The public health case for action is strong. Those involved in deciding policies and services for prisons now have the evidence of effectiveness to add to the successful experiences in several countries in Europe and elsewhere. They should conclude that harm reduction measures can be safely introduced into prisons, that such measures can significantly bolster preventing the transmission of HIV/AIDS in communities and that action in the interests of public health as a whole is now required.

Introduction

The presence of illicit drugs and the associated harm from their problematic use has changed considerably the reality of prisons throughout Europe and the rest of the world. In the past two decades or so, the linked resurgence of communicable diseases such as tuberculosis and sexually transmitted diseases and the arrival of the new life-threatening epidemic of HIV/AIDS as well as the increasing attention being paid to the prevalence of hepatitis C has led all countries to seek the best ways of reducing their harmful health, economic and social effects.

This report summarizes the evidence on harm reduction in prisons, bearing constantly in mind the considerable differences between the countries in Europe, including legal system, point of departure, epidemiological situation and economic situation. The report aims to provide evidence for action that will reduce the health-related harm associated with drug dependence within the overall objectives of the WHO Health in Prisons Project to protect and promote the health of those imprisoned in the interest of public health. This report should be seen as following up the Project's consensus statement on prisons, drugs and society issued by the WHO Health in Prisons Project and the Pompidou Group of the Council of Europe (2002).

Although this report has been produced specifically to meet the needs of prison systems throughout Europe, the report is consistent with the relevant resolutions of the United Nations and WHO as well as the Council of Europe and the European Union and therefore should be relevant in a global sense, as the challenges are similar.

Although this report concentrates on harm reduction, the underlying basic needs of prisoners remain crucial: decent space and less overcrowding, good hygienic conditions, acceptable nutrition, a stable and safe environment and prison regimens that are conducive to improving health and self-esteem and to helping prisoners take back the control of their lives.

This report is the result of research evidence and expert opinion derived from various expert sources and from the conclusions of both a special expert group discussion and a dedicated round-table session at the 7th European Conference on Drug and HIV/AIDS Services in Prison: Prison, Drugs and Society in the Enlarged Europe: Looking for the Right Direction held in Prague, Czech Republic on 25–27 March 2004. The Conference was organized by the European Network on Drugs Services in Prisons (now renamed the European Network on Drug and Infections Prevention in

Prison (ENDIPP)). A Task Force of the WHO Health in Prisons Project discussed a previous draft on 13–14 May 2004. A special conference held in De Leeuwenhorst, the Netherlands as part of the Annual Meeting of the WHO Health in Prisons Project on 21–22 October 2004 considered and accepted the final draft.

Background

Two of the greatest public health problems facing all societies overlap: the epidemic of HIV/AIDS and the pandemic harmful use of psychotropic substances such as alcohol and illegal drugs. Although knowledge about controlling HIV/AIDS and evidence of how transmission can be reduced have grown considerably, 10 people globally are infected with HIV every minute of every day. In 2004, 39 million adults and children were estimated to be living with HIV/AIDS globally. The rates of new infections in eastern Europe and in central, south and south-east Asia are the ones growing most rapidly. An estimated 13.2 million people worldwide inject drugs – including between 3.3 and 5.4 million in Europe and central Asia. The importance of injecting drug use in contributing to HIV epidemics is well documented.

The imprisonment rates of some countries in eastern Europe are among the highest in the world. For example, the imprisonment rate in the Russian Federation in 2003 was 600 per 100 000 population, second only to rates in the United States of America. Typical rates in western European countries are 50–100 per 100 000 population.

In most countries in Europe and central Asia, rates of HIV infection are much higher among prisoners than among the population outside prisons. Studies in countries in Europe have found great variation in the rates of HIV infection among prisoners. The rates are generally higher in eastern Europe, for example: Estonia (12% in 2002), the Russian Federation (4% in 2002) and Ukraine (7% in 2000). High rates in prisoners have been reported in some western European countries, such as Portugal (11% in 2000), but other countries (such as England) that have successfully targeted injecting drug users with prevention interventions early in the epidemic have HIV prevalence rates among prisoners that are typically less than 1%. Major HIV outbreaks

have occurred among prisoners in Glenochil, Scotland in 1993 and more recently in 2002 at the Alytus Prison in Lithuania.

Prisons are extremely high-risk environments for HIV transmission because of overcrowding, poor nutrition, limited access to health care, continued illicit drug use and unsafe injecting practices, unprotected sex and tattooing. Many of the people in prisons come from marginalized populations, such as injecting drug users, which are already at elevated risk of HIV infection. In most cases, high rates of HIV infection in prisons are linked to the sharing of injecting equipment and to unprotected sexual encounters in prison. Syringe sharing rates are invariably higher in prisons than among injecting drug users outside prison.

This situation is exacerbated by high rates of tuberculosis (often multidrug resistant), sexually transmitted infections and hepatitis B and C. In 2002, the tuberculosis rate in prisons in the Russian Federation was 9.8% and the syphilis rate about 1.2%. Published studies have found that 20–40% of prisoners are living with hepatitis C and the rates of hepatitis C among prisoners who inject drugs are routinely two to three times higher than among prisoners who have no history of injecting drug use.

An estimated 10% of all cases of HIV infection worldwide result from unsafe injecting behaviour. In countries in eastern Europe and central Asia, up to 90% of the people reported to be infected with HIV are injecting drug users. The rates of HIV infection are significantly higher among inmates of prisons and other detention centres than among the general population. Certain populations that are highly vulnerable to HIV infection have an elevated probability of imprisonment because they use illicit drugs and engage in sex work. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) annual report for 2003 (EMCDDA, 2003), hepatitis C among injecting drug users in the 15 countries that were members of the European Union before 1 May 2004 plus Norway varies between 30% and 97%, although most figures are local estimates; the national data vary between 32% (United Kingdom) and 79% (Italy). Some countries are now experiencing an increase in the prevalence of liver disease due to hepatitis C infection. In addition to the risk of AIDS and of hepatitis C, HIV-infected drug users have a great risk of serious opportunistic illnesses such as tuberculosis. In Europe, 30% of injecting drug users in western Europe, 25% in central Europe and well over 50% in eastern Europe have tuberculosis.

A disproportionate number of prisoners in Europe have personal histories of drug use and many of the people entering prison have a severe drug problem. According to the EMCDDA (2004), the prison population reporting having ever used an illicit drug varies widely in the European Union (11 of the 25 countries plus Norway for which data are available): between 22% and 86%. Similar to the general population, cannabis is the most frequently reported illicit drug, with lifetime prevalence rates among inmates of 11–86%. Prisoners' lifetime prevalence of cocaine (and crack) use is 5–57% and that of heroin 5–66%.

Regular drug use or dependence prior to imprisonment is reported by 8–73% of inmates and lifetime injecting drug use by about 15–50%, although some studies have reported values as low as 1% or as high as 69%. Where comparable data are available, they show that young offenders are less likely to inject than adults and that women are more likely to inject than men.

From evidence to action

Overwhelming scientific evidence shows that a comprehensive package of interventions can prevent and reverse an HIV/AIDS epidemic as well as epidemics of other infections among injecting drug users.

International organizations such as UNAIDS and WHO recognized the need to move from evidence to practice in the 1990s. The United Nations General Assembly Special Session on the World Drug Problem in 1998 explicitly identified prisoners as an important group for activities to reduce demand (United Nations, 1998). In 1999, the European Union endorsed an action plan to combat drugs for 2000–2004 (European Commission, 1999, 2001, 2002). Among the targets set were those aiming to substantially reduce, over five years, the incidence of drug-related health damage (such as HIV, hepatitis C and tuberculosis) and the number of drug-related deaths.

The Council of the European Union (2003) recommendation on the prevention and reduction of health-related harm associated with drug dependence of 18 June 2003 pointed out that:

Since, according to research, the morbidity and the mortality associated with drug dependence affects a sizeable number of European citizens, the health-related harm associated with drug dependence constitutes a major problem for public health.

The Recommendation (Council of the European Union, 2003) put forward the following targets for the member states of the European Union.

- Member states should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.
- Member states should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction.
- Member states should consider [developing] appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks.

The WHO Regional Office for Europe established the WHO Health in Prisons Project in 1995 to establish a network of countries from all of the WHO European Region willing to come together to share experiences in dealing with the major public health challenges of prison health, to produce consensus guidelines and to disseminate best practice. The WHO Regional Office for Europe (1999) issued, with UNAIDS, guidelines on HIV infection and AIDS in prisons.

In 2002, the WHO Regional Committee for Europe adopted resolution EUR/RC52/R9 on scaling up the response to HIV/AIDS in the European Region of WHO that urged Member States:

to promote, enable and strengthen widespread introduction and expansion of evidence-based targeted interventions for vulnerable/high-risk groups, such as prevention, treatment and harm reduction programmes (e.g. expanded needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, substitution drug therapy, STI diagnosis and treatment) in all affected communities, including prisons, in line with national policies.

Also in 2002, with its partner organization the Pompidou Group of the Council of Europe, the WHO Health in Prisons Project (2002) issued a consensus statement on the considerable role of prisons in contributing to a public health strategy for dealing with the harmful effects of drugs to public health, to the users, to staff and to the management of prisons. The principles, policies and practices outlined in that statement remain valid and should be considered along with this report. The statement strongly recommended harm reduction but did not include a detailed consideration of the evidence.

Now that more countries are becoming aware of the economic, social and health benefits for societies and individuals of all aspects of harm reduction, it is time for a joint effort to be made to get the political will and the ongoing commitment so that the scientific evidence from evaluation of interventions throughout the world is more widely put into practice.

Definition of harm reduction

Preventive and clinical medicine use risk reduction to indicate what could be done to lessen the chance of harmful consequences arising from certain types of individual behaviour, from specific social or medical interventions or from certain adverse environmental conditions. It can be applied widely and often relates to high-risk behaviour or “unsafe” practices. In injecting drug use, harm reduction has become the preferred term in recent years.

Unfortunately, harm reduction has been interpreted in a bewildering variety of ways. A Europe-wide appeal for making more rapid progress in the face of the continuing epidemics might require agreed international definitions and terms.

A simple definition WHO has used mainly relating to injecting drug use is as follows.

In public health “harm reduction” is used to describe a concept aiming to prevent or reduce negative health consequences associated with certain behaviours. In relation to drug injecting, “harm reduction” components of comprehensive interventions aim to prevent transmission of HIV and other infections that occurs through sharing of non-sterile injection equipment and drug preparations.

Harm reduction is an important public health measure because reusing and sharing needles or other equipment for preparing and injecting drugs represent a highly efficient method of transmitting HIV and hepatitis C. In the absence of harm reduction activities, HIV prevalence among injecting drug users can rise to 40% or more within one or two years after the virus is introduced in their communities. Worldwide, more than 114 countries now report HIV epidemics associated with injecting drug use.

However, the WHO Health in Prisons Project is concerned with all the negative health effects arising from imprisonment. These include the impact on mental health, the risk of suicide and self-harm, the need to reduce the risk of drug overdose on release and the harm resulting from inappropriate imprisonment of people requiring facilities unavailable in prison or in overcrowded prisons.

The WHO Health in Prisons Project proposes the following definition for its purposes.

In public health relating to prisons, harm reduction describes a concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health.

Rationale and suitability of harm reduction in prisons

The rationale for harm reduction in prisons is based on public health principles and human rights. Public health has been defined as what society does collectively to assure the conditions for people to be healthy. An essential principle of public health is that people should have the knowledge and the facilities or access to them to maintain and improve their own health. As part of the human rights of prisoners, free access to health care at least equivalent to what is available to those not in prison should be available and this should include equivalent access to preventive and public health measures. These principles should also be respected for programmes for harm reduction in prisons.

Success requires involvement and cooperation between governing bodies, agencies, prison staff and those with personal experience.

Successful harm reduction is based on a policy, legislative and social environment that minimizes the vulnerability of problematic drug use. To be comprehensive, many sectors have to be involved, beyond health services, to include the legal framework, the law enforcement practices and the cultural, social and economic environments in which problematic drug use has emerged.

Suitable policies and their implementation will only develop if all levels of government are involved, together with civil society, nongovernmental organizations and community-based organizations.

Involving people with personal experience of severe drug dependence and people living with HIV/AIDS or with other infectious diseases such as hepatitis will ensure that policies and practices are based on reality and have the best chance of being effectively applied.

The necessary collaboration can be achieved if everyone accepts that harm reduction aims to help injecting drug users and other problematic drug users to avoid the negative health effects of drug injecting and of sharing other paraphernalia, such as pipes, to reduce the risk of serious infection and improve not only their own health and social status but that of the community. The potential gain to public health is very great.

Approaches to reducing harm recognize that many drug users cannot totally abstain from psychoactive substances in the short term and aim to help drug users to not start, to stop or to reduce their injection frequency and increase injection safety and safety in tattooing.

Evidence is increasing that HIV transmission can be reduced in prisons (WHO, UNAIDS and UNODC, 2004a). Since the early 1990s, various countries have introduced prevention programmes in prisons. Such programmes usually include:

- information, education and communication on HIV/AIDS
- voluntary testing and counseling

- distribution of condoms
- bleach or other disinfectants
- exchange of needles and syringes
- substitution therapy.

Additional components of a harm reduction programme with a significant potential to reduce individual risk behaviour associated with drug injection and other risk behaviour include treatment and care related to HIV/AIDS, hepatitis and tuberculosis, including access to highly active antiretroviral therapy.

Does harm reduction threaten prison systems?

The introduction of harm reduction measures is relatively new to prison systems and is often perceived as threatening to the traditional abstinence-oriented drug policy in prisons. It is widely seen as undermining the security measures of the prison system. But this is the result of failing to see harm reduction as more effective treatment and care for prisoners with special needs. An important aspect of the thinking behind harm reduction is to add another valuable element to the health care of drug-dependent prisoners and to reduce the health risks to personnel.

Some aspects of harm reduction are now widely accepted and applied throughout Europe. An analysis of prison-based programmes contained in the EMCDDA information system Exchange on Drug Demand Reduction Action (EDDRA) (Merino, 2003) found that about one fifth of the prison interventions had reducing drug-related harm as their main objective.

Prison systems in Europe are often especially reluctant to support the introduction of needle- and syringe-exchange schemes because they feel it might lead to an increase in injecting drug use, accidental needle pricks and conflicts between prisoners or between prisoners and staff and the risk that syringes or needles would be used as weapons. Evidence shows that schemes have been introduced in prisons in Spain and in five other European countries without these problems arising (Lines et al., 2004; Stöver & Nelles, 2003).

Nevertheless, harm reduction in prisons involves much more than needle-exchange schemes. Useful harm reduction programmes can still be established where such schemes are currently not being considered.

How harm can be reduced

A continuum of approaches

The harm reduction framework provides for a continuum of approaches, including education and health promotion, detoxification and substitution therapies, needle exchange and disinfection facilities, with abstinence from drugs a possible outcome. For harm reduction in prisons, in each of these aspects, the particularities of prison life and the characteristics of prisoners must be considered.

Most of the 15 countries that were members of the European Union before 1 May 2004 have specific policy guidelines on harm reduction, but implementation is inconsistent between prisons

and even within prisons. Blood screening, vaccination programmes and disinfectants are available in theory in almost all prisons in 8 of these 15 countries but not available at all in three of these 15 countries. In addition, even though services are available, prisoners are often either not informed about them (for vaccination for hepatitis in a number of countries) or are not properly trained to use them (for bleach distribution for disinfection). Only in Spain are harm reduction services available in all prisons.

This variation in provision reflects the crucial role of national policies in determining the availability of harm reduction in prison services.

Although this report gives priority in harm reduction to drug dependence and especially injecting drug use, the concept also applies to the control of other prison health problems, such as alcohol abuse and unsafe sexual practices.

Information, education and communication

Providing information to prisoners and staff about HIV/AIDS, what it is and how it is transmitted, is one of the most widespread methods of reducing harm throughout Europe. The use of modern educational methods and of visual aids is now well established. Understanding will produce more effective collaboration between prisoners and staffs in reducing the spread of HIV.

Involving drug users in developing, designing and delivering information materials is critical to increase their appropriateness and range of reach. The content should cover both the risks of injection and sharing practices and advice on how to reduce these risks and avoid sharing.

Information should be delivered through a variety of channels, including general awareness campaigns, providing targeted information through health and social services frequented by problematic drug users and delivering information through peer and drug user networks and outreach workers. Harm reduction counselling is based on face-to-face communication and provides an opportunity for drug users to turn information into actual behaviour change through a process of clarification and reinforcement.

In community harm reduction services, embedding harm reduction activities into comprehensive prevention, treatment and support packages for problematic drug users can be crucial to their success. Psychosocial support is known to add major additional impetus to such programmes. As the drug scene is often hidden and rapidly changing, reaching as many individuals as possible who inject regularly or occasionally represents a particular challenge to harm reduction services and requires in-depth understanding of the local patterns and contexts of drug use.

The particular needs of imprisoned ethnic minorities must be considered. Language is the most obvious barrier, but most ethnic minority prisoners would have experienced difficulties in accessing health and social care before admission and this could affect their health and addiction problems. As Europe already has a high proportion of foreign nationals among inmates in prisons, a range of measures may be necessary to facilitate information, education and communication among them.

Health professionals working in prisons often have little contact with the health professional networks outside prison. In addition, they are often not able to access continuing education and training, which aggravates the isolation of prison health services. The treatment of drug-

dependent prisoners, as outlined above, emphasizes the importance of an integrated approach between the prison and the community health services.

In harm reduction, as in other health issues in prisons, the implementation by national policy-makers of the WHO Moscow Declaration on prison health as part of public health (WHO Health in Prisons Project, 2003) is of great significance.

Detoxification and drug substitution therapy

The frequency of serious problems that arise during the period of withdrawal on admission to prison, including self-harm and violence, strongly support the need for a planned approach to detoxification. This should be included as part of a clinical programme for the treatment and care of drug-dependent prisoners.

Drug substitution therapy means the medically supervised treatment of individuals dependent on opioids based on the prescription of opioid agonists such as methadone and buprenorphine. These substances can be used for detoxification and maintenance therapy.

As with other health conditions, such as hypertension, diabetes and heart disease, people dependent on opioids can stabilize their condition by developing and incorporating behavioural change and by using medication appropriately. Relapse after detoxification is extremely common and detoxification on its own therefore rarely constitutes adequate treatment of substance dependence. The options include managing withdrawal on admission as gradual detoxification, proceeding to abstinence-oriented treatment or proceeding to long-term substitution maintenance. Successful outcome of interventions requires that they be as client-tailored as possible and applied differently using a case-by-case approach.

Substantial scientific evidence shows that substitution treatment is effective in reducing illicit opioid use, reducing criminal activity, preventing overdose deaths and preventing HIV infection. Good evidence also demonstrates that methadone maintenance treatment improves the overall health status of drug users infected with HIV. Substitution maintenance treatment reduces heroin use and is more effective in retaining drug users in treatment than detoxification. Substitution maintenance treatment has many other benefits, including stabilizing drug users, interrupting chaotic lifestyles and thereby improving the levels of social functioning and employment.

Scientific evidence clearly suggests that substitution treatment is the treatment option for managing opioid dependence that is most effective in preventing HIV and hepatitis transmission and in caring for drug users living with HIV/AIDS or with other infections. Substitution maintenance treatment also offers opportunities for improving the delivery of antiretroviral therapy to drug users with HIV/AIDS, notably by increasing access to treatment and improving retention in programmes and adherence to treatment.

Maintenance therapy is thus part of a programme of clinical care for drug-dependent people. The position paper WHO, UNODC and UNAIDS (2004b) recently published on substitution maintenance therapy concludes that providing substitution maintenance therapy of opioid dependence is an effective strategy for preventing HIV/AIDS that should be considered for implementation as soon as possible in communities at risk of HIV infection. Once HIV has been introduced into a local community of injecting drug users, it may spread extremely rapidly.

Given the evidence that substitution maintenance therapy is effective in both managing opioid dependence and in preventing and treating HIV/AIDS, the WHO Regional Office for Europe, in accordance with Regional Committee Resolution EUR/RC52/R9 (see previously), fully supports the position paper (WHO, UNODC and UNAIDS, 2004b) and the related policy brief (WHO, UNODC and UNAIDS, 2004a) on reducing HIV transmission through drug-dependence treatment.

There are strong reasons for prison services to consider introducing substitution therapy. These include:

- problems in managing regimens and difficulties for staff that arise during withdrawal, including drug smuggling and acts of violence toward staff and other prisoners;
- the growing problem of suicide and self-harm during the period of withdrawal among imprisoned problematic drug users and drug-dependent people;
- the importance of equity in provision between prisons and communities;
- the drive to provide clinical services at a standard equivalent to internationally agreed best practice;
- the risk of a fatal overdose in the first few days following release from prison, especially for short-term prisoners.

Substitution therapy programmes report several valuable benefits, including decreased use of other drugs, decreased crime, decreased mortality, less HIV transmission, less hepatitis C transmission and marked improvements in the health of drug users. This treatment has been shown to work and to be cost-effective.

In Australia, a randomized controlled trial of methadone maintenance therapy in prison (Dolan et al., 2003) studied 382 injecting drug users in 1997 and reinterviewed them in 1998. Random allocation was between a methadone use group and a control group. The results showed a lower hepatitis C incidence and less heroin use in the methadone use group compared with the control group.

Substitution therapy in the form of methadone or buprenorphine maintenance is already provided in prisons in Spain. Substitution treatment is available in almost all prisons in 6 of the 15 countries that were members of the European Union before 1 May 2004. Five of these countries offer it in only a few prisons and the others in no prisons.

Another aspect that remains disputed is the aims of treatment and the type of approach. The evaluation research that has shown benefits usually concerns programmes with a high dose and a high threshold. The dose is adjusted to a level that can reduce craving and then block any use of heroin as a euphoriant. This programme requires that the user accept some control, supervision and involvement in psychosocial consultations. The aim is to increase the quality of life and improve social functioning and living conditions. Low-threshold programmes, which may involve supplying methadone on an outpatient basis, are not considered further.

Reducing the harm of drugs in prisons is bedevilled by the illegality of certain drugs in most countries. This is also the case for harm reduction in the community, since several countries make possessing drugs, even for personal use only, illegal. Harm reduction activities, such as substitution therapy, have incorrectly been characterized as being in conflict in both letter and spirit with the United Nations Drug Control Conventions (UNODC, 1961, 1971, 1988).

However, these Conventions were set up to protect public health and safety and they permit the use of narcotic drugs and psychotropic substances for “medical and scientific purposes”. Their use in properly supervised health programmes, in which the agents used have been thoroughly evaluated, treatment is administered by accredited professionals in the framework of recognized medical practice and there is appropriate clinical monitoring, is in accordance with the Single Convention on Narcotic Drugs (UNODC, 1961) and the Convention on Psychotropic Substances (UNODC, 1971).

The England and Wales Prison Service is producing a detailed protocol for the clinical management of drug dependence in the prison setting, covering reception, assessment, stabilization, opiate agonist maintenance, detoxification and counselling. It would be useful to establish whether other prison services are doing the same and to see whether the protocols have common elements.

The results of research into substitution therapy in prisons in Europe show considerable variation in practice, not just between countries or even between prisons in the same country but between health care staff within the same prison. Authoritative guidance is strongly needed to lead to a standardized approach, including that in handling detoxification and maintenance therapy and in initially assessing new prisoners with drug problems. The policy being pursued must be more transparent, as some prisoners have been reported to be convinced that substitution therapy was being used as a reward for good behaviour or not prescribed as punishment.

The exchange of experiences of those trying to implement substitution treatment schemes in prisons has demonstrated that guidance is required for several important questions on clinical services and approach. These included dosage, privacy, supervision of intake and how best to choose between the substitution therapy substances now available. The importance of programmes including adequate psychosocial support has been stressed. The need for proper preparation for discharge from prison to reduce the chance of fatal overdose has also been stressed. Further, existing studies indicate that continuity of care is required to maintain the benefits of treatment in prison.

Characteristics of good models include: the adequacy of the period of time available for treatment; the availability of close links to community health and drug services; the amount of retraining provided for the physicians and nurses involved; and the extent to which the views of the prisoners themselves have been considered.

A recent position paper on substitution maintenance therapy in managing opioid dependence and preventing HIV/AIDS (WHO, UNODC and UNAIDS, 2004b) authoritatively summarizes the benefits of substitution maintenance therapy in the community. It states that substitution maintenance therapy is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families and society at large by reducing heroin use, associated deaths, HIV risk behaviour and criminal activity. Some of the benefits to prisons as well as to drug-dependent prisoners have been indicated above.

Needle and syringe exchange in prisons

Many communities throughout Europe currently provide a community-based needle- and syringe-exchange facility, which reduces the transmission of HIV and hepatitis from injecting drug use. The aim of such schemes is to ensure that the drug users who continue injecting have

access to clean injection equipment, including needles and syringes, filters, cookers, drug containers and mixing water, thus reducing the risks of HIV and hepatitis infection and transmission. Such programmes can also serve as information points and may engage drug users with drug treatment services.

HIV is now known to be able to survive in used needles for several days and hepatitis C for several weeks (depending on temperature, humidity and other factors). A public health approach must therefore emphasize the importance of collecting used needles and syringes. The effectiveness of this approach in breaking the chain of transmission of HIV and other bloodborne viruses such as hepatitis is well established.

In prisons, needle- and syringe-exchange schemes are still controversial. However, by 2002, some European prisons had had 10 years of experience with such programmes. Syringe-exchange programmes had been introduced in six European countries: Belarus, Germany, Kyrgyzstan, Republic of Moldova, Spain and Switzerland. In Spain, needle exchange has been introduced in all prisons.

An evaluation of 11 programmes (Stöver & Nelles, 2003) showed that syringe distribution did not support fears that were expressed before the scheme was introduced. For example, neither drug use nor injecting drug use increased, syringes were not misused and disposal of used syringes was uncomplicated. The discrepancy between the success of syringe-exchange programmes in prison and its low acceptability was striking.

The relatively little evidence available appears to show that, where risks are great, such as in countries with high prevalence rates of HIV and hepatitis, carefully introducing a syringe- and needle-exchange programme would be justifiable based on the experience already available in some parts of Europe. When prison authorities have any evidence that injecting is occurring, they should consider an exchange scheme, regardless of the current prevalence of HIV infection.

If needle- and syringe-exchanges schemes are not considered to be feasible or desirable, disinfection programmes can be used. Disinfection is usually achieved with chemical substances such as bleach and users should disinfect after using and also before reusing injecting equipment. Serious problems are related to the use of bleach in prisons. For example, prisoners are highly unlikely to spend 45 minutes shaking the syringes to clean them while waiting to inject in some hidden corner of the prison. Bleach can therefore create a false sense of security between prisoners sharing paraphernalia.

The effectiveness of disinfection procedures therefore depends greatly on the method used. Effectiveness varies and disinfection is now regarded as a second-line strategy to needle- and syringe-exchange programmes.

Many countries with well-established exchange schemes in the community do not make them available in prisons. Evidence shows that needle-exchange programmes can be provided in prisons and that they can be safe, as effective as those outside prison schemes and acceptable to both prisoners and staff (Lines et al., 2004; Stöver & Nelles, 2003).

The experience of the prisons that have successfully used this approach should be used to give guidance on the most acceptable way of exchanging the injecting equipment and of ensuring safe and effective service.

Several countries in Europe clearly recognize the discrepancy between the syringe-exchange services provided in the community but not in prison. In the Netherlands and the United Kingdom, local evidence suggests that tight but supportive prison regimens or a switch from injecting to smoking has led to very low drug injection in prisons. They therefore concentrate on other aspects of harm reduction such as drug substitution therapy.

Treatment and care related to HIV/AIDS

Health care and psychosocial care aim to help drug users living with HIV/AIDS cope with the infection. Involving HIV-positive drug users in primary health care and/or in antiretroviral therapy programmes provides an opportunity for them to adopt and consolidate safe behaviour and may yield significant effects in preventing HIV transmission. This applies especially when care is provided in the context of specific information and counselling services.

Harm reduction in prisons in its social, political and cultural context

The drug problem in Europe is still being addressed in a variety of ways. A simple analysis of these show three main approaches.

- The therapeutic model mainly views drug dependence as an illness and concentrates on treatment and cure, taking a primarily symptomatic approach to the drug problem.
- The social control model is based on the objective of a drug-free society and emphasizes abstinence; social control and suppression are key factors in the national drug policy.
- The damage limitation model accepts drug use as a social reality; drug dependence is often regarded as a passing phase in the life of a person and damage limitation is intended to help ensure that this phase is passed through without harm or with the least possible harm.

These models rarely appear clear-cut, as most countries seem to implement a rather diverse mix of approaches, even if one predominates at any one time.

However, regardless of which model predominates in a particular country, it is highly likely to influence considerably the priorities, expectations and attitudes of politicians, prison services, policy-makers and staff, including health care staff. This is why the consensus statement on prisons, drugs and society (WHO Health in Prisons Project and Pompidou Group, Council of Europe, 2002) was based on the principles for working with prisoners who are (or have been) misusing drugs. These included the recognition that drugs and prisons have to be seen in the wider social context; that people move between prisons and the community; that imprisonment should not mean more punishment than the deprivation of liberty; that prisons must be safe, secure and decent places in which people live and work; and that people working in prisons must work within the law as it stands. The statement also pointed out that there can be tension between some harm reduction measures and other issues related to operating a prison, such as security, criminal justice and occupational health.

Regardless of the continuing debate as to which model is best for each society, this report aims to demonstrate that considerable scientific and research evidence justifies harm reduction measures in prisons in all countries of Europe and a powerful public health case supports the urgent development of these harm reduction services. The actual measures to be taken and to what extent they should be applied will vary with the circumstances of each country.

Harm reduction action in prisons: what would be a minimum standard?

The evidence of the effectiveness of harm reduction action is now overwhelming. The fact that progress in incorporating these within the prison systems of Europe is so slow is becoming increasingly unacceptable.

All prisons and prison systems are therefore recommended to be able:

- to accept the importance of information and understanding about the harmful consequences of inappropriate drug use as part of an approach based on public health and human rights, even if this means acknowledging the limitations in depending on an official enforcement of total abstinence;
- to receive newly admitted drug-dependent prisoners with understanding of their needs, support for their immediate problems and knowledge of what can be provided in the prison for them;
- to provide what is required so that prison staff could ensure that all prisoners are given basic knowledge relating to HIV/AIDS and other bloodborne diseases and how they spread;
- to provide clinical management of drug-dependent prisoners at a standard in prisons equivalent to that in the local community;
- to ensure that adequate information and guidance are provided at the pre-release stage; and
- to provide follow-through care with links to community services, which is important for all prisoners with health problems but is essential for those dependent on drugs.

All prison systems are urged to move as quickly as resources allow to introduce important additional harm reduction action.

- developing a planned and comprehensive clinical treatment programme for drug-dependent prisoners, including the use of opiate substitution maintenance therapy;
- developing a needle-exchange programme equivalent to that available in the community, especially if the local prevalence of HIV or hepatitis C is high or if injecting drug use is known to occur in the prison;
- providing an effective method for disinfecting needles and tattooing instruments along with appropriate information and training should needle and syringe exchange be considered not necessary or feasible.

Conclusion

This status paper has reviewed the evidence on what prisons can do to reduce the risks of adding to the prevalence of HIV and other bloodborne diseases by neglecting harm reduction measures for drug-dependent prisoners. Considerable progress has been made in collecting the evidence necessary for action; the evidence that substitution maintenance therapy works and is cost-effective is so overwhelming that attention should now be diverted towards progress in implementation and in developing whatever support for staff is required, including clear guidelines.

Although introducing needle- and syringe-exchange schemes depends on the assessed amount of injecting drug use in prisons and the prevalence of HIV and hepatitis C, 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.

The public health case for action is strong. Those involved in deciding policies and services for prisons now have the evidence of effectiveness to add to the successful experiences in several countries in Europe and elsewhere. They should conclude that harm reduction measures can be safely introduced into prisons, that such measures can significantly bolster preventing the transmission of HIV/AIDS in communities and that action in the interests of public health as a whole is now required.

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Prison Health, London
WHO Collaborating Centre for Health and Prisons