



PRISONS, DRUGS AND SOCIETY



**WHO (EUROPE) HEALTH IN PRISONS PROJECT AND
THE POMPIDOU GROUP OF THE COUNCIL OF EUROPE**

PRISONS, DRUGS AND SOCIETY
A consensus Statement on
Principles, Policies and Practices

**WHO (REGIONAL OFFICE FOR EUROPE)
HEALTH IN PRISONS PROJECT AND THE
POMPIDOU GROUP OF THE COUNCIL
OF EUROPE**

BERNE, SWITZERLAND

September 2001

HEALTH 21

HFA TARGETS from WHO EUROPEAN REGION which apply to the Consensus Statement

TARGET 2 **Equity in health**

Strategy for target attainment: reduction of social and economic inequities between groups, through policies, legislation and action.

TARGET 12 **Reducing harm from alcohol, drugs and tobacco**

Strategy for target attainment: Broad strategies to prevent addictions and treat victims.

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ABSTRACT

It is insufficiently recognised that much more can be done within our prison systems to reduce the harm from drugs and to treat successfully a large number of those prisoners who are addicted to drugs. The promotion of health in prisons can make a major contribution to national strategies for tackling the problems of drugs (including alcohol) in society.

Current national strategies to deal with the ill effects of illicit drugs are based upon laws aimed at the reduction of supply, demand, use and harm resulting from drugs. A rising proportion of those imprisoned are there because of breaking these laws relating to drugs. Experience in the WHO Regional Office for Europe's Health in Prisons Project has shown that any national strategy for reducing the harm from illicit drugs must include how to tackle the drugs issues in prisons. Many of those sent to prison are already addicted and require treatment and assistance to reduce the harm from their drug use. Prison is a unique opportunity to address these health issues while also addressing the causes of offending behaviour.

This Consensus Statement is based on the accumulated experience and advice of member country representatives of the WHO Health in Prisons Project and the Pompidou Group of the Council of Europe, together with advice from selected experts from many parts of Europe. It was finalised after discussions held by delegates at the WHO/Council of Europe conference on Prisons, Drugs and Society held in Berne, Switzerland in September 2001, hosted by the Federal Government of Switzerland.

It has been produced for consideration by those in government and non-governmental organisations who influence the development of health-related policies in prisons. It offers the prospect of significant health gain for some of the most disadvantaged and socially excluded groups in Europe. It is important that each country considers the recommendations from a position relating to its own legal, economic and cultural circumstances. As effective implementation is the goal, this Statement should be brought to the attention of all relevant staff and, where appropriate, also to prisoners themselves, as sustainable progress will only be made if desired policies are understood and accepted by the key people involved.

Underlying the Statement are the guiding principles of the WHO (Regional Office for Europe) Health in Prisons Project. Imprisonment must be seen as taking away the freedom of inmates as the sole legally decided punishment. Imprisonment must not remove the dignity and remaining autonomy of prisoners, or their self-respect and sense of responsibility for their future health and welfare. Many of them are already from those groups in society that are most deprived, lacking in education, with low self-esteem, suffering the effects of poverty, lack of employment and often with poor mental health.

In recommending high priority for the circulation, consideration and implementation of this Statement, the sponsors of this document wish to emphasise that all recommendations are based on current best practice. In several countries in Europe, many of the recommendations are already implemented and are known to work. Europe should strive to be the first WHO Region to have comprehensively and successfully tackled the problems of drugs in prisons, and in so doing contributed considerably to harm reduction from illicit drugs throughout society.

To facilitate implementation, appendices have been added providing guidelines and checklists for key staff and governors/managers of prisons. It is important to share as much information as possible with prisoners and this is covered within the checklists.

What action should follow on from the published statement?

- Member countries and partner organizations are asked to draw this statement to the attention of key policy makers and practitioners.
- All who create or implement policy in this area are invited to check current practice against this guidance, and to consider taking action, including resource implications where appropriate.
- Consideration should be given to following up and reporting on action taken, so that the benefits of learning from each other's experience can continue.

Constraints, limitations and opportunities

It is recognised that prisons and drugs have to be considered in the particular social, economic, cultural, legal and political context of each member state. What may be appropriate to a well-resourced prison in an economically wealthy country may be inappropriate or no more than an aspiration in a prison operating on a tight budget in a country facing major economic challenges. Similarly, the total size of the prison population and number of prisons in each system will make tackling drugs in prison a much bigger challenge in some countries than it is in others. Differences of values and culture, including attitudes to drugs, as well as locally devolved powers, can result in very different approaches in different regions of the same country.

Adopting and using the Consensus Statement is an opportunity for policy makers to:

- review current policy and practice;
- be clearer about why current priorities are in place;
- where necessary, set an agenda for action that sets and guarantees minimum standards of services for people misusing drugs.

This Consensus Statement recognises that the law around possession and distribution of drugs varies considerably from one country to another. There are also considerable variations between countries in the options that are available to the police and the courts when responding to a person who is found to be unlawfully in possession of, or distributing, any of these drugs.

The Statement asks policy makers in each country to consider the range of reasonable options now available to the police and the courts, which could ensure an appropriate balance to be found between each person's health and social care needs on the one hand, and the need for deterrence on the other.

THE STRUCTURE OF THE CONSENSUS STATEMENT

The Consensus Statement is organised into four main parts

PART 1: Principles for working with prisoners who are (or have been) misusing drugs

PART 2: Policy and practice throughout the criminal justice process

This is arranged around

- the different stages an offender or prisoner can pass through within the criminal justice and prison systems;
- cross-cutting issues concerning groups such as women or younger offenders.

PART 3: Cross cutting issues and special needs

PART 4: Checklists for key staff and governors/managers of prisons

PART 1: PRINCIPLES FOR WORKING WITH PRISONERS WHO ARE (OR HAVE BEEN) MISUSING DRUGS

1. General principles

1.1 **We recognise that misuse of drugs in prisons reflects misuse of drugs in wider society.** For example, in prisons, as in the community, there is an increasing tendency towards poly-drug use, including a wide range of substances (e.g. cannabis, medicinal drugs diverted from their proper use, alcohol etc). It follows that any programme in prison should be complementary to that available in the community.

1.2 **We recognise that people move between prisons and the community.** This movement of people means that diseases being transmitted within prisons are often acquired in the community and will spread back into the community. Public health protection in the community depends on the provision of appropriate health services to people in prison.

1.3 **We recognise that imprisonment as a punishment extends only to deprivation of liberty.** Prisons should not add to that punishment by also depriving people of other human rights, such as access to health care equivalent to that available in the community, or exposure to greater risks to their health than they would face in the community.

1.4 **We recognise that prisons must be safe, secure and decent places in which people are living and working.** The health, safety and welfare of all prisoners and staff depend on there being clear rules, clear procedures, and clear sanctions for people who try to operate outside of these boundaries.

1.5 **We recognise that many prisoners are socially and economically excluded people,** often with complex problems around their psychological wellbeing health, and relationship with their families. These factors are often associated with misuse of a wide range of psychoactive substances.

1.6 **We recognise that people working in prisons must work with the law as it stands.** The criminal law around the wide range of misused substances varies from one state to another. For example, the ages at which alcohol may be legally purchased and/or consumed differs considerably across national boundaries. From time to time there are debates about changes in laws relating to some drugs. But prisons must enforce whatever the current legal position happens to be.

1.7 **We recognise that a range of criminal behaviours can be associated with the misuse of drugs.** Some people are in prison because they were (or are suspected of having been) in possession of, and/or distributing, and/or misusing illegal substances. Others have been imprisoned because they were (or were suspected of) committing an acquisitive crime, which might have been motivated by the need to fund a drug habit, or because their judgement was affected by the pharmacological action of drugs. Some people can also be imprisoned because of involvement (or suspected involvement) in crimes of violence and intimidation, associated with some of the illicit ways in which drugs are distributed in the

community. Helping people deal with issues around drug misuse is therefore not only important to their health and social care; it is also a way of reducing their likelihood of being involved in future crime.

1.8 We recognise that responses from the criminal justice system to people misusing drugs must take account of the ways in which they have breached the criminal law, as well as addressing their health and social care needs. An appropriate balance is more likely to be achieved where decision-makers keep themselves and the public well informed about the health and social care and criminal justice aspects of drug misuse. Often, health and social care interventions for substances whose use is legal in the community (e.g. alcohol in most contexts) resemble those for illicit drugs.

1.9 We recognise that health professionals alone cannot tackle the problem of drugs in a prison context. A multi-disciplinary approach is necessary. For example, people misusing drugs may need help in the form of counselling, information and education, and assistance with housing, learning, employment and finance issues on release. There is a need for prison managers and officers to ensure that appropriate security measures are in place to minimise the possibility of drugs getting into prison.

1.10 We recognise that appropriate harm reduction measures are essential, to reduce the incidence of damage to health associated with the misuse of drugs. Examples include the transmission of infections, such as HIV and hepatitis, and also violence, coercion and sexual abuse which can be associated with the illicit ways in which drugs are distributed in prisons. We also recognise that there can be tensions between some harm reduction measures and other issues around the running of a prison, such as security, criminal justice and occupational health. These tensions are likely to be resolved in very different ways in different countries and settings. *This is discussed further in a later section of this Consensus Statement.*

2. Principles about the provision of services in prisons

2.1 We affirm that there should be health services in prisons which are broadly equivalent to health services in the wider community. This principle of equivalence suggests the offer of services which:

- are based on assessed need. People in prisons are likely to have higher levels of health care need than many people in the community, as they are more likely to be from socially excluded and economically deprived backgrounds;
- support people in overcoming or treating their drug dependency;
- involve each prisoner as a partner in planning and taking responsibility for his/her care and treatment;
- prevent the spread of communicable diseases;

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- promote healthy habits (including, for example, smoking cessation service provision); and
 - reduce the personal and environmental harm resulting from high-risk behaviours.

2.2 We affirm the importance of professional ethics in the provision of all health care.

One important aspect is the **principle of autonomy**, recognising the right of patients to be fully consulted about medical interventions (including the possibility of refusing care), and the importance of health care staff being professionally independent of prison management and able to undertake their duties according to the ethical guidance of their professional organisation. Members of different professions need to consider how best to manage the tension between client confidentiality and multi-disciplinary working. Some multi-disciplinary teams ask clients to give informed consent to the sharing of relevant information in specified circumstances.

2.3 We affirm that ethical care implies evidence-based care and that this should apply

equally within prison and outside. Giving priority to further research into what works best is essential as a way of developing more effective services. It is important to ensure that where prisoners are taking part in research, proper regard is had to the ethics of consent and confidentiality.

2.4 We affirm that service provision should be efficient and effective.

This can be achieved when services are planned on the basis of needs assessment, are evidence based, feature clear responsibility for delivery, and entail documentation of individual treatment and support plans which have clear objectives and are regularly monitored and reviewed. Overall outcomes should be evaluated as part of a regular review of the whole service.

2.5 We affirm the importance of ensuring that there is continuity of care.

People with issues around substance misuse who move between prison and the community can find short periods in prison very disruptive to their community based treatment and support programmes. There must be **real co-operation between prisons and external agencies** to address the needs people have, both when they go into prison, and when they leave it. This must be an integral part of the health care strategies for those with drugs problems in prisons.

2.6 We affirm the importance of providing all prisoners and prison staff with information and education about drug use and the risk of communicable disease.

It is important to recognise the contribution that a good prison health service can make to public health as a whole. Information is often available from organisations based in the community. It can be disseminated in a number of ways in prisons e.g. distribution of leaflets, and discussions in peer support groups. The latter are especially useful for people who may have difficulty in reading written material.

2.7 We affirm the importance of taking all reasonable action to reduce the supply of drugs inside prisons,

thereby minimising prisoners' opportunities to use them, encouraging prisoners to take the option of treatment, and also reducing the harm that can be associated with their illicit supply (e.g. bullying, extortion and loan rackets – with their implications for

mental health promotion – as well as such public health issues as the spread of infections through shared injecting equipment). Prescribed medication is sometimes misused, so reducing the supply of drugs should include providing effective systems for controlling the availability of prescribed medicines.

2.8 We affirm the importance of taking all reasonable action to reduce the demand for drugs in prisons. The provision of comprehensive assessment, treatment and aftercare services supports prisoners in their efforts to stop misusing drugs, and thereby reduces the demand for them.

2.9 We affirm the importance of addressing each prisoner’s drug treatment needs in the wider context of working with him/her to address his/her offending behaviour, thereby reducing the risk of re-offending, and to encourage him/her to reduce risks to his/her health by adopting harm reduction strategies.

This Statement has based its recommendations on the above principles and also on the accumulated experience of the network of European nations working together in the WHO Health in Prisons Project and with the Pompidou Group of the Council of Europe.

PART 2: POLICY AND PRACTICE THROUGHOUT THE CRIMINAL JUSTICE PROCESS

We believe that policies and practices are best understood in relation to stages in the person's contact with the criminal justice process. Each of the stages provides opportunities for intervention.

These stages may include:

1. Arrest and police custody on suspicion of a criminal offence;
2. Possibility of diversion into treatment programmes or community facility before or after sentencing;
3. Entry to prison;
4. Time on remand (awaiting trial), either in prison or in the community;
5. Time spent in prison, if so sentenced by a court;
6. Preparation for release;
7. Release into the community;
8. Aftercare in the community.

After these have been discussed in turn, several crosscutting issues are also considered.

The stages of contact with the criminal justice process

1. Arrest and police custody

All member states have laws which make possession and/or selling of some substances a criminal offence and many drug users are arrested from time to time. For example:

- they may be arrested for possession or dealing;
- many drug users find that it can be difficult to obtain sufficient funds to pay for supplies, so they become involved in other, acquisitive, criminal activities.

In addition, a significant proportion of offenders are also consumers of psychoactive substances (including alcohol), whether or not this is related to the offences committed.

Our policy at this stage is to make best use of this identification of a person using drugs to assess the appropriateness of the various options available.

Practices which can support this policy may include:

- ensuring that police and social services staff know what options exist;
- having custody health care professionals at police stations, working alongside other staff, to assess newly arrested people for a range of health and social care needs (including effective treatment of any overdose or withdrawal symptoms, and ensuring continuity of any previously started treatment), and to identify possible interventions available from community and prison based agencies;
- ensuring that police officers are trained to identify early signs of drug use so that they can make appropriate referrals to such custody health care professionals;
- having outreach workers from a range of drug agencies visit police stations to take referrals from police officers and/or health care professionals. There may be occasions when a newly arrested person is already one of their clients, in which case they can provide continuity of treatment in the light of the client's changed circumstances;
- ensuring that the range of agencies involved are developing ways of working together which maximise awareness of one another's roles, and support referrals and the appropriate flow of information.

2. Court appearance and possible diversion into treatment programmes

Our policy is to recognise that it is important to use the drug user's experience of arrest and court appearance as an opportunity to encourage him/her to address his/her habit and his/her associated criminal behaviour.

Practices which support this policy may include:

- prosecuting authorities having the discretion to decide not to prosecute on the basis that the person is making positive progress on a health and social care programme that is addressing his/her drug use and related criminal activity;
- courts being empowered to underwrite drug users' co-operation with health and social care programmes by making their continued co-operation a condition of not being punished for proven offences;
- ensuring that such programmes form part of wider community based sentences, such as probation orders, community service orders, part-time attendance at detention centres, and fines.

3. Entry to prison

Our policy is that:

- prisons should make all reasonable efforts to ensure that prisoners do not have access to any drug, from whatever source, that has not been legitimately supplied;
- prisoners should be fully assessed so that those who no longer have access to their drug of choice (including alcohol) can be identified, and so that appropriate health and social support can be offered to them;
- information should be provided to all new prisoners about drugs, and about the importance and availability of harm reduction measures;
- prison staff should be aware that people who may not have used drugs before might start to use them whilst in prison.

In addition to needing support in coping with the shock of having been admitted to prison, prisoners who have been using drugs will also need support with no longer being able to access substances in the way they had been doing in the community. This support should address **physical dependence** and **psychological dependence**.

Physical dependence

A number of strategies can help here. These include the following options:

Detoxification: through pharmacological and/or other therapies, the person is helped to reduce physical dependence on substances that they have been using.

Substitution: the person is helped to reduce physical dependence on one substance by being introduced to the use of an alternative¹. This sometimes forms a stage in a detoxification programme. With other patients it might be part of a longer-term strategy of maintenance.

Maintenance: EITHER the person is helped from reverting to the use of a substance by receiving clinically prescribed maintenance doses of a substitute substance.²

OR the person is helped to reduce and control their use of a substance by receiving clinically prescribed maintenance doses of the substance.³

Legal issues and professional guidelines around some of these options vary from one country to another.

Psychological dependence

Programmes of psychological and social care are often needed to address this long after physical dependence has either been overcome or stabilised. These are discussed in Section 5.

Practices which support this policy at the point of entry into prison:

- whatever services are made available within prisons, it is important that new prisoners are assessed for which options are most appropriate to their needs. It is especially important that people who were already involved in a community based treatment should continue to receive a service that is as similar as possible while they are in prison. It is unlikely to be appropriate or lawful for people, whether or not they are in prison, to be treated for substance dependency without their consent, except where they are officially recognised as being mentally ill;

¹ e.g. substituting methadone for heroin.

² e.g. providing maintenance doses of methadone as an alternative to heroin.

³ e.g. providing maintenance doses of heroin. However, although there is an evidence base for this in the community, the evidence base *in the prison setting* is lacking; what does exist is a report of positive results from a small trial in two prisons in Switzerland.

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- as some prisoners might be reluctant to disclose their use of drugs in the community, it may be appropriate to consider testing the urine of all new prisoners for traces of drugs, as part of the initial health care assessment process. It is extremely important, where such tests are undertaken by health care staff, that the results remain confidential to the health care team;
 - continue to monitor prisoners after they have first been received, so that those whose drug use has been missed on arrival, or who start to use drugs while there, can be identified and offered appropriate services;
 - offer a planned programme for detoxification for people with a history of misusing drugs and/or alcohol, with trained staff and followed where appropriate by supervised abstinence;
 - provide an environment where pressures for continued drug use are reduced, such as drug free areas within the prison, where inmates can volunteer to be located and supported by a programme of voluntary drugs testing;
 - provide programmes of social and psychological care, which might include peer support schemes or individual psychotherapies;
 - use a supervised programme of prescription of a substitute drug such as methadone or buprenorphine, as part of a detoxification programme;
 - use methadone or buprenorphine as part of a long-term maintenance programme;
 - introduce action to reduce harm arising from toxicity caused by overdose and/or contaminants and/or infections of various kinds (see later section on harm reduction.)

4. Time spent awaiting trial, either in prison or in the community

In many countries there can be several court hearings before it is decided whether a person is guilty of an offence, and, if so, what would be an appropriate sentence. Often, at each hearing it will be decided whether the time spent awaiting trial should be spent in prison, or in the community. Someone going through this process may have to go in and out of prison at short notice.

Our policy is that:

- programmes of health and social care provided to people in these circumstances should link up – it is important that each person experiences continuity of care, regardless of major changes in their circumstances;

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- there must be recognition that this can be a very anxious time increasing the likelihood of substance abuse. There is also the possibility of serious self harm, or even suicide, if the person feels unable to cope.

Practices which support this policy are likely to include those listed in section 3.

5. Time spent as a sentenced prisoner

Time spent in prison should be used as an opportunity to work with all prisoners on their offending behaviour and on their continuing health care needs which should include systematic identification of those with problems of substance misuse.

Many prisoners will continue to need access to those services that have been described in earlier sections of this Consensus Statement.

Once a person has been sentenced to a period of imprisonment, it is possible for him/her, and people working with him/her, to plan how the time can be used to address identified needs. Often, the time scale involved will mean that physical dependence is already being addressed, and that it is now appropriate to consider how best to tackle psychological dependence.

Our policy is that:

- as part of sentence planning, care plans should be developed, in consultation with the prisoner, which build upon and continue work already started;
- there should be help and encouragement for the prisoner to face up to his/her use of drugs and his/her engagement in criminal behaviour as part of the wider issues s/he is facing and his/her future life plans.

Practices which support this policy may include:

- *for the whole prison*
 - provision of purposeful activity to provide meaning and motivation e.g. education, employment whilst in prison and preparation for employment on release;
 - continued security measures to minimise the supply of illicit substances in the establishment;
 - availability of drug free areas within the prison, supported by voluntary testing programmes;
 - mental health promotion support (see WHO HIPP Statement on mental health promotion in prisons);

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- health promotion, education and harm reduction measures;
 - where possible, provision of opportunities for a range of purposeful activities e.g. employment, education, opportunities to take part in culturally appropriate creative activities and involvement in drugs education programmes.
 - *for staff*
 - drugs (including alcohol) awareness training;
 - encouragement of working in conjunction with specialist and health care staff, based on ethical principles;
 - awareness of principles of health promotion.
 - *for individual prisoners*
 - continuing assessment of, and programmes addressing, individual needs and motivation;
 - provision of services such as counselling;
 - facilitation of peer support schemes;
 - provision of advice about and means for reducing harm associated with drug use (see discussion later);
 - possibility of being able to transfer from prison to live in a therapeutic setting, where this is assessed as being clinically appropriate;
 - ways might be found to enable prisoners to maintain links with families, both as a means of support during imprisonment, and to enable more effective resettlement on release.

6. Preparation for release

Our policy is that:

- he/she will need to be told and to fully understand that it is dangerous and often fatal to return to doses that may have been used and tolerated by one's body prior to imprisonment;
- preparation for release should start at the beginning of a person's time in prison;

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- it is important that the person experiences continuity of treatment once they are back in the community;
 - the prisoner should understand the importance of continuity of treatment and support;
 - sentence adjustment (e.g. conditional release) is particularly relevant for drug dependant persons.
 - he/she will need encouragement and support in not returning to community based sources of supply and drug using subcultures.

Practices which support this policy may include:

- development of sentence adjustment measures;
- education about the risks and means of preventing overdose on release;
- provision of support in searching for appropriate housing, employment, primary health care and continuing education;
- encouragement to maintain or refresh links with families and other supportive networks.

7/8. Release and aftercare

Our policy is to recognise that this is a testing time for prisoners, as they will face:

- pressure to re-engage with the same opportunities to obtain a range of drugs as before their arrest, drugs which will be more easily available than when they were in prison – carrying with it the risk of overdosing after a period of abstinence or reduced usage;
- challenges, prejudices and frustrations as they seek accommodation, employment and appropriate social networks.

Continuing care in the weeks following release is essential to the efficacy of the work started in prison. If the progress made whilst in prison is not supported when the person is released, then s/he is likely to start using drugs again. Cumulatively, this will increase public health risks and levels of crime in the community.

Practices which support this policy should aim at empowering the person to successfully deal with a range of new opportunities and challenges. These practices can include:

- ensuring that appropriate referrals have been made to community based agencies thereby enabling continuity of support and treatment;
- active involvement of the prisoner in his/her resettlement planning. This might include the possibility of the prisoner being able to have some contact with post-release support agencies while still in prison;
- helping prisoners to access accommodation, with appropriate support services, after release.

PART 3: CROSS CUTTING ISSUES AND SPECIAL NEEDS

A number of issues are relevant to all the stages identified above. Where this section considers the needs of particular groups of prisoners (e.g. women), it is important to bear in mind that any special arrangements suggested here would be in addition to the measures relevant to all prisoners, that have already been described above.

1. Staff training and support

Our policy is that everyone working with prisoners, or with former prisoners, should have an awareness and understanding of the work being undertaken by colleagues both in prisons and in a range of community based agencies. This is vital if services are to be joined-up.

Practices which might support this policy

- In many prisons there is a need to encourage staff to see health and social care interventions as an important and central part of the work that prisons must do if they are to support resettlement and reduce the risk of people committing further crimes after they have been released.
- Providing training for staff in groups drawn from a range of disciplines and agencies (both within and beyond the prison) helps to encourage wider perspectives, mutual understanding and multi-disciplinary working.
- Staff whose primary role is the day-to-day supervision and management of prisoners will need to have drugs awareness training so that they can understand the scientific basis of addiction and its treatment, and can work in partnership with drugs workers. Similarly, drugs workers need to have an understanding of all aspects of the regime in the prison where they are based.
- Staff training and personnel policies need to raise awareness that staff are often role models for prisoners. For example, prisoners are aware of any staff who happen to use even small amounts of alcohol before work or during breaks. This behaviour can be used to justify (to themselves and to others) their own use of a range of substances. It follows that any staff who have problems with alcohol must have ready access to support in addressing their problems. Similarly all staff need to be aware that sometimes colleagues may themselves be using drugs, and could be at risk of being pressurised or tempted to supply drugs to prisoners. It follows that any staff who are misusing drugs must have ready access to support.

2. Women

Our policy is to recognise that:

- there is a more significant proportion of women than men in prison, whose offence can frequently be related to the misuse of drugs;

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- that similarly a significant proportion of women entering prison need to treat their dependency;
 - women who misuse drugs have specific health care needs, particularly those who are also pregnant;
 - some women fund their misuse of drugs through prostitution in the community;
 - some women in prison have had risky relationships with male intravenous drug users;
 - women are, more often than men, the primary carers of children, and this has implications for the health and social care needs of both the women and their children.

Practices which support this policy may include:

- providing specialist advice on treatment of pregnant women who are using drugs;
- providing appropriate health and social care for mothers and babies if they are living together in prison;
- providing appropriate health and social care for imprisoned women's children who are living in the community. This should include assessing, while putting the interests of the child as paramount, the appropriateness of maintaining contact with their mother in prison;
- providing education on relationships, sexual health (including contraception) and harm reduction to women in prison.

3. Young people

Our policy is to recognise that young people are still developing and have special needs. For example:

- many young people are still developing life and social skills;
- families and other supportive networks can be especially important sources of support;
- there is a growing number of young people who are, or who have been, misusing drugs and/ or alcohol;
- some youth cultures encourage use of a wide range of substances in an experimental and risky way.

Practices which support this policy may include:

- the inclusion of drugs and alcohol awareness training in education programmes;
- ensuring that education programmes address identified needs for skills development (e.g. literacy, numeracy and self-care);
- provision of physical activities;
- linking up with community based youth and social services when developing services which prepare young people for release and which help them to find appropriate housing, training and employment opportunities;
- establishing schemes which encourage young people to maintain or revive contact with their families;
- encouraging culturally appropriate group activities, peer-led education and positive role models for young people, especially when trying to develop self-responsibility.

4. Ethnic minorities

Our policy is to recognise that members of ethnic minorities can face additional major problems which may require positive intervention. For example:

- racial prejudice and discrimination, which can undermine effective resettlement, self-esteem and well-being must be combated;
- where language and culture are not the same as the main ones in the country in which they have been imprisoned, there should be special measures to ensure they are not disadvantaged;
- their attitudes and understanding of issues around the use of drugs and alcohol may not be the same as that of other people living in the country of imprisonment.

Practices which support this policy can include:

- prison managers and staff finding ways of challenging and tackling any racism in their establishments;
- providers of community based services must also ensure that all aspects of their practice are free from discriminatory attitudes and practice;
- providing additional support in accessing housing, employment and training, as these are areas where considerable discrimination can often be experienced;

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- providing support with education, including language tuition, where appropriate;
 - providing diversity awareness training for members of all groups of staff and prisoners.

5. People who have been imprisoned while visiting/working in another country

Our policy is to recognise that these prisoners can face major additional problems. They can include people who have been carrying drugs whilst travelling from one country to another. These prisoners are often required to return to their countries of origin when they are released, and this clearly limits the extent to which preparation for release can fully achieve continuity of health and social care.

A practice which might support this policy – where prison managers identify that they are regularly dealing with groups of people from particular places, it may be helpful to establish links with community based agencies in those countries, as a way of developing some continuity of care after release and relocation.

6. Harm reduction

As set out as a General Principle, **our policy is that** appropriate harm reduction measures are essential, to reduce the risk of a wide range of damage to health that can be associated with the misuse of drugs. Examples include:

- the transmission of infections, such as HIV and hepatitis – which have serious implications for the wider community as well as the individual prisoner;
- the effects on health of violence, coercion and sexual abuse which are associated with the way in which drugs are supplied and paid for in prisons; a particular risk in this regard is the transmission of sexually transmitted infections;
- the risk of overdose;
- the risk of using contaminated drugs;
- the risk of side effects from misused substances;

We also recognise that there can be tensions between some harm reduction measures and other issues important to the running of a prison, such as security, criminal justice and occupational health considerations. These tensions are likely to be resolved in different ways in different countries and settings. Variables can include:

- resources available;
- types of prisoner involved;

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- size and security level of the establishment;
 - legal and cultural context;
 - economic context.

Practices which may support this policy

Reducing harm associated with transmission of infections

The principle of equivalence suggests that a range of harm reduction measures might be put in place in prisons, similar to those provided in the community. Measures in the community include confidential testing with pre- and post-test counselling, effective treatment, public information campaigns, personal information and counselling, group education on safer drug use and safer sex, peer education and peer led initiatives, vaccination against those viruses where such vaccines are available and approved (e.g. Hepatitis B), advice on using bleach or other disinfecting methods to clean needles and syringes, the provision of sterile needles and syringes, and the provision of condoms.

A number of countries are already providing a wide range of health education programmes and harm reduction advice to prisoners. A number are also offering prisoners vaccination against Hepatitis B. In many countries, hepatitis infection amongst prisoners with a history of intravenous drug use is now more prevalent than HIV infection.

As identified above, the provision of services in prisons must take account of their legal, social, economic and cultural context. This context enables prisons to offer some options which are not available in the community, such as drug free wings where prisoners volunteer to be located away from the pressure of dealers, and to be tested regularly as a means of ensuring that the area remains truly drug free.

The custodial context also results in a range of views around harm reduction measures such as needle exchange.

Currently there are syringe exchange schemes in 20 prisons in Europe (in Switzerland, Germany, Spain and Moldova), which form part of comprehensive drug strategies in those establishments. The prisons use a range of models. For example, in Centro Penitenciario de Basauri, men's prison in Spain the syringes can only be exchanged through contact with a specific member of staff, as this provides an opportunity for other matters to be raised. At Hindelbank women's prison in Switzerland, and Vechta women's prison in Germany, drug counselling contact is separated from the process of exchanging syringes, through the use of slot machines in residential areas. At a prison in Moldova, syringes are distributed by volunteer prisoners who are taking part in a peer support scheme. In Switzerland, the Ministry of Justice has responded to the evaluation of these schemes by advising that such programmes are legal and necessary. One canton (Berne) now requires needle exchange schemes in all its prisons.

The evaluation studies report that needle exchange programmes can be useful as an integral part of a general approach to drug and health services in prisons. Where they are provided there should also be other services which include health promotion measures, counselling, drug-free treatment and substitution treatment. The studies suggest that successful implementation depends on ensuring that systems are put in place which guarantee the maintenance of confidentiality and the assurance of health and safety arrangements for everyone working in the prison. Successful implementation also depends on being able to gain acceptance of the practice amongst prison staff, prisoners themselves, professionals, legal authorities and the general public.

In contrast, there is also the view that needle exchange schemes can send out ambivalent messages about the use of illicit drugs. Some countries make disinfecting tablets available to prisoners as a way of trying to balance the difficult tension between health promotion and security issues. Others consider it important to provide these alongside any needle exchange programme.

It is important that all policy makers addressing issues around the use of drugs in prisons should remain informed of different developments in this area, and should regularly review their harm reduction policies and practices.

Reducing other drug related harm

Much harm can be reduced by providing prisoners with services which support them in not using drugs, or in using them (or substitutes) in a clinically structured manner, as described elsewhere in this Statement.

It is also important that staff training programmes cover how staff can protect themselves from harm, and that staff be provided with appropriate equipment to be able to do so.

Policies and practices should in any case be in place to address issues such as violence, coercion and sexual abuse, as these can also arise for reasons not connected with the distribution of drugs in prisons. Guidance on this has been provided in the Health in Prisons Project's Consensus Statement entitled *Mental Health Promotion in Prisons*, which was agreed at a conference in The Hague in November 1998.

7. Co-morbidity

Our policy is to recognise that prisoners who use drugs often have other physical and/ or mental health problems. Some of these may be related to drug misuse, e.g. infections acquired through contaminated needles or self neglect related to the diversion of funds from the acquisition of food and fuel to the acquisition of drugs. Sexual health problems, arising from relationships with intravenous drug users who are themselves sharing needles, or from undertaking paid sex work as a means of funding the acquisition of drugs, should also be seen as problems relating to drug misuse. Others can be the result of side effects of substitute medication (e.g. many people using methadone develop dental problems). It has also been noted that drug misuse (including alcohol) can often be associated with mental health

problems such as depression or psychosis. It is not currently clear whether this association might involve a causal link. It is important that care and treatment programmes holistically address the full range of health and social problems faced by people who are misusing drugs.

Practices which might support this policy

- comprehensive health assessment and monitoring;
- liaising with previous health care providers to ensure that information about previously identified health problems and treatment programmes is obtained;
- liaison between different groups of professionals who may be involved in different aspects of a prisoner's health and social care;
- provision of dental, mental health and sexual health services in prisons.

8. Monitoring and evaluation

There is a need for evaluation of programmes and approaches that are being put into practice, which would provide an evidence base for the development of Standards.

PART 4: CHECKLISTS FOR KEY STAFF AND GOVERNORS/MANAGERS OF PRISONS

1. Checklist for local health care providers

People in custody come from the community and will return to the community. Public Health depends on the provision of effective health services in custody, and on continuity of care when people leave it.

The following measures may help local health care organisations to provide effective services to people leaving custody who have been using drugs:

- 1.1 Developing links with police stations, courts and prisons, enabling referrals to be made by staff working in them;
- 1.2 Where prisons, courts or police stations do not have any health care staff, considering what input might be offered to them;
- 1.3 Meeting with health care staff from prisons and police stations to establish protocols for information exchange which would support continuity of treatment as people move in and out of custody and to exchange information on developments in practice;
- 1.4 Ensuring that the special needs of women, young people and members of minority ethnic groups are addressed;
- 1.5 When gathering information and routine data on the health needs of the local population consider including prisoners as an important part of your local population.

2. Checklist for prison managers

Public health depends on the provision of effective health services in custody, and on continuity of care when people leave it. Prison provides an opportunity to address a wide range of health problems, including those associated with drug misuse.

The following measures may help prison managers to provide effective services to prisoners who have been using drugs:

- 2.1 Give consideration to the checklist contained in WHO Health in Prisons Project's *Mental Health in Prisons* Consensus Statement, which provides guidance on measures to deal with bullying and intimidation in prisons, as part of a wider recommendation on promoting health in prisons;
- 2.2 Develop links with police stations, courts and community based health providers, enabling referrals to be made to prison based health care staff;

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- 2.3 Meet with health care staff from police stations and community based health providers to establish protocols for information exchange which would support continuity of treatment as people move in and out of custody, and to exchange information on developments in practice;
 - 2.4 Ensure that all staff are trained so that everyone working in the prison has an awareness of the issues around drugs and can understand their role in a multi-disciplinary approach. Ensure that this training includes coverage of harm reduction measures, both for prisoners and for staff;
 - 2.5 Arrange meetings between groups of staff in the prison to encourage multi-disciplinary working;
 - 2.6 Ensure that health care staff are able to follow ethical principles in their work;
 - 2.7 Consider and review the extent and appropriateness of harm reduction measures in the prison, both for staff and prisoners;
 - 2.8 Consider and review the extent and appropriateness of procedures to identify and assess people who are misusing drugs (including alcohol) when they first enter prison;
 - 2.9 Consider and review the extent and appropriateness of health and social services provided for prisoners who have been (or who are) misusing drugs (including alcohol);
 - 2.10 Develop a policy on smoking which would move the prison towards a position where all prisoners and staff can choose to live and/or work in a smoke free environment;
 - 2.11 Ensure appropriate provision of services for people with mental health problems, and those who have dental and hygiene problems.
 - 2.12 Ensure that the special needs of women, young people and members of minority ethnic groups are addressed;
 - 2.13 Consider how patterns of drug use might be monitored with a view to this information supporting the development of appropriate services;
 - 2.14 Ensure prisoners have adequate information (through education as well as in written form) on drugs, including their effects, risks to health, harm reduction, and relevant services on offer in the prison and on release;
 - 2.15 Ensure that copies of this Consensus Statement are available to both health care and other staff working with drug users and is available in the library facilities available to prisoners;

2.16 While encouraging each prisoner's sense of responsibility through appropriate systems for individual self care, consider the need for effective control of prescribed medicines to reduce the potential for diversion and misuse. (However, this should in no way restrict the principle by which prescribing medication is the responsibility of the medical services.)

Notes

Notes

Published in September 2002 by WHO (Regional Office for Europe)
Collaborating Centre for Health in Prisons,
Prison Health Policy Unit, Department of Health, England.
The development of this publication was carried out in
partnership with the Pompidou Group of the Council of Europe

