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Drug use in prison

EMCDDA 2002 selected issue

In EMCDDA 2002 Annual report on the state of the drugs problem in the European Union and Norway

were divided according to their route of administration, inhaling or injecting, and then subdivided according to the intervention — those receiving only methadone and those receiving a combination of methadone and heroin. The main finding of the study was that for severely addicted, older, heroin users methadone plus heroin was more effective than treatment with methadone alone, irrespective of the route of administration. The study furthermore showed that at the end of the trial, 30 % of the clients in the experimental group no longer met the inclusion criteria (their general condition having improved considerably), whereas it was only 11 % in the control group (van den Brink et al., 2002).

In Germany, a trial with the prescription of medical heroin for opiate addicts has been developed and refined over the past couple of years. The trial which began in spring 2002 will last for three years with seven German cities participating. The main question to be answered is if and under which condition the prescription of heroin for an extremely deprived group of opiate addicts can contribute to improving their situation in terms of health, social and legal aspects. The patients in the trial will be divided randomly into an experimental group and a control group. These groups will be further divided into two groups receiving different types of psycho-social intervention — one group 'case management' and the other 'psycho-education'. The study is expected to provide further insights on psycho-social intervention and its efficiency in the treatment of opioid addiction (<http://www.heroinstudie.de/>).

In Denmark, an alternative to a heroin project was launched for 2000–02 with the aim of initiating special pilot projects for drug addicts in methadone treatment, involving massive psycho-social activities. The qualitative and quantitative evaluation will study the extent to which results can be achieved in the form of better social, health-related and mental functioning, reduction of drug use, reduction of infectious diseases and crime, as well as an extension of network relations.

Conclusions and future perspectives

Success depends on the purpose of a given treatment intervention and consequently that success should be assessed in accordance with the pre-established objectives. There is already a considerable wealth of research that, when comparing objectives with outcomes, has enabled insight and knowledge to be gained on the effectiveness and/or success of various types of treatment.

It is, for instance, an important outcome that retention rates are crucial for treatment outcomes or 'success', but

knowledge needs to be gathered on how to keep clients in treatment or, in other words, on which elements in treatment are crucial for increasing the retention rate. Identifying the 'active ingredient' in any kind of treatment is a difficult task and it is essential to improve the performance of treatment services, thereby improving treatment outcomes.

However, having the theoretical knowledge and insight is one thing and implementing it another. An example of this is the importance of accompanying psycho-social interventions in medically assisted treatment, which much research has found to contribute to success but which nevertheless are still not adequately implemented in practice.

In recent years, much emphasis has been placed on expanding treatment services and this has to a rather large extent been achieved. The challenge now is to widen the fan of treatment services and refine the interventions themselves, thereby increasing the 'success' of these.

Drug use in prison

The presence of drugs and drug use has fundamentally changed the prison reality over the past two decades and, nowadays, all countries in Europe experience major problems due to drugs and drug-related infectious diseases in prisons.

Drug demand in prison ⁽⁶¹⁾

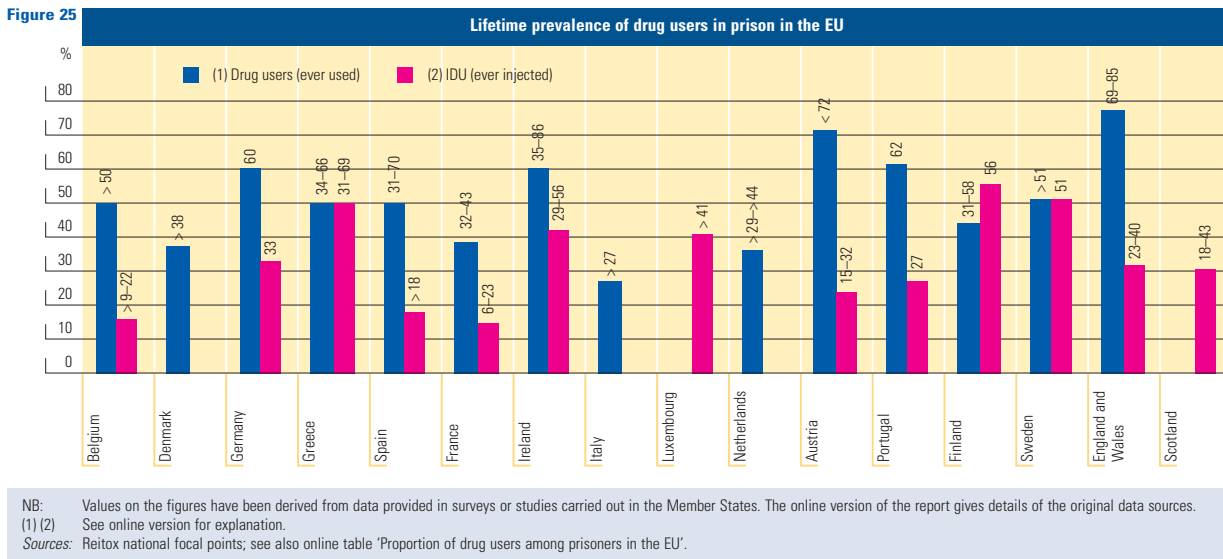
National routine information on drug use, patterns and consequences amongst prisoners is rare. Most of the data available in the EU come from ad hoc studies carried out at local level amongst a small sample of prisoners. This makes extrapolations very difficult.

Prevalence of drug users in prison

The prison population can be considered as a high risk group in terms of drug use. Indeed, compared with the community, drug users are over-represented in prison. The proportion of inmates in the EU reporting ever having used an illicit drug varies according to prisons and countries between 29 and 86 % (over 50 % in most studies) (Figure 25). As in the community, cannabis is the most frequently experienced substance, but several studies also show high levels of heroin experience (close to 50 % of the inmates or more in some cases).

⁽⁶¹⁾ See also the table: Proportion of drug users among prisoners in the EU (online version).

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According to different studies, prisoners reporting more regular and/or harmful use such as intravenous drug use, regular use or dependence, represent 6 to 69 % of the prison population.

Level of drug use within prison

Incarceration does not mean cessation of drug use. Most drug users tend to stop or reduce their drug use after imprisonment due to the low availability of illicit drugs. However, some continue to use drugs, to an even greater extent in some cases, and others commence once incarcerated.

Drug use within prison is reported by 16 to 54 % of inmates; regular drug use by 5 to 36 %. Between 0.3 and 34 % of the prison population have ever injected while incarcerated.

Women drug users in prison

The number of women in prison is lower than the number of men. However, drug use seems to be particularly acute amongst the female prison population. Where data are available, they show a higher proportion of drug users among women in prison — considering last six months prevalence of drug use in Denmark, last year and lifetime prevalence of heroin use in Ireland, and proportion of prisoners with a drug problem and with a severe drug problem in Sweden.

As regards risk behaviours within prison, studies carried out in Germany (NR, 2001) and France (WIAD-ORS, 2001) show a higher proportion of prisoners sharing drugs, sharing injecting material and prostituting themselves amongst female drug users, compared to males. Whereas other studies carried out in Austria (NR, 2001) and England and Wales (WIAD-ORS, 2001) report more injecting material sharing amongst male prisoners.

Initiation to drug use and injecting also takes place in prison. According to several studies in Belgium, Germany, Spain, France, Ireland, Italy, Austria, Portugal and Sweden between 3 and 26 % of drug users in prison report their first use of drugs while in prison, while between 0.4 and 21 % of IDUs in prison started injecting in prison (NR, 2001; WIAD-ORS, 1998).

Health and legal consequences

Risk behaviours

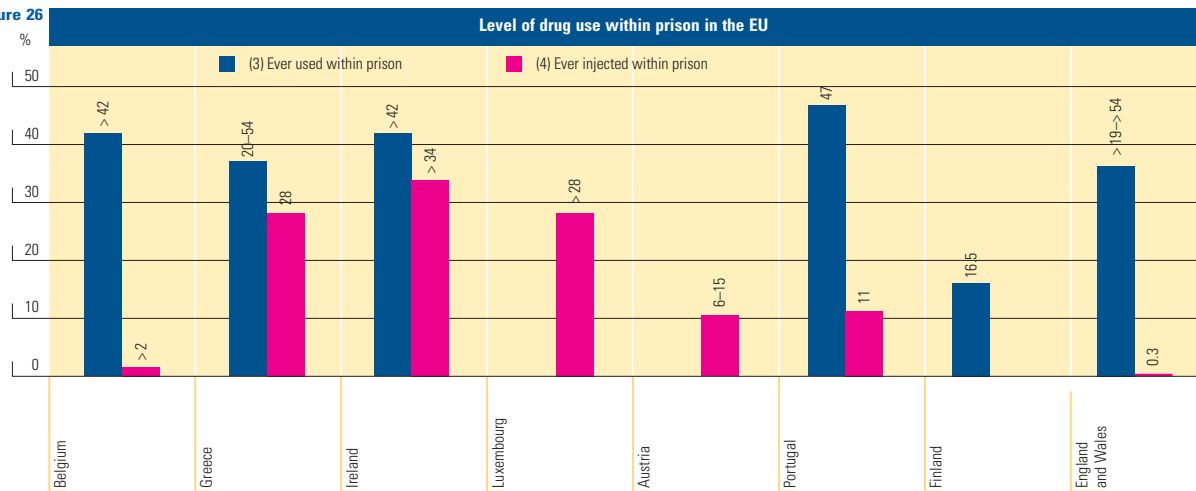
Studies conducted in Belgium, Germany, Greece, France, Ireland, Luxembourg, Austria and the United Kingdom (NR, 2001) show that a high proportion of IDUs in prison share injection equipment. Within prison, intravenous drug use is often associated with the sharing of injecting material, and in some cases up to 100 % of IDUs report sharing behaviours. A Luxembourg study (NR, 2001) reports that, in 70 % of cases, syringes are cleaned with water only and, in 22 % of cases, they are not cleaned. The data available show that sharing injection equipment in prison is more frequent than in the community.

A multi-centre study carried out in some prisons in Belgium, Germany, Spain, France, Italy, Portugal and Sweden in 1996/97 (WIAD-ORS, 2001) reports more tattoos and piercings during incarceration among IDUs, compared with non-IDUs. IDUs also report a higher level of unprotected sexual intercourse in Belgium, Germany, Portugal and Sweden, but less in other countries.

Infectious diseases

Data on HIV and HCV status among injecting drug users (IDUs) in prison were provided by Belgium, Germany, Spain (HCV only), France, Ireland and Luxembourg (NR, 2001).

Figure 26



NB: Values on the figures have been derived from data provided in surveys or studies carried out in the Member States. The online version of the report gives details on the original data sources.
 (3) (4) See online version for explanation.
 Sources: Reitox national focal points. See also online table 'Proportion of drug users among prisoners in the EU'.

They come from local studies carried out in a few prisons, and thus are not representative of the national level. The prevalence of HIV among IDUs varies between 0 and 13 % in the prisons investigated. Levels of HCV positive status are much higher, between 14 and 100 % among IDUs according to the prison centre and the country. As in the community, the prevalence of HIV and HCV is higher in IDUs than non-IDUs.

Sanctions for drug use/possession

Prisoners caught in possession of illicit drugs are usually sanctioned and punished under prison regulation. The incident might be reported in the personal file of the prisoner. The common sanctions applied include restriction of rights (visits from friends or family, telephone calls), deprivation of prison leave, expulsion from specialised treatment wings and/or punishment in an isolation cell.

Possession can have consequences on the execution of the conviction. For example in Denmark, there is a risk not to be granted release on parole after having served two thirds of the sentence. In the United Kingdom, when a urine test is found to be positive, the sentence can be lengthened by at least a few extra days.

Prisoners caught with drugs might also be charged and prosecuted for it out of the realm of the prison.

Drug availability and supply in prison

Availability of drugs

Access to illicit drugs is far more difficult within prison than in the community. However, illicit drugs are reported to be easily available in prison for those wanting to use drugs — mostly cannabis, heroin and medicines

(benzodiazepines) — but anything is obtainable in exchange for payment.

Prisoners report large variations in quality, continuity and the price of illicit drugs within prison. Prices of drugs are estimated to be two to four times higher than outside prison, which makes drugs 10 to 20 times more expensive in terms of spending power. Payment forms other than money are extensively used: exchange of services (prostitution, cell cleaning) or goods (telephone cards, tobacco) and/or participation in drug distribution.

Smuggling and trafficking

There are many ways of accessing drugs in prison. All contacts with the outside world are occasions for smuggling drugs into prison: during visits (on visitors' clothes or in their body cavities or inside food), transfers or transportation to court for trial, after prison leave, through the mail (parcels). Drugs can be thrown inside balls over the prison walls. They are also smuggled in by prison staff.

Drug distribution and trafficking varies from one prison to another and between countries. Belgium reports (NR, 2001) trafficking at individual level as well as pyramidal networks in which (as in the community) high-level dealers organise the drug trade but do not use drugs themselves. Germany mentions (NR, 2001) small-scale trafficking in which many prisoners are involved through several channels without central organisation. A study recently carried out in Mountjoy prison in Ireland (NR, 2001) shows a system based on personal arrangements: those having access to drugs in the community, smuggle them into prison and distribute them to their personal network. Drug trading within prison is reported to be far

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more distressing than in the community, leading to intimidation, bullying and criminality.

To prevent drug smuggling, several measures are implemented — on a routine basis or on suspicion. These include searches of cells, body searches after prison leave, interdiction of parcels, monitoring of visits and placing a net over exercise yards. The United Kingdom has recently set up measures to reduce supply, such as increasing the use of dogs to deter and discover smugglers and banning visitors caught smuggling drugs into prison.

Seizures of illicit drugs within prison or at the entrance are reported by many countries, usually of small quantities. Drug injection material, chillums and other paraphernalia are also found during inspections.

Demand-reduction policy in prison

Current demand-reduction measures inside prisons consist predominantly of discouraging drug use through increased control, such as cell searches and random drug testing combined with sanctions or loss of privileges. For example, in Sweden, prisoners undergo an average of two to three urine tests per month.

Confronted with an increasing number of drug users, prison systems have set up specialised addiction care units (e.g. in the Netherlands), have centralised drugs services in specific prisons (Ireland and Austria), or ‘imported’ expertise in addiction care from external drugs agencies.

Since 1995, an expansion of services for drug users in prisons has been noted (Ambrosini, 2001) and measures to prevent the transmission of infectious diseases introduced. Compared to the community, however, there was a considerable time lag. The current offer of addiction care services does not match the potential need of the estimated over 50 % of drug users among the prison population.

Since many drug users return to prison various times with the same or even worse problems of drug use and infectious diseases, prison administrations have had to acknowledge the need to tackle addiction, drug use, related risks and health consequences in a more systematic way within prison settings. A recent development in many EU countries that reflects this is the adoption of genuine ‘prison drugs strategies’, the provision of directives on the care and treatment of addicted prisoners, or

the development of quality standards for specific services⁽⁶²⁾. Prison drug strategies usually cover a range of measures to treat prisoners, discourage drug use and reduce the supply of drugs.

Addiction care

Health care services in prisons are traditionally provided by the prison’s own health care staff under the authority of the Ministries of Justice, but prison systems across the EU and in Norway rely to a large extent on additional external expertise and resources in the care of drug users. Striving towards ‘equivalence of care’ between the community and the prison (Council of Europe, 1993; WHO, 1993), France, in 1994, and Italy, in 2000, have moved the responsibility for the care of addicted prisoners to their Ministries of Health and thus involved local and regional health care agencies on a statutory basis. Concrete cooperation agreements between the judiciary system and public or non-governmental health services were also established in Ireland in 1999, Portugal in 1999 and Spain in 2000, to increase the quality and coverage of care for imprisoned drug users.

External drugs specialists play an important role in the support to drug users in most, if not all, European prison systems. However, the extent to which prisons are covered and the level of service provision vary considerably between and within countries. Notable exceptions in terms of coverage are: Scotland, which has drug counsellors in every prison; Spain, where addiction care services are available in 71 out of 73 prisons; Sweden, where a third of the estimated number of inmates with drug problems were covered by treatment motivation programmes in the year 2000; and England and Wales, where since 1999 all prisons have specialised external teams (CARAT — Counselling, Assessment, Referral Advice and Throughcare Services) which aim to cover drug-using prisoners’ needs from intake to aftercare — although a bottleneck seems to be the lack of referral possibilities (Spacca, 2002). In Scotland, prisoners can now also receive transitional care during the first 12 weeks after release, to facilitate their return to the community.

The services provided by external agencies are general drug prevention information and education, treatment motivation programmes and preparation for release, including referral to community-based treatment and to aftercare. In Belgium and Greece, non-governmental organisations (NGOs) are so far the primary providers of the limited services that are available to drug users in prisons. In

⁽⁶²⁾ Table 13 OL: Recent prison drug strategies, ministerial directives and service standards in the EU and Norway (online version).

Germany, the history of the work in prisons of external drugs agencies and of specialised internal drugs services dates back to the mid-1980s and, in 2000, more than 350 drugs counsellors provided their services in German prisons; however, the coverage of this service varies between the federal states (*Länder*). In 2000, the involvement of external professionals continued to be an important trend in France; and, in Italy, the public drugs services SerT noted a large increase in client numbers, due to their new responsibility with regard to prisoners. The Spanish national strategy on drugs (2000–08) defined the participation of external specialists in the care of drug users in prisons as a priority, and multiannual cooperation plans between prisons and NGOs have resulted in more than half of the addiction care services (GAD) in Spanish prisons being staffed by external NGO experts.

Services provided

Written information materials on drugs and drug-related infectious diseases seem to be available in most prisons in the EU and Norway; however, systematic and repeated opportunities to address prevention issues face-to-face are rare and often depend on the initiative of external agencies or individual prison staff.

Detoxification is in general offered through medical prison services or in specialised detoxification wards, but quality guidelines are often lacking. A programme through which 1 200 to 1 500 prisoners received detoxification per year has been described as being provided in an 'essentially unstructured and unsupervised fashion, with no follow-up or medium to long-term planning' (Department of Justice Equality and Law Reform, 1999). However, quality standards are starting to be introduced, for example the prison service order of December 2000 requests that all prisons in England and Wales offer qualified detoxification services.

In some countries, external agencies are also directly involved in providing longer-term treatment of addiction. Examples are the small intramural programmes for drug users in Denmark and Norway, which are run by specialised external drugs agencies ('import model'), and substitution treatment in Spanish, French and Italian prisons. The high coverage in Spain has been achieved through the massive involvement of external drugs services.

Nine EU countries have structured abstinence-oriented treatment programmes inside prisons and Norway provides a treatment motivation programme. The total num-

ber of places is, compared with the estimated number of prisoners with drug problems, very low. However, in Spain, 8 984 prisoners participated in the 18 available drug-free treatment programmes in 2000 and, in England and Wales, 3 100 entrants were registered in the 50 intensive treatment programmes in 2000/01. In Sweden, 10 % of prison facilities, with a capacity to receive 500 prisoners, are specially reserved for voluntary and compulsory treatment of drug users (Lýsen, 2001) and, in Finland, 18 % of incoming prisoners participate in alcohol or drug rehabilitation programmes (Jungner, 2001). In the Austrian prison Favoriten, specialised exclusively in the care of addicts, 110 treatment places are available; Denmark has 30 places and Ireland has nine. The Norwegian treatment motivation programme can take 18 prisoners in charge per year⁽⁶³⁾.

Except for Greece, Sweden and two *Länder* in Germany (Bavaria and Baden-Württemberg), substitution treatment is now available in prisons in all EU countries and Norway. However, even in countries where a large percentage of problem drug users in the community are in substitution treatment, prisons often follow a detoxification policy. For example, rates in prisons in Germany and the Netherlands are thought to be between 1 and 4 % (Stöver, 2001; WIAD-ORS, 2001) compared to an estimated coverage of 30 to 50 % in the community. Most prison maintenance policies indicate the treatment only during short-term sentences, for pregnant drug users, and for those with long addiction careers or severe mental or physical health problems. Initiation of substitution treatment in prisons is rare, even though it is legally possible in most countries. The major exception is Spain, where substitution rates inside and outside prison correspond⁽⁶⁴⁾.

Ten EU countries and Norway run drug-free units or prisons. The purpose of some of them is not only to protect non-dependent inmates from drugs, but also to provide treatment for addicts. Prisoners under methadone substitution are usually excluded from drug-free units. The 20 drug-free addiction guidance departments in Dutch prisons can cater for 446 prisoners; however, one third of the capacity remained unused in 1999. Sweden has 356 places in drug-free units and, in Finland, where currently 10 % of all prison wards are drug free, an expansion to 50 % is envisaged. Portugal recently opened seven drug-free units with 195 places, evaluated it as a 'great success' and is planning two more units. An analysis of research on penitentiary addiction care (Rigter, 1998)

⁽⁶³⁾ Table 14 OL: Abstinence-oriented treatment and drug-free units in prisons in selected EU countries and Norway (online version).

⁽⁶⁴⁾ Table 15 OL: Substitution treatment in prisons in the EU and Norway (online version).

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concluded, however, that there was a shortage of reliable and valid results worldwide.

Prevention of infectious diseases

The prevention of the transmission of blood-borne diseases during incarceration has become a priority target for several prison systems in Europe — also with regard to the notable increases in pharmaceutical expenditure due to the treatment of drug-related infections (e.g. HAART, interferon) that prisons have to cover.

Many countries aim to follow the general principles and specific recommendations made by the WHO in their *Guidelines on HIV infection and AIDS in prison* (WHO,

1993). Several risk-reduction measures are difficult to implement, because they are politically loaded, meet resistance from staff and are perceived inadequate in prison settings. Selected prevention measures of the WHO guidelines and the extent to which EU countries and Norway implement them are presented in Table 2. Even though the coverage of these measures appears still to be insufficient in many countries, some progress has been made ⁽⁶⁵⁾. Needle exchange programmes can be implemented now in all Spanish prisons ⁽⁶⁶⁾ and Luxembourg and Portugal are discussing their introduction. More countries recommend prisoners' access to diluted bleach and implementation of this measure has improved.

Table 2 Overview of selected measures to prevent blood-borne diseases in prisons in the EU and Norway

	Information/education	Hepatitis B vaccination	Provision of disinfectants	Needle/syringe exchange
Belgium	++ but not in all prisons	+ protocol being developed by MoH	+	0
Denmark	0	++ but coverage very low (2 %)	++ with instructions	0
Germany	+	n.a.	+	+
Greece	+ but provision relies primarily on external agencies	+ only one prison	+ only one prison	0
Spain	++	++ and encouraged	++	++
France	+	++	++	0
Ireland	0	++	+ but ++ recommended by Review Group on Prison Health Care, 2001	0 Review Group on Prison Health Care does not recommend N/S exchange, because of risks of attacks
Italy	0	n.a. (mandatory vaccination at age 12, whole population, introduced early 1990s)	++	0
Luxembourg	+	++	0	0 under discussion
Netherlands	+	++	++	0
Austria	+	+ (!)	++ with instructions on cleaning	0
Portugal	+	++ national vaccination programme	++ in practice: +	0 under discussion
Finland	+	++	++	0
Sweden	0 depends upon prison	0 decision on general introduction of vaccination pending	0	0
UK	+	++ (Scotland)	++ England/Wales: not easy to access. After pilot study, tablets are being made available Scotland: ++ with instructions	0
Norway	n.a.	n.a.	0 health authorities asked prisons to make bleach available	0

NB: n.a. = information not available

Information/education

0 general written materials
+ written materials specifically developed for prison setting
++ prison-specific materials plus safer use training

Hepatitis vaccination

0 not systematically available
+ available in few prisons
++ available in all prisons

Disinfectants

0 not available
+ in some prisons
++ in all prisons (at least in theory)

Needle/syringe exchange

0 not available
+ programme in few prisons
++ programme in all prisons

Sources: Reitox national reports.

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(!) Spiring, H. and Ess-Dietz, O. (2001): 'Preventive measures in Austrian prisons', in WIAD-ORS, pp. 234–300.

⁽⁶⁵⁾ For information on the situation up to 2000, see the web site (http://ar2001.emcdda.eu.int/en/chap2/specific_demand.html#table2).

⁽⁶⁶⁾ Except prisons located in Ceuta and Melilla. The autonomous community of Cataluña has its own competence in management of prisons.

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