I. Risk reduction strategies in prison – why and how?

It is evident that strategies have to be developed for the prison setting, to address problems such as the use of injectable drugs, unprotected sexual contacts and tattooing with non-sterile equipment, lack of knowledge about transmission of viral hepatitis, HIV/ AIDS and the dynamics of addiction.

The limited possibilities in prison call for creativity and unconventional solutions. 'Second best' or 'better-than nothing'-strategies which are effectively pragmatic solutions to these problems have to be considered. Sometimes, prison-based rules and traditions can be followed. We know for instance, that, if it comes to injecting drugs without having a syringe available for all those involved in the act, in some prisons the inmates will stick to the rule that HIVpositive inmates inject last. Another example is that a used syringe is cleaned by simply drawing up several times with cold water because of a lack of effective means of either thermal or chemical disinfecting. To reduce health risks, inmates tend to develop their own forms of risk assessment, sometimes based on far from scientifically proven facts. For example, fatal errors can occur when inmates select their needle sharing partners by looking into their eyes in order to try and see whether the partner is hepatitis positive or not. Trust plays an important role among inmates and their culture and hierarchy. These onsets of risk reduction may serve as a starting point for risk reduction activities, such as discussing drug use, prison conditions and the spread of viral infections. Risk reduction should integrate the existing knowledge and practices of the target groups: drug users will often already know more than any trainer from outside, and staff have already developed their strategies for tackling intoxicated prisoners. This starting point should form the basis for further discussions.

When developing information material on risk reduction in prisons one has to keep in mind the specifics of the prison situation. Medical staff require different information than guards (prison officers). Inmates have their own specific background, subculture and language. Prevention material designed for target groups in the community cannot simply be transferred to the prison setting. The relevant target groups require prison-adopted versions. This makes it necessary to get input from each of the different groups concerned. This information can be collected through interviews or focus-group discussions. Initial drafts and design need to be tested and approved. The WHO states that: "it is important to recognise that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should therefore actively participate in developing and applying effective preventive measures, in disseminating relevant information..." (WHO 1993).

Developing a network of key persons can be a helpful strategy. This can serve as a valuable background support. Key persons should be selected on the basis of their role in their specific networks (e.g. services for drug-using inmates). It is their task to provide crucial information about the situation in their working area (specific needs, where to organise activities, identifying partner organisations to collaborate with, pointing out other key persons, etc.), in the process of developing and realising modules of any risk reduction approach in prisons.

In many European countries community drug teams, AIDS projects or other health services are included in the care of drug-using inmates. Some prisons even have their own advisory board on drug issues. Sometimes, social and health workers from the community are involved in health promotion and risk reduction activities in prisons. In contrast to prison staff, these workers are

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more widely accepted and trusted by prisoners as they are not part of the prison system. In some countries, these 'outsiders' even have a duty to maintain confidentiality and have the right to refuse to give evidence. Moreover, they generally have a lot of valuable expertise, e.g. about the content of and requirements for the various services offered. They can provide this information on services in and outside prison to inmates. They also can contribute to the process of motivating drug-using inmates to overcome their drug use, e.g. through enrolling in prison or community therapy programs. However, they also can play an important role in delivering a prevention and risk reduction message. Including staff from community services facilitates the development of a chain of treatment, linking prevention and treatment in the community to prevention and treatment in prisons. Thus using such people generally contributes to continuity of health care, avoiding inefficient interruptions in services provided. It underlines the link between prison and community and promotes the advantages and need for prisons to be oriented towards the community.

To sum up, it can be said that when developing risk reduction measures in a prison, the chosen strategies should focus on the specific needs and beliefs, on the myths and the living and working conditions of the target groups. Strategies successfully applied outside cannot necessarily be applied inside without adaptations.

II. Problems in transferring risk reduction measures into the prison settings

Risk reduction strategies commonly applied outside prison are often regarded as undermining the measures taken inside prison to reduce the supply of drugs. To support, on the one hand, the hygienic use of illegal drugs (by means of bleach and syringe/ needle provision) and then, on the other hand, confiscate them when they come to light is a fundamental contradiction. Risk reduction strategies are regarded as a challenge to the prison policy of drug free orientation in general, and may be seen by some as not taking the risks connected with drug use seriously enough.

These risks are the focus of risk reduction strategies which should be seen as an additional strategy to drug free-oriented measures. Drug use itself should be avoided, but when it does occur - which seems to be the case in most prisons - irreversible damage to the user's health and to that of other inmates, prison personnel and inmates partners and families in the community - should be avoided. Inmates should not leave prison with more damage to health than they had when entering prison. This point of view is clearly supported by the World Health Organisation (WHO 1993).

Additionally, most drug-using prisoners seek to hide their drug use in order to avoid losing privileges (such as home leave, segregation, higher levels of control, frequency of visits, etc.) or being subjected to intensive controls, such as body search (both of themselves and also their visitors), cell searches, discrimination by non-drug-using prisoners (due to fear of transmission of infectious diseases), etc.

This background makes it difficult for the prison authorities to cope adequately with the health risks of drug users in prison. Due to a lack of anonymity and confidentiality even making contact with the target group on this issue might pose a problem.

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Other problems are:

- Difficulties talking about sex, drugs and infectious diseases
- Lack of confidentiality and anonymity when talking frankly about drug use and sex.
- Gender specific taboos (men having sex with men without homosexual identity).
- Utilising the knowledge and status
- Inside/outside: integrating people from the community
- Self-help groups or self-organisations?
- Any knowledge acquired is not just for application during the time spent in prison.
- Looking at the specific prison conditions: overcrowding, infrastructure, 'Healthy Prisons', structures of communication and co-operation.

III. Organisational aspects

The aim of risk reduction activities in prison is to achieve a level-headed approach to the health care matters that concern drug addicted inmates and the health risks of the prison personnel. Therefore the organisation of risk reduction activities must be prepared carefully. One should approach this task via the following steps:

- Needs assessment
- Setting priorities and aims
- Defining the target group(s)
- Choosing an approach
- Evaluation

III.1 Needs assessment/collecting information

The initial point of departure is a needs assessment, which should be based on a general understanding of the aims and target group(s). Therefore, the first step will be to collect information on the following issues:

- What are the needs/problems of inmates when it comes to health risks?
- What are the needs/problems of prison staff concerning health risks?
- What services are available?
- How are these services functioning? (quality, accessibility, etc.)
- What services are lacking?

This information is necessary in order to verify any prior assumptions. It also provides the basis for establishing priorities regarding the specification of aims and target group(s).

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Important steps in this process are:

- Collecting and reading written information such as: statistical material about the characteristics of the target group(s) (age, gender, ethnic background, health risks faced, awareness, knowledge, etc.).
- Studies of drug users in prison.
- Reports of prison and community services (number and types of drug users, information on health services avail able, information on health problems, etc.).
- Identifying key persons (staff of prison and communitysevices, drug users, etc.) and collecting information from them.
- Getting information inside prisons, exploring the situation (when, where and what drugs are used, what healt problems and safety risks are encountered by inmates and prison staff, etc.).

It is worth bearing in mind that all these sources of course have their limitations and biases. Therefore, it is important to check and compare information to get a relatively accurate picture of the situation.

When collecting this information it is helpful to begin by making a rough plan:

- What data is relevant? (e.g. how many drug users are HIVpositive, how many inject, how many are homeless, etc.)
- Where to find this data? (at which organisations, on the street, etc.)
- who is collecting such information?

III.2 Setting priorities and aims

Based on this initial information, priorities for risk reduction activities should then be formulated. First of all, it has to be clear what one wants to achieve via these activities. Making the goals of such a project clear is important for different reasons, e.g.

- To create common ground for the people (both staff and inmates) involved
- To explain to the ‘outside’ world what you are aiming at.This is not only important to convince policy makers of the urgency of financial support but also for public relations rea sons.
- To have a standard by which you can measure the results.
- This is not only important because one will have to prove the results of one’s work to external agencies, such as policy makers, funding organisations, etc. Similarly, it is important for one’s own organisation to gain a clear insight into the results of any work. This provides a basis from which one can learn from one’s successes and mistakes and subsequently improve one’s approach.
  The aims therefore should be smart, i.e.:
    - Specific, describing as exactly as possible what one wants to reach through the activities. Global aims like reducing risk behaviour within the target population are not enough.
    - Measurable, allowing a final evaluation to determine whether one has reached the goals that one wanted to reach.

- Acceptable, for both inmates and prison management and staff (everyone involved should be fully informed about the aims and content of your work, otherwise it might cause suspicion or be perceived as threatening).
- Realistic, meaning that they should be achievable. It is important here to establish priorities (what aims are most important and what is less important), and to get a picture of what could realistically be achieved in the actual situation. It does not make sense, for example, to state that activities are aimed at getting all inmates drugfree.
- Time specific, meaning that one should produce a plan identifying how much time it will take to realise these aims.

Risk reduction activities in prison could, for example, aim at:

- Improving knowledge of infection risks and safer behaviour among prison staff and inmates (this can be measured by using the information in the following chapter about the con tent of the message).
- Increasing general health awareness in the drug-using community (taking care of injuries, nutrition, etc.).
- Changing social norms, attitude and behaviour of prison staff and inmates.

III.3 Defining the target group(s)

Selecting the target group(s) is closely linked to setting the aims of the project. The selection of a target group(s) could be made upon

- Priorities within a problem area, e.g. based on an epidemic profile
- Identifying the limits of the reach of existing prevention programs, and/or
- Pragmatic criteria

Priorities within a problem area

In the field of risk reduction activities, the target group(s) with a high incidence of health risks - both for prison staff and inmates - will generally take priority. Thus, an epidemic profile can be very useful. In order to establish priorities one has to collect information on the current state of the epidemic (e.g. an estimate on how many drug users are HIV-positive or already have AIDS) and on the expected future development. Different sources can be used to obtain this information, such as:

- Sero-prevalence studies
- HIV counselling and testing programs,.
- AIDS service programs
- Knowledge, attitudes, beliefs and behaviour surveys
- Prison medical services, etc.

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The limits of the reach of existing services

In combination with an epidemic profile, data can be collected on which inmates or groups are not successfully being reached by current risk reduction activities. To be more precise, these could be:

- Inmates who literally are not reached by risk reduction activities, e.g. because the main part of HIV/AIDS prevention measures are aimed at drug users, or focus more or less exclusively on dependent opiate injectors. Thus, the socalled recreational, non-dependent drug users - people who are using or injecting substances other than opiates and people who are starting or experimenting with injecting or other types of drug use - are more or less systematically neglected. Other groups who sometimes tend to be over looked are women, homosexuals and ethnic minorities.
- Inmates who have got information about HIV/AIDS, safer use and safer sex, but don't appear to have achieved reasonable results. This might be due to:
    - Incomplete or inadequate information
    - An inadequate approach, e.g. getting information during a methadone intake assessment
    - Factors or problems on the user's side, such as feelings of distrust, lack of motivation, negative attitude, social norms, lacking resources, etc.

Pragmatic criteria

Experiences with risk reduction activities in prison have shown that pragmatic considerations can be very useful in selecting the target group(s). In general one should consider starting by informing prison staff, as their support will be needed to work with drugusing inmates successfully.

III.4 Choosing an approach

In general, among the various risk reduction activities in prison, certain approaches currently dominate. As we stated above, in this course we distinguish between three major approaches to risk reduction in prison:

- An individual approach (individual counselling)
- Agroup oriented approach (training seminars)
- Services and supportive measures

The choice of approach depends on a number of different issues, such as:

- The target group(s); e.g. if one is focusing on prison staff or on inmates, or trying to get new people involved in risk reduction activities then an individual approach will be preferable. Alternatively, if targeting people who are not yet involved then a seminar might be an adequate option.

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- The aims; what is the best way to reach your aims? For example, if a snowball effect is a key aim then a training seminar for drug-using inmates ('how to pass on the message effectively', for instance) can be of great value.
- The specifics of the situation one is working in; again, pragmatic considerations play a major role here. Which approaches are acceptable for those in the criminal justice system, prison management and staff?
- The available human resources; the qualifications of the drug users and/or professionals involved, and the availability of professional support are decisive factors in determining what can be done.
- The available resources; this is especially important where there is not enough money to do both outreach work and training seminars. As outreach work by peers generally is seen as less expensive and time-consuming (due to the limited involvement of professionals) than organising training seminars, often the decision to use outreach work will be made on this pragmatic consideration.

III.5 Preparing activities

When preparing activities the following things should be considered:

- It is of vital importance to obtain permission from the prison governor and any national or regional criminal justice authorities prior to anything else. These people should be consulted about the activities planned in plenty of time, inviting them to give their opinions and have input into the plans. Having them involved in the planning of the activities is necessary to get them both convinced and committed. A usefulstrategy could be:
  - To identify the people one would have to address
  - To send these people information about the extent and range of health problems, on your plans for risk reduction activities and on your organisation, acknowledging in the accompanying letter that you need their support and would like to discuss your plans with them, and finally, informing them that you will call to make an appointment.
  - To make an appointment for a personal meeting by phone,
  - Discussing the plans at this meeting, trying to convince them to co-operate.
- Organising a seminar or meeting on this issue and inviting prison governors and criminal justice authorities; involving as speakers governmental and inter-governmental officials (e.g. from WHO) might be another initial step.

- As already stated, the support and commitment of prison staff is a vital prerequisite. Once again, a seminar can be an appropriate format to give information about the relevance of risk reduction activities for both inmates and prison staff; both to provide information about your plans and as a means of getting people involved in a discussion on how to realise risk reduction in their prison - while taking into account that particular prison's specific circumstances.

- The value of co-operation between prison services and community health (drug) services in the creation of risk reduction services should be given careful consideration. Using the expertise and support of the latter has proved highly effective in numerous countries. These organisations can contribute to the knowledge and skills of prison staff and inmates, on issues such as infection risks

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and how to avoid them. It is also efficient to use such services as it avoids the necessity for prison staff to 're-invent the wheel'. Finally, such co-operation can also contribute to better coordination between health services, facilitating continuation of treatment when drug users enter prison and referral to community health services when they leave.

- Providing information about the activities you are planning to these community services can be seen as the first step in developing co-operation with them. At this stage, suggestions about ways of working together can be pro posed. Here again, a seminar involving representatives from prisons and community services can be an appropriate choice for kick-starting a project of this nature, as it faciliates a discussion between prison and community services.
The contribution of community services to risk reduction activities in prison can vary widely. Some organisations can offer professional support, e.g. the development of working methods, training and supervision of the prison staffin volved, etc. With other organisations, regular consultations over issues such as fine tuning the policies and creating a basis for satisfactory referral might be a better approach. These consultations should not be limited to the formal level - informal talks between individual workers can be valuable and effective as well. Through this process, a local network can be developed or maintained.

- Clear arrangements between prison administrations and community health services should be made, defining and dividing the tasks between the various organisations and individuals involved. The specific conditions of the prison will have to be accepted, meaning that the structure of decision-making, communication and co-operation in the prison system has to be acknowledged. There might be considerable differences between different countries and regions. Every prison has its own policy, its own population of inmates and its own way of communication and co-operation with external drug and AIDS services. Careful preparation is necessary to target the specific needs of the inmates, as well as the staff members.

- Due to the fact that drug use, sex and tattooing are forbidden in prison, there is a desire for anonymity and a need to protect the privacy of inmates. This can be a significant obstacle to organising risk reduction activities in prisons. Admitting drug use, or even showing interest in information about safer use might be avoided due to the fear of being treated differently. These fears range from being identified by the guards as an active or current drug user and being the target of intensified checks such as cell searches or searching visitors, intensified urine testing and losing privileges such as home leave, things that are all very important in the everyday life of a prisoner. This is a particular problem for those inmates who so far have been success ful in hiding their drug use. For these inmates, participation in risk reduction seminars would be comparable to a coming out as drug user. Their interests might be different from the interests of those inmates who believe that they have nothing to lose and whose drug use is common knowledge. Talking openly about drugs, drug use and risk reduction in prison might also be interpreted by staff members as not taking the problems connected with intravenous drug use seriously. However, this could be used as a starting point for a thorough discussion of the issues.
Another problem, also linked to privacy, might be that interest in participating in

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a safer sex training seminar might be interpreted by other (male) inmates as a sign of either having sexual problems, or being a homosexual. The willing ness to participate in the safer use/safer sex program always reflects the climate of confidence, acceptance and policy in that specific penitentiary system.

- It is also worth considering ways to introduce and discuss risk reduction activities in prison with other relevant organisations and with the general public. This should only be done with the agreement and co-operation of the prison and criminal justice authorities. By other organisations, we mean not only drugs and HIV/AIDS services but also general social and medical services, politicians, policy makers, police and criminal justice officials. This is one basis on which tuning in and co-operation can be realised.

- With regard to public relations, one possible strategy could be the following:
    - Begin by considering if representatives of the most relevant organisations should be informed, even before the actual start of any activities. Collecting information on the local and regional specifics will provide the information on which organisations should be contacted. Generally, an informal personal conversation is more effective than sending written information. In this first meeting, the aims and the approach of the activities can be explained and discussed. In addition, first plans for attuning the services can be made at this meeting.
    - Directly before the start of the activities, all relevant organisations could get a letter with ample information on the project, covering its aims, approach, starting date, contact person, etc.
    - In the starting phase, additional meetings for the teams of these organisations can be organised, in order to inform the workers about your activities in greater detail.
- Informing the general public generally means informing the media. As with the drugs and AIDS service organisations, a written general announcement can be sent to the media. In addition, a press conference can also be organised. This shows the press and public alike that one has nothing to hide and satisfies any curiosity about what risk reduction activities in prison might look like. Finally, if one has particular media contacts who you know from experience will sympathise with this sort of initiative, they should be invited for an exclusive interview or story.
  In some cases, it might be better not to go public at the very beginning. There might be good reasons for initially establishing the activities and being able to present some results prior to announcing the project. This is especially true when your activities might be expected to meet some resistance.
  However, not going public involves the risk of losing control over the information process. A single inaccurate or negative article in a newspaper - based on rumour or secondhand information - can cause major problems. Once out there, correcting this false picture is invariably very difficult. Moreover, by not informing the public voluntarily, one can give the impression that one has something to hide. Any discovery by accident may well result in negative publicity.

- Public relations on these different levels - can also be very important in the later stages of a project. Consider whether to provide the media and other relevant organisations with information on the project's activities on a regular basis. This

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can be done through things like an annual report, but also through other strategies for disseminating news about the project. News, in this context, can mean organising a seminar on the public health implications of infectious diseases in prison, or starting a new activity, having new people appointed, new collaborative working arrangements with other organisations, etc.

- Throughout all of this, one should take good care to create and maintain a positive image of the project's activities. Gaining public acceptance can be an extremely important means of support. To facilitate this, it generally is very effective to have good contacts with one or two journalists who sympathise with one's work. This can be helpful not only during possible conflicts, but can also offer the possibility of press coverage of one's activities on a regular basis. This sort of press coverage can be helpful in convincing the public of the value of one's work.

- Besides the internal need for evaluation, necessary to be able to adapt and improve the work (see below) there is also a demand to prove to the outside world (politicians, other organisations, etc.) that risk reduction activities are having a very real positive impact on the target groups. When designing evaluation strategies for internal and external purposes, it is useful to seek professional assistence, particularly when the evaluation is for external use. This is especially true if one is aiming at getting statistical information from the evaluation. Undoubtedly, the best option is to employ an experienced researcher to take care of this aspect of the work. However, the available financial and human resources might not allow this. In this case, support could also come from a volunteer expert at a university or from a social science student in his practical training, etc.
  One workable and very efficient solution to this problem is to develop and use the evaluation measures and results we describe below, both for internal use and also for external purposes.

III.6 Monitoring and evaluation

At any given time, there is always a need to see what has been accomplished, who has been reached, what the result has been, which step has to be taken next, and if and how the chosen approach can or should be developed or modified, etc. This process requires relevant and accurate information, both for internal and external purposes. Therefore, it is important to collect data and monitor and evaluate risk reduction activities. There are a number of different ways to do this.

First of all, one should consider a process evaluation. This is a detailed description of the development and realisation of the risk reduction activities undertaken. A process evaluation should cover a description of all of the steps that we've mentioned above, i.e.

- Needs assessment
- Setting priorities and aims
- Defining the target groups
- Choosing an approach

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- Preparation of activities
- Realisation of activities

The first five points can be covered by writing a report that describes what has been done, which decisions have been taken and why these decisions have been taken. To evaluate and monitor the risk activities undertaken, one can use a more standardised form of collecting information (see below).

Always keep in mind that the effect of risk reduction activities in prison might be hard to measure in quantitative terms. Many experts doubt whether a solely quantitative approach to research would make sense when investigating this issue. This is particularly true when considering the effects of peer support by snowballing' i.e. drug users who are reached by the project and then pass on the information they have learned to their peers), as it is difficult to establish a representative statistical sample that can measure such an effect. When dealing with these effects, more qualitative research (field observation, interviews with drug users, etc.) tends to provide the most useful material, both for evaluation and also for those authorities who are interested in new ways of HIV/AIDS prevention as for drugs services and drug user self-organisations. However, quantitative data tends to be most highly regarded, and is often insisted upon by funding organisations, policy makers, etc.

Evaluating and monitoring individual counselling

To evaluate and monitor the results of individual counselling, registration forms are a useful instrument for getting the necessary information about the reach and results of one's project.

Important issues to record can be:

- Date of counselling session
- Gender
- Age
- Ethnicity
- Is this a new or repeat contact?
- Risk assessment, including:
    - Modes of drug use, levels of sharing drugs and drug use equipment (syringe and needle, spoon, filter, water; frontloading, backloading, etc)
    - Sexual risks (forms of sexual behaviour, different partners, sex work, etc.)
    - Knowledge
    - Attitude
    - Social norms
- Who initiated the contact? (staff or inmate)
- How has the contact been made? (accidental talk or appoint ment)
- Where was the contact made? (In a cell, at medical ward, in the corridor etc.)
- What did the contact consist of?, e.g.
    - Introduction
    - Advice giving
    - Counselling
    - Handing out condoms, syringes and needles, other paraphernalia

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    - Referral
- What role can the contact play in the development of a network? ('chain' referral to other inmates, etc.)

It is evident that, for reasons of privacy, no personal information(name, date of birth, exact address) should be collected, where possible. The inmates who participate in these programs should receive full information on who has access to what information, what will be done with the information, etc.

To avoid or minimize the problems with sorting data where there are several different forms on the same person, a list of those people who have been contacted that is separate from the registration forms can be made. On this list, each person will correspond to a certain code (a number, nickname, whatever). On the registration form only the code is filled in. However, the latter should only be done if one can guarantee that this list, linking the code to an actual person, is absolutely secure and no negative ramifications for the individual are likely to result from their participation.

One problem tends to be that collecting all of the data of potential interest is just too much work. If filling in the form takes more than five minutes, then it might not work. Though having someone to remind the counsellors to fill in the forms can be helpful, it still is important to develop a form which can be easily and quickly filled in. One good suggestion here is to split the registration form into two, with one part focusing on general information about the contacts made, followed by a second part that concentrates on one specific issue.

The first part has to be filled in for all contacts, comprising the first five points listed above plus the section on 'what did the contact mean'. This approach allows the collection of good, albeit primarily quantitative, information on the reach of a project.

The second part of the registration form can then be on different specific issues, for example, on modes of drug use and how they change, on (changes in) sexual behaviour, etc. After having monitored one issue in this manner for a period, (say two or three months) one can then change to another issue. Using this process of registration at least some indicators, albeit qualitative, can be discovered on certain issues. This two-part design of the registration form, then, results in relatively short forms that are easy for workers to complete.

We have suggested that it may be useful to seek some professional support for the design of the registration form, the evaluation, etc. This support can come from a sympathetic or interested expert from a local university, who may have a social science student seeking practical research experience, etc.

Having somebody from outside the prison system (i.e. somebody from a university or a community health service) doing the actual evaluation, particularly the interviewing, might also help to gain trust and therefore more truthful answers from the inmates. In addition, it might be worthwhile to consider using inmates themselves as evaluation interviewers. An approach that mixes a number of these strategies could also be considered, as it is one way to reduce possible biases by making them visible.

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This sort of data collection has a severe limitation, insofar as it is restricted to the active period of the project. It does not tell you anything about the effect of your interventions. In case of a project of short duration (some months) this is a significant disadvantage. It is impossible to assess the longer term effects of one's work on issues like changes in attitude and behaviour of the target group. In such a case a combination of an evaluation during the course of the project and a small outcome evaluation (e.g. some interviews with people from the target group) following the project is advisable.

An additional evaluative instrument could be focus groups, i.e. meetings of a selected group of participants (such as prison staff or inmates) to discuss with them their impression of the results of the risk reduction measures, and any necessary adaptations they may consider desirable or feasible in the light of their additional experience in this area.

The collection of additional data on issues like the prevalence of health problems of the inmates can provide us with some indications of the impact the project is having. For instance, the reduction in the number of abscesses, number of new infections (number of people who prove positive in a test on HIV, Hep C, etc. while having been tested negative before), etc. can serve as an indicator - although not as a proof - that people are less frequently engaged in risk behaviour.

Evaluating/monitoring training seminars

An evaluation of a training seminar can provide relevant information for the organisation responsible for the seminar, for the trainers and the participants. The responsible organisation and the trainers can learn about the following:

- Has the content been relevant for the participants? What issues do participants regard as a priority for future training, seminars, etc.
- Were the format and didactics adequately chosen to pass on the content effectively? (Was it a well matched mix of presentations, discussions and exercises? Were there enough breaks, etc.?)
- Has the seminar been well organised? (Adequate accom modation, etc)
- Has the seminar been well performed? (Clear, understand able presentations, friendly, open attitude of presenters, trainers, etc.)
- What are the participant's further training needs?

For the participants, an evaluation can help them to reflect on their level of knowledge, skills, etc. and on further training needs.

An evaluation of a training seminar can cover a number of different elements. It can be:

- A reaction evaluation, eliciting information about the general response of the participants to the seminar. Did they enjoy the seminar? Did they like the atmosphere in the group? Did they like the presentation style? This will tell you something about the choice of the trainers, the choice of composition of didactic tools, the balance of the program, the logical composition of contents, the choice of the target group, the composition of the group, etc.

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- A learning evaluation eliciting information about the extent to which the participants learned what they were intended to learn. This type of evaluation covers skills, insight in problems and attitude in addition to knowledge. Again, this will tell you something about the choice of the trainers, the choice of didactic tools, the balance of the program, logical composition of contents, the choice of the target group, the composition of the group, etc. It can also provide insights about the learning aims, about the question of whether participants could relate to the subject and about their needs for further training.
- A performance evaluation, eliciting information about whether the trainers performed well. Were they well prepared? Did they present well? (Understandable and well structured.) Did they behave well? (Friendly attitude, etc.).
- An outcome evaluation, eliciting information about whether the training seminar has had or will have an impact on risk reduction. This type of evaluation will tell you something about the adequacy of the learning aims, and the choice of the target group, but also about the question of whether the participants could relate to the subject, about possible barriers to realising risk reduction (E.g. people know and want to change behaviour but don't have the necessary means to do so), and again, about potential needs for further training.

However, instead of using forms, one could also opt for a discussion at the end of a course, which would be structured by a series of questions taken from the evaluation forms. This could be achieved in a focus group like set-up, discussing issues such as further training needs.

Another option might be an exam format, using a quiz format similar to those we offer in earlier sections. One can also use observation. A good format here can be a role play or demonstration where participants are requested to show what they learned. This is especially usefull in skills training. Finally, for the long-term effects of a training seminar, assignments can be used, requesting participants to work on certain issues after the seminar. In a follow-up meeting the results of the assignments can be discussed.

Evaluating and monitoring services: supportive measures
By services here, we mean things like condom or bleach distribution. Supportive measures could be producing and distributing a newspaper or magazine or leaflets for inmates.

Both services and supportive measures can, in general, be evaluated in a quantitative way. One can count how many people have requested bleach or condoms or how many condoms or bleach tubes have been taken from an anonymous distribution service. The same measures apply to leaflets and newspapers or magazines.

In addition to this quantitative data, you can also choose additional 'qualitative' information. This can be done through individual talks or through group meetings. Individually, this can be an element of a counselling session or through an evaluation interview using a questionnaire. Questions about the use of services and supportive measures can also be answered anonymously, e.g. by depositing short questionnaires at an anonymous distribution service. This latter, of course, might suffer from a serious bias as you cannot check if people are serious when giving the answers. Furthermore, only

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some people will fill in the questionnaire and this selection will be far from a representative sample.

Monitoring cycle

Evaluation is not a static thing which can be done once, e.g. after a training seminar or at the end of a risk reduction project, and then forgotten. It is much more effective to use evaluation at a certain stage, e.g. after a seminar as an element in an ongoing monitoring process. Another option is to have evaluations on a regular basis, e.g. every three months.

Each evaluation step can provide relevant information that necessitates the adaptation of the program of risk reduction activities. This will lead to a process of ongoing evaluation identifying what is going on and resulting in a monitoring cycle that will allow you to adapt risk reduction activities to the actual needs and problems as and when they are discovered and identified.

Monitoring process can focus on all the organisational elements mentioned above, on:

- Needs assessment - have the needs changed? For example through a change in the inmate population (target group) or through the outbreak of a new epidemic(an outbreak of TB might lead to the urgent need for a general TB test and subsequent prevention measures). Additional questions might be: Is the picture one has of the situation concerning health risks still accurate?Is he definition of the problem still accurate?
- Priorities and aims - do the priorities and aims have to change? For example through the results of earlier risk reduction activities (e.g. the introduction of condom distribution may make other needs a priority). Besides a check on whether the aims and priorities are still up-to-date, a regular check might be considered if the aims could or should be more specific, better measurable, acceptable enough for the target group(s), still realistic and adequately specified in time.
- Target group(s) - have they changed? (Through the growing influx of a particular ethnic group with specific risk patterns of drug use).
- Approach and activities - does the approach have to be adapted to a new target group? (Counselling about sex risks will have to take into account the cultural, religious background of inmates) or would other activities be more appropriate? (Individual counselling instead of group meetings to discuss delicate issues).

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IV. Main concepts for assisting drug users in prison

How can health risks related to drug use, sex or tattooing be avoided? We all know that individual habits, social rituals, norms and external factors and lack of information often form obstacles to changing behaviour that is perceived as risky or even damaging. From prevention theory we know that inside information, knowledge from personal experience and trust are important factors in the take up and cessation of a certain behaviour. In the fields of illegal drug use and risk behaviour, trust is a basic requirement. The peer group and the norms of the prison subculture are very important with regard to influencing the attitude of drug users towards safer behaviour. Self-efficacy by role modelling is another highly important feature. This means that providing social information plays a much more important role than simply providing mere facts. This is even more important in settings like prisons, where anonymity and confidentiality is hard to achieve and to realise. Quite often, the level of factual knowledge may be quite high. Elements of factual knowledge which have proved to be important generally refer to specific details (e.g. infection risk by sharing the spoon or the filter).

Being familiar with the group norms and being trustworthy for drug users also serves as a basis for getting reliable information on risk behaviour. Drug use, sexual contacts, tattooing have also to be understood as part of the inmates' subculture. Being involved in this behaviour always includes an element of resistance against the prison system.

'Dissonance-Shaping' is a term from health psychology used to describe the notion that the gap between objectives (of risk reduction) and coping abilities should not be too big. If this gap is too big, then the health objectives we want to be achieved can be rejected easily and will not be integrated into the user's sense of identity in everyday life. The strength of this 'dissonance' should remain 'acceptable' as a confrontation with the user's fundamental goals is not fruitful.

This means:

- Changes should be realised step by step. This generally means setting goals below the maximum objectives
- Objectives should be acceptable and achievable, i.e. realistic
- The credibility of message and messengers are vital
- The initial point of departure is the user's individual resources and living conditions.

But which factors do influence the user's behaviour and beliefs? These can be illustrated by means of a model for behaviour change. Like all models, this model is a simplification of reality. For instance 'attitude' is a complex phenomenon - it is a fair way from being a result of rational decisions. More aspects are relevant: emotional, motivational and environmental aspects may contribute to changes in behaviour as well. It is, however, useful for clarifying how peer support activities can be initiated and how they can be realised. We will briefly describe these factors by giving some examples and indicate how one can influence them by peer support activities.

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IV.1 External variables

External variables include demographic factors which cannot be influenced (such as gender, age, race etc.) but also residential factors (serving a sentence in a prison) or the political reality (drug policy in prisons).

- **Examples**

Elements of political reality are the drug law, drug policy, public opinion, prison reality, (e.g. no lobby or trade union for inmates etc.). These elements determine drug users' daily life. For instance, whether or not allowing substitution treatment, distribution of syringes, bleach, general hygienic improvement, gender- and migrant specific services, overcrowding, segregation of (HIV+) drug users, etc.

- **Risk reduction measures**
    - Proposing a survey of infectious diseases and the situation of drug-using inmates in prison to (local) health authorities
    - Discussing and assessing the drug and infectious disease situation with the prison doctor, colleagues in the medical department, prison staff members.
    - Trying to influence public opinion in favour of measures like bleach or condom distribution by offering valid reasons (Public health risks) for a risk reduction policy.
    - Developing a plan for a substitute drug program(detoxification and maintenance).
    - Attracting allies to support this policy, for example, journalists, scientists, politicians (i.e. local AIDS self-help groups or drug counselling agencies).

IV.2 Attitude

Attitude says something about how a person values certain behaviour. Valuing behaviour is weighing advantages against disadvantages, which is not just a logical and rational process. Irrational habits, emotions and beliefs also influence the relative weight of advantages against disadvantages.

- **Examples**
    - Clean syringe for each injection is valued positively for being hygienic, safe and sharp. But licking a drop of heroin from the needle after the air is pushed out is both unhygienic and ineffective, yet it is valued as positive by some drug users.
    - Not having a clean needle available in the prison does for many drug users not necessarily mean that they will stop using intravenously. Instead, they rely on trusting other inmates when they claim that they are HIV- or hepatitis negative.
    - The attitude towards the use of condoms is tremendous important. Condom use is valued negatively by many people, as they see more disadvantages than advantages associated with their use. It is difficult to mention advantages because most advantages do not give immediate

benefit (it's all about avoiding some thing). The only benefits one could think of is that the sperm is instantly ready for disposal.
    - Many of the prison staff members might have the attitude that drug users are not capable of changing their behaviour in order to follow precautionary rules or of controlling their drug use in order to comply with health warnings.
- **Risk reduction measures**
    - Discussing motives, ideas, beliefs towards safer behaviour.
    - **Safer use**: discussing with drug-using inmates their beliefs about effective disinfection practices. Which alternative routes of administration do they know? What are the reasons for not applying them?
    - **Safer sex**: discussing about the advantages and dis advantages of condom use in a partnership. It also should be stressed that the chance of getting infected and re-infected among drug users and their partners is relatively high.
    - **Tattooing**: discussing measures designed at preventing infections: which are known and applied by prisoners?
    - Discussing with staff the risks of becoming infected and their beliefs of how best to avoid a risky exposure (i.e.when searching the body or cell). What is their knowledge of transmission of virus and bacteria?

IV.3 Social influence

Direct social influence means that all social surroundings, i.e. the peer group, the institution, partners, family and friends expect certain behaviour. Not behaving in accordance with these expectations can lead to sanctions. Indirect social influence means that norms are internalised; people behave according to the norms as if they are their own rules.

- **Examples**
    - Direct social influence: in many prisons it is common to share the syringe and needle of a trustworthy inmate simply by rinsing with clean cold water. Refusing a used needle needs to be justified.
    - Indirect social influence: smoking heroin by means of chasing the dragon was initiated in the Netherlands by people from Surinam, a former colony of the Netherlands. Meanwhile the majority of drug users in the Netherlands have adopted this behaviour.

- **Risk reduction measures**

From different so-called peer support projects - both in and outside prisons - we know that positive social influence by peers can contribute to risk reduction. If some skilled drug-using peer supporters offer a good example of safer behaviour (e.g. proper injecting or alternative routes of administration), then other drug users will tend to follow them. An important prerequisite is that drug users active in a peer support initiative are so-called 'peer leaders' meaning that they are both influential and trustworthy, and that they serve as a role model.

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IV.4 Self-efficacy

Self-efficacy is the assessment of a person's abilities to carry out certain behaviour. "Will I succeed in avoiding the use of injectable drugs during this prison sentence?", and if not, why not? Is my success due to myself, my experience, my intelligence, my persistence or the support of my partner? Do I have enough self-control to avoid simply taking any drug that happens to be available in prison (Including benzodiazapines and others)? Can I resist the various temptations? If a drug user is convinced that they will manage, they can be said to have a high level of self-efficacy. The opposite, however is extremely common. Many drug users regularly experience negative judgements from others in their environment. This influences not only their sense of self-efficacy but also their sense of self-esteem in a negative way. One example of limited self-efficacy is when people are acknowledging and complaining that things are not going well, but there is nothing they can do about it, because everything is the responsibility or product of other people's actions.

- **Examples**
  - Many drug users have tried several times to kick he habit. The failure to stay drug free has an influence on the decision to try it once again. Repeatedly relapsing results in low self-efficacy.

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  - If a drug user in prison has some drugs but only has a used syringe, will they take the time to look for disinfectant and clean the syringe? If they are determined to do this and in the end actually manage to do so, then they have shown high self-efficacy.

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  - Condom use depends, in part at least, on the self-efficacy of the man: can he keep his penis stiff while putting on a condom? If he doubts - due to disappointing experiences earlier on - he might not want to use a condom in order to avoid a failure.

- **Risk reduction measures**

Successfully carrying out activities enhances one's self-efficacy. Consequently. when it comes to safer injecting, techniques should be discussed and practised. From so-called self-control projects we know that every drug user does have control techniques that they apply in different situations, such as drug use, drug purchase, selection of other drug users etc. Sharing these control techniques to see if inmates can learn valuable things for their own situation from their peers can contribute to risk reduction. This can be done both intentionally and systematically in a training seminar setting but also on an individual basis. In the case of safer sex though, it is a little more complicated to practice proper techniques.

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IV.5 Intention

The intention is the actual plan or desire to carry out a particular behaviour. All conditions (positive attitude, supporting social influence and self-efficacy) are - at least for an important part - fulfilled. Now, strictly speaking, there are only two things that can prevent the person from carrying out the behaviour: barriers and lack of skills.

IV.6 Barriers

Even when people do wish to change behaviour, in prison people often lack the means to facilitate this behaviour change - which can result in them being unable to make the desired changes in their behaviour.

- **Examples**

In general, a drug user might be used to using a clean syringe for each injection. Unfortunately clean works are generally unavailable in the prison setting.

- **Risk reduction measures**

If new syringes are hard to find, or not available at all, then providing bleach or a hotplate, and giving out accurate information about cleaning and disinfecting syringes would be the next best solutions. Also, providing methadone is a measure to consider here.

IV.7 Lack of skills

If somebody wants to practice safer behaviour but does not know how, lacks experience or doesn't have any routine to practice, then safer behaviour is much more difficult. People will need to acquire the necessary skills to enable them to engage in safer behaviour.

- **Examples**

Drug users who behave in a perfectly safe manner outside prison - using a new syringe for every fix - might run into problems inside prison. They might consider chasing the dragon but lack the necessary skills to do so. They might consider cleaning works but lack both the knowledge and the necessary skills to do so.

- **Risk reduction measures**

Drug users often think of themselves as being experts in injecting, but analysing their injection procedure often reveals 'hidden risks': either hygienic precautions are not taken or sharing the drug or injection equipment is exposing the drug user to risks. One issue that requires almost permanent attention is that of the injec- ting practices of drug-using in prison, because the prerequisites for safe practice enjoyed outside are not available and drug use takes place in hidden and often unhygienic places. Support for either alternative routes of administration or on proper injecting can be organised, as well as information on disinfection methods. With the support of the prison medical or

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community health service, staff can provide safer use instructions that can be followed effectively.

V. How to make contact with drug-using inmates

(Based on Trautmann /Barendregt '*European Peer Support Manual*')

There is one basic problem in reaching drug users in prison. A prerequisite for discussing safer behaviour is that generally inmates would have to 'out' themselves as former, current, actual or potential drug users. The only exception to this is when distributing general information, e.g. on a leaflet handed out to all individuals on entering prison. Outing oneself as a drug user, however, is not easy in an institution that punishes this behaviour severely (through loss of privileges etc.). So methods of making contact have to be developed that protect drug users by making sure that no disadvantages result from participating in a training seminar or other risk reduction activity. One option might be to find - through discussion with the prison management - ways of allowing confidential counselling or less public ways of organising risk reduction seminars, e.g. by using rooms in the general education unit so that the purpose of the training is not apparent.

Aside from this basic problem, making contact can be regarded as a task on its own, even if it doesn't immediately result in other risk reduction activities. To reach the target group of drug-using inmates, one needs to have a network of contacts among the general inmate population in order to be able to reach those who are difficult-to-reach or 'unreached'. One problem here is that while the 'unreached' is a popular term, it is not very specific. Therefore, before going into detail about how to make contact it is worthwhile to define what is generally meant by the term. This can be helpful in the process of establishing the types of people who constitute the target group.

Among those considered to be 'unreached' we would include:

- Inmates who have never had any significant contact with an HIV or drug counselling service either outside or within the prison.
- Inmates who have so far avoided any contact with prison health services about their drug use.
- Inmates who do have contact with health services in prison but are not being reached by risk reduction measures.
- Inmates who are not being successfully reached by risk reduction measures and drug counselling.
    - Either due to incomplete or inadequate information
    - Or due to an inadequate approach
    - Or due to factors or problems on the client's side: motivation, attitude, social norms, lack of resources, etc.

In general, one can say that the more repressive the prison setting is, the more difficult it will be to approach drug-using inmates. Peer support, i.e. drug-using inmates contacting other drug-using inmates, can be helpful here, firstly as a first step to risk reduction by peer support, and secondly as a means of facilitating risk reduction activities by prison or community service staff. The latter might have an advantage over prison staff, by being

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independent from the prison system and thus possibly being more trusted by inmates. However, prison administration differs widely in every European country, as do the conditions under which 'outsiders' are allowed access to prisons. There are countries where good co-operations between community drug and health services exist. However, in other countries this is far from being the case.

Another factor that may impede the process of making contact might be that the drug-using population is not homogenous. There are differences regarding drugs of preference, methods of administrating drugs, ethnic backgrounds, sexual preferences, etc. These sort of differences can make developing contacts even more complex. This problem can, to some extent, be addressed by selecting peers or staff of the same gender or ethnic background as the people targeted when seeking to engage in risk reduction activities.

V.1 The first steps

Before actually making contact, one has to at least have a vague idea of who it is that one wants to reach and what one wants to achieve. Starting from our general notion of target groups and aims, we can then begin to take the first steps and start to explore the situation. Important things we need to know will be:

- What is the situation of drug users in prison?
- What are their specific needs?
- What drugs are used, how are they used and what health risks are involved?
- What is the situation concerning the spread of infectious diseases and drug-related diseases?
- What is the extent of sexual contacts and what health risks do they imply?
- How widespread is tattooing and what disinfection techniques are applied?
- What are the risk reduction resources of the institution?
- How can risk reduction activities be implemented and institutionalised?

Important sources of information for answering these questions will be found through discussions with key persons, staff members and colleagues and probably inmates or ex-inmates. Though one will generally only get rough estimates and anecdotal information about risk behaviour, combining and triangulating this information from different sources will provide some valuable indications of what is going on. Additionally it will be important to get a picture of how justice authorities, prison governor, middle management and prison medical service officials view the problem, what they want to do about it and what they expect from risk reduction activities.

This information will serve as the basis for redefining and choosing the target group (criteria, priorities, etc.). Then making contact - the first step in any risk reduction activities - can be started. Of course, the process of collecting this information will have already resulted in us making some contacts.

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The process of making contact includes:

- Visiting the prisons and getting in touch with inmates (the first step for community service workers);
- Communicating the aims of the risk reduction activities; getting a conversation started; generally this start will tend to be a casual chat, just to get on speaking terms and create a basis for further talks about risk reduction, and finally;
- Introducing oneself (again, this is especially important for community service staff), i.e.
    - Explaining what one's task or aim is
    - Telling people what organisation/group you are working for (you can leave a business card)
    - Describing what you stand for
    - Explaining what you can do for the target group, etc.
- Establishing credibility and a trusted relationship with the target group(s), for instance by:
    - Proving that you are aiming at improvements in their situation
    - Always being honest (about what you are, what you can and cannot offer)
    - Offering support for those with problems, being careful to only offer what you can actually deliver.

V.2 Getting in touch

In the attempt to really make contact, the start of the process can be a long-term, frustrating enterprise, especially if one has to begin from scratch in a prison. One has to decide:

- Where to make contact (in a cell, in the corridor, in a community room, etc.)
- When to make contact (which is the right moment, do people have time, are they in the mood for a talk, etc.)
- Which person to contact first (generally, one should consider starting with informal leaders of the inmate community)
- What is the right way to handle it (a direct or less direct approach)
- What can you offer
- When to stop (temporarily, at least), when is it time to take a break and leave

For clarity's sake, two ways of getting in contact can be distinguished:

- Doing it on your own, or
- Getting introduced by someone

Making a new contact on your own

When you intend to make a new contact on your own, you have the choice between:

- An indirect approach, e.g. by starting some casual chat (about soccer, etc.). Such a chat often will develop into a more personal talk, at which point you can introduce your self, or may be asked to introduce yourself ('what the ... do you want from me?').

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- Or a direct introduction of yourself as (community) health worker,
    - explaining what your task is
    - what you stand for
    - what you can do for the target group, etc.

The most difficult approach, without doubt, is how to start on your own. For prison staff it is possible to just walk around in the prison, starting a casual conversation as a prelude for counselling or getting people involved in a training seminar. Moreover, they generally know or are known by the inmates. Inmates will be aware of their role as social or health workers. For people working in community services though, this might be more difficult. However, there are useful tools that can make things easier. Risk reduction activities (counselling, seminars and services) can be announced through:

- Prison staff, during educational and recreational activities and in working places. One also can consider whether to organise recreational activities, such as sport, music, etc. which are focused on paying attention to health issues.
- A poster. The poster should be presented in a 'safe' place, where people can read it without being seen, e.g. in toilets.
- A leaflet. To avoid the problem that inmates receiving or having the leaflet are seen as admitting their drug use one can consider to hand out the leaflet to all inmates or to have it available at a 'safe' place.
- A newsletter or magazine. In some prisons a prison news letter or magazine is produced. An announcement on risk reduction activities can easily be included in this. One also can consider the possibility of producing a risk reduction/health promotion magazine, and including an announcement of services available in this.
- An inquiry using a questionnaire, seeking to determine what the health needs and problems of the target groups are.
- Giving out condoms/bleach/syringes.

Using these devices as supportive measures for making contact has proved to be quite useful in the past. They can facilitate the start of a personal discussion or the participation in training seminars.

Being introduced by someone

As soon as prison or community service staff have some contact with people from the target group or groups, things begin to get easier. Making new contacts can then be achieved by being introduced by those people that one already knows. It may even be possible that the initiative for making contact is taken by one of these people. If people trust the staff members they might introduce their friends to them. This latter situation is, of course, the easy way, and is what many people employed in this function often dream of.

However, even making the first contacts can be a relatively easy job. If you, as a prison or community service worker, are in a community room with some members of the target group where you already know some people and want to make contact with others:

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- You can join a group with some people you know and start a conversation. By doing so, you will generally get introduced or get the chance to introduce yourself to those people you do not yet know.
- Alternatively, you can explicitly ask one of the people you know (do this beforehand) to introduce you to people you want to make contact with. You also can ask if people know others who could benefit from information on risk reduction activities, etc.

Here again, success depends on an appropriate assessment of the situation. It can be helpful to visit informal meeting places (the corridor, TV room, sports facilities) on a regular basis, on the same day, at the same time. This makes it easier for the target group to find the staff involved in risk reduction activities, either for their own sake or for introducing or referring a friend to them. 'If you go to this place on Friday at 10 o'clock you can meet them').

As a community service worker involved in risk reduction activities in prison you can also consider getting introduced through people in positions of trust (such as the social worker, priest, medical personnel). However, you should also bear in mind the inmates' privacy. You should never ask for names of inmates to speak to. The only thing you can ask is that these trusted individuals inform inmates about your work, refer them to you. It is then up to them to turn to you.

VI. Counselling information and education

(Based on Trautmann /Barendregt 'European Peer Support Manual')

Counselling is a direct, personalised, and client-centred intervention designed to help initiate behaviour change, e.g. to keep people off drugs, avoid infections or, if already infected, to prevent transmission to other inmates or partners, and to obtain referral to additional medical care, preventive, psychosocial and other valuable services that are necessary in order to remain healthy. Counselling can consist of giving short advice and information, it can be referral, it can be the core of longer and more intensive assistance and, finally - of course - of prevention. In this manual, we concentrate on counselling as a useful method of risk reduction, although the information that follows might also be useful for other tasks.

Consequently, the following issues will be discussed here:

- How to raise the subject of safer behaviour;
- How to discuss the subject of safer behaviour.

Either instead of, or in addition to individual counselling, you also might consider running group meetings to discuss safer behaviour. However, discussing touchy issues such as using drugs and having sex (especially true in prisons) requires mutual trust. You should make sure that people feel safe enough to do so in a group.

VI.1 How to raise the subject of safer behaviour

Getting into contact with drug users is one thing, starting a conversation about things like injecting behaviour, hepatitis or HIV/AIDS, another. Those who work in a prison and are responsible for risk reduction work often realise that accidental contacts and talks can be quite fruitful, though this often means working without a clear agenda and without a well defined structure. Nevertheless it is worthwhile to set an agenda for yourself. This can result in a guideline offering some structure for the work:

Nonetheless, talking to prisoners in an unstructured setting has a lot of advantages:

- It can be very effective because one is acting in close proximity to the target group's own environment. One can react directly to real life, spontaneous situations, to questions people have, etc. (trust building);
- Operating in the daily surroundings of the target groups generally facilitates an atmosphere of trust;
- One is getting valuable information about the actual living situation, the actual needs of the target groups;

If people know what one is doing, they will sometimes start talking about AIDS or other health-related subjects by themselves. Besides this, there are various other ways to raise the issue:

- One strategy is to look for openings in the contacts - whether casual or planned - in order to raise the issue. One can give a short reminder about safer use when confronted by a drug user with an abscess. Other opportunities arise if someone has been kicked off the substitution program, if someone suffered an overdose, etc. Thus, making use of unexpected chances is very important.
- Exclusively focusing on HIV/AIDS, or only discussing safer use and safer sex will soon be boring. It is not attractive to drug users. Thus, it is advisable to incorporate the risk reduction message in a broader framework of drug users subculture, e.g. focusing on health in general or hygiene conditions in the prison.
- If you meet people you know but have not seen for a while, the questions `How are you', `How are things going', might be enough to get a conversation started in which health may be one subject.
- Here, too, some of the methods mentioned above that can be useful:
    - A leaflet
    - A newsletter/magazine
    - An inquiry on what the needs and/or problems of the target group(s) are
    - Giving out condoms, bleach or syringes.

Handing out things and asking questions, addressing and acknowledging the expertise and knowledge of inmates can help to start a talk about the issue of risk reduction. It is vital to have a broad repertoire of means to raise the issue, especially because it is evidently not enough to just raise or discuss the issue once. Short reminders, repeating the message from a different angle or by a different approach can be very effective.

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VI.2 How to discuss the subject of safer behaviour

Whereas most papers on counselling refer to a structured, therapeutic setting, counselling in prison often lacks this clear structure of well-defined roles and setting. One has to create a setting for a confidential talk (finding rooms, etc.) and is therefore highly dependent on spontaneous opportunities. However, there are some rules for discussing the subject of safer behaviour.

Attitude and behaviour

- **Do not be judgmental**, e.g. simply judging or condemning risk behaviour as stupid, incredible, will not change someone's behaviour.
- As a result of this principle, it is important, **not to ask`why'.** The question `why' often simply shows that you don't understand `why' and are therefore judging. Open questions inviting people to tell **their** story brings about more important information.
- **Do not patronise**, and so avoid giving advice regarding personal business like whether or not someone should get tested for HIV or how they should behave. (`If I were you I would ...'). Instead, try to offer relevant, complete information and discuss alternatives. Making one's own decision is more effective than adopting some one else's view. However, in impersonal or objective matters advice can be very useful (`In this case you need a lawyer. You can refer to ...;' 'For getting an HIV test you can refer for further information to …. You first have to make an appointment by phone'; 'You should boil a syringe for 15 minutes and not just flush it with boiling water'; etc.).
- **Do not take responsibility for** someone's problems, try to motivate and support people to solve their problems by themselves.
- **Listen carefully**. This means do not talk too much, do not interpret, but make sure that you understood well by recapitulating briefly what you believe someone has said and asking if this is what they meant.
- **Stick preferably to the `here and now'**, what do people feel or think now, what do things/emotions mean to people now, what do they see as perspective, etc. This generally gives more relevant information to realising safe behaviour than discussing the past.
- **Pay attention to emotions**. How and what do people feel? What do certain events mean to them, etc.? This can give insight into why people behave as they do.
- **Show that you understand and care, show interest**. Ask people how they are, how things are going, where they were (if you have not seen them for a while).If you have not seen someone for a while, ask their mates where they are, what has happened to them, or if you know, you can visit the person in their cell, in the hospital wing, etc.
- **Treat people with respect**. For example, thank people for their information and assistance, apologise when you are bothering someone, invite them for a cup of coffee, etc.
- **Do not play therapist or `shrink'**. Although carefully listening and paying attention are important one has to avoid playing the role of an uninvolved therapist. Questions like 'Tell me, how does it feel?', 'What does this mean to you?' can raise feelings of aversion, especially when given as a reply to questions

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for advice or help. Drug users might know this way of counselling by their attempts to kick the habit. These experiences with therapeutic treatment are frequently quite negative.

Most of these rules are closely linked to one's personality, and to one's attitude towards the target group. It is evident that one genuinely has to care, understand, etc. Simply pretending is not enough, nor is just adopting these rules. It is obviously nonsense to use the jargon or codes of the target group if you don't feel familiar or comfortable doing so. One has to integrate these rules and codes into your own, personal style of behaviour.

To get a picture of how one is developing a personal style of working, regular feedback is necessary. This can be done by supervision through a colleague or - preferably - an external expert. As supervision is not based on direct observation of how someone is working, immediate feedback is not possible.

Practical rules

- **Try to find** a quiet place to talk where you have an undisturbed conversation, e.g. a quiet room, where you can sit down.
- **Make sure** that somebody has the time and feels like talking. Generally you can see at first sight if somebody is in a hurry, feels restless, etc. If you are aiming at a longer conversation you can ask explicitly if someone has time. You also can invite someone to have a cup of coffee.
- **Use appropriate language**, i.e. language that is readily understood and accepted. It is important to know or learn the jargon, the subcultural codes of the target groups.
- **Provide consistent**, complete and neutral information, offering the chance for a well-considered decision. Informing people is not just telling but also listening. Particularly when asking personal questions, state clearly that people don't have to answer, that you don't want to be offensive. Explain the reason why you are asking this question, e.g. to get a picture what information some one needs.
- **Provide relevant information**, i.e. information people need. This can be done by a formal risk assessment
    - Using a form to collect relevant information on level of knowledge (what do people know about routes of transmission of HIV/AIDS, hepatitis etc.), attitude (e.g. how do people view condom use) and risk behaviour of the target group members (do they share their injecting equipment, etc.).
    - Explaining the basics about the relevant infectious diseases (transmission of the virus, different forms (and levels) of risk behaviour, etc.)
    - Asking and answering questions
    - Discussing the possibilities for reducing risks, etc.

A formal risk assessment enables both prevention worker and drug user to set risk reduction goals and structure outreach prevention. However, it generally will be not possible to reach all outreach contacts with this formal instrument. For people who cannot be reached by this instrument you have to have a less formal, appropriate variant. This means one has to be able to improvise.

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- Besides explicitly talking about HIV/AIDS and hepatitis related issues, a drug worker can also touch on or present safer behaviour information to be 'read between the lines'. One can talk about other health subjects as how to stay healthy in prison, about drug user's life-style (not just the misery, but also having fun, how to enjoy life). This approach can be effective in preventing people from getting tired of being confronted with yet another talk about HIV/AIDS, hepatitis and drug-related health risks.

- Do not stick exclusively to AIDS prevention. Harm reduction work in prisons takes place in the environment of people. Therefore it will be impossible and inadequate to confine yourself to AIDS prevention. If you have people's confidence they will regularly contact you for matters other than AIDS prevention. Their first priority will probably not be getting information about safer use and safe sex. They might be more in need of other services. If you do insist on AIDS-prevention topics, you might lose your credibility. Therefore it is important to have knowledge of and contacts with other potentially relevant services.

- Support (positive) changes in behaviour and attitude to reinforce these changes, even if they seem to be quite small. This support for changes towards safer behaviour is important to foster self-esteem and self-efficacy and thus is the basis for ongoing change.

- Do not judge or reject a person for failure to change their behaviour

- Encourage and support snowballing
    - By simply asking drug users to pass on the information to their peers,
    - By discussing how this can be done,
    - By involving drug users in the making and handing out of information material, etc.
- Stop a talk in good time. Do not force people to go on, either implicitly -- by ignoring the unspoken signals that someone wants to stop, and thus maybe forcing some one to continue, or explicitly ('Wait a minute, I want to ask you one other question.'). Indicators that suggest stopping (or not beginning) a conversation can be:
    - If the conversation is getting less intense, e.g. if people stop asking questions, stop talking by themselves and only react briefly to your questions
    - If people are getting restless
    - If people's attention gets diverted often, e.g. if they start talking with somebody else or change the subject
    - If people start looking around.

If you want to talk with people again, you can try to make an appointment or just tell them that you will come around again to continue where you left off.

Further information and examples from practice on counselling and education on drug related issues can be found in the manual from the UNODC Treatnet network "Drug Dependence Treatment. Interventions for Drug Users in Prison" chapter 3: Interventions, available at http://www.unodc.org/docs/treatment/111_PRISON.pdf

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VII. Training seminars

Training seminars for both prison staff and inmates are an important means of transferring relevant information about risk reduction. However, training seminars as part of a risk reduction strategy in prisons are - in most countries - a relatively new phenomenon. This is especially true for seminars in which both prison staff and inmates participate. Training seminars on risk reduction - particularly the ones aimed at inmates - are often perceived as threatening to the traditional abstinence-oriented drug policy in prisons.

Therefore risk reduction seminars must be prepared very carefully with clear arrangements between prison administration and other parties involved. Obtaining permission from criminal justice authorities and the prison governor is the primary prerequisite. The same goes for taking into account the specific conditions of the prison involved. Due to differences in policy, in inmate population, in health problems, in communication and co-operation with community drug and health services and in available human and financial resources, careful preparation is needed to successfully target the specific needs of both prison staff and inmates. If risk reduction activities are planned by prison staff, all relevant units should be informed or integrated. The medical health care unit should be asked for professional support, along with community health services and organisations (e.g. AIDS self-help groups).

The venue of training seminars for staff members seems to be of great importance for the atmosphere and the readiness to talk. It is vital to find a place where people feel at ease. It can make a big difference whether a seminar for prison staff is carried out within the prison walls or outside the prison in training centres. Both options are possible. Carrying out seminars for the staff within the prison has the advantage that the number of participants will be higher, because the threshold for participation is low. Choosing a venue outside prison, on the other hand, has the advantage that it might be easier for the participants to address controversial topics more frankly.

Bearing in mind what has been said above about general organisational matters, the following steps have to be taken:

- Needs assessment
- Setting priorities and aims
- Defining the target group or groups
- Planning and designing a seminar program
- Evaluation

In the following section, we will discuss the basics of how to prepare and conduct training seminars.

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VII.1 Needs assessment

Training needs can be identified through directly asking prison staff and inmates what they need to know and what issues might be of special interest. This can be achieved through a group discussion, formally, through a group interview or focus group, or informally via an additional question.

The focus of this needs assessment should include knowledge about safer behaviour, skills, attitudinal aspects, social norms and self-efficacy. So, when interviewing drug-using inmates, you could include questions like:

- "What does 'safer use' mean to you?"
- "How do you manage to maintain your hygienic requirements?"
- "What is most important to you in your current situation?"
- "What have you found most interesting about this topic?"

When having these discussions or interviews with staff and inmates, one should pay attention to information you get from 'reading between the lines'. Answers to questions about factual knowledge might also tell you something about people's attitude and their social and cultural norms.

Furthermore, information about factual risk behaviour can tell something about actual needs. Valuable information can be obtained here from the prison medical service and from community health services. For example, abscesses are an indication that people do not inject safely.

VII.2 Setting priorities and aims

Based on the needs assessment, the priorities and aims of the training activities can be defined. Important issues here include:

- Which steps have to be taken to realize the training seminars? In which order should these steps been taken?
- Which target group is the main priority? In general, staff training will be required prior to the training of inmates. One has to make sure that the prison staff is aware of the health risks and acknowledges the need for risk reduction activities.
- What content do you prioritize? Should the focus be on awareness, knowledge, skills, attitude, social norms or some specific combination of these things?
- Are the aims 'smart'?

VII.3 Defining the target groups

Although there are issues that are of interest to both inmates and prison staff (e.g. the effects and risks of drugs) and the transmission of viruses, bacteria and parasites there are issues that are only of interest to either the inmates ('What damage is caused by which drug?' or 'How can I avoid damage while continuing drug consumption?') or to staff ('How can I avoid a needle stick injury when searching cells?').

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Possible target groups are

- Prison staff, i.e. guards, health workers and/or management.
- Inmates. One can work with individual drug users, for example, to train them as peer tutors (group meetings could be seen as threatening for the system) or with a group. Depending on the issues to be dealt with in a seminar one can consider whether to differentiate the target group by gender, age or ethnic background. When dealing with sexual behaviour and safer sex, for example, women might feel safer discussing these issues when there are no men present. If training seminars for inmates are not possible, one can consider organising seminars on life and health risks in prison for drug users in the community, since many of them either have been in prison in the past or will end up there at some point in the future. Training drug users in the community can be a means of facilitating peer support in prison, as the trained drug users can then pass on the information gathered through training in the community to other inmates when in prison.
- Community health service staff. These can be an important target group as some of them work with drug users in prison. Moreover, since many drug users in the community have experienced or will experience imprisonment, the work of community drug and health service workers outside prison can be of importance. Finally, community drug and health services can play a supportive role to prison staff in developing risk reduction activities in prisons.
- A mix of these target groups. Combining target groups can be quite powerful with regard to an exchange of information, change in attitude etc. It can facilitate mutual under standing. Possible target groups are prison staff, drug users and drug service or health service workers.

VII.4 Planning and designing a seminar program

As stated earlier, training seminars should not only focus on transfer of knowledge about risk reduction but also on transferring skills, influencing attitude and social norms, and enhancing self-efficacy. To ensure that more than only factual knowledge is transmitted the interactive character of the training session is important. Participants should not be taught but stimulated or even provoked to take part in the discussions. Therefore, it is important to limit lectures to what is strictly necessary to transfer relevant information and include as many interactive work forms as possible. One should also keep in mind that a transfer of knowledge also can be achieved through structured discussions on relevant issues, such as how to inject safely. The role of the trainer is then to guide the discussion and to make sure that no inaccurate information is provided and nothing is missed. The exercises included below are meant to facilitate this active learning.

It is clear that inmates in different prisons in diverse countries will attend risk reduction seminars with different motivations and different interests. The motivation and interest of the participants should be reflected in the design and contents of seminars. It is also worthwhile checking if risk reduction is an appropriate issue to get people involved. In some cases embedding risk reduction in the broader framework of health promotion has proven beneficial, as it is less linked to taboos than a narrower focus on sexual behaviour and drug use.

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When preparing a seminar program, pay attention to the following things:

- Define the size and composition of the group, keeping in mind the subject of the seminar, specific target groups, etc.
- Select the trainers. Trainers have to be experts, but they also have to have a positive attitude towards the target groups, and they have to be flexible, i.e. being able to change the program if needed, etc.
- Define the course regulations, e.g. one person speaking at a time, giving respect to different opinions, letting people finish what they have to say, no aggression or violence, etc.
- Choose teaching methods
- Choose assessment and evaluation methods
- Design a detailed seminar program and timetable
- Prepare visual aids (sheets, slides, flipchart, etc.)
- Prepare handouts and photocopies for exercises
- Choose and book the venue
- Plan and organise logistics (devices like overhead projectors, technical assistance, lunches and refreshments, etc.)

General considerations when organising a risk reduction seminar

- Invite potential participants well in advance. People, especially drug users, might have to get used to the idea of being invited to a training seminar. The background of the seminar should be talked over and explained. An official letter might underline that the presence of those invited is appreciated.
- In the meantime, it can be a good thing to keep people informed about the development of the training seminar and the planned risk reduction activities.
- Do not stop motivating people to attend the training course until they actually have arrived.
- One could consider inviting more people than one actually wants to train. Due to the taboo on sex and drugs in prison, some people might not show up despite their promises to participate.
- The number of people to be trained at any one time should not exceed 20 people.
- It might be better to organise a training course consisting of three afternoons rather than one that runs for an entire day.
- It is important to use methods of delivery that take the skills and experience of the participants as a starting point.
- Consider giving a small present to the participants after finishing the seminar as an appraisal for their presence.
- Consider giving people a diploma after the seminar.
- Always end a training course with an oral or written evaluation. What have you learned, what was lacking, suggestions for improvement, etc.
- Choose a room for the course close to where people feel comfortable. The room will thus have a greater psychological accessibility.
- Organising a training course for drug users can be valuable, but it can become even more valuable if some kind of follow-up activity is organised.

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The opening session

A well-prepared beginning to a training seminar is crucial for its success. The opening session of the seminar should include the following:

- A general welcome to everybody, e.g. thanking people for showing interest.
- An introduction of the trainers (name, organisation, profession, experience, etc.).
- An explanation of the reasons for and aims of the seminar.
- A presentation of the program.
- A round in which the participants introduce themselves (name, what is their main interest, what do they want to learn, etc.)
- Working with 'icebreakers' at the beginning (refer to a recent newspaper headline on a relevant issue, connect the training topic to well-known persons, make a joke, etc.)

Methods to be used

Depending on the groups' experience in the prison, interests and needs, some of the following approaches may be useful elements in a training seminar (elements of this course have been adapted from Brian Murtagh: Peer education (book 2). Health Promotion Unit of the National Youth Federation Ireland):

Group work

Start in small groups where all inmates feel more confident to speak and then to move to larger or plenary discussions. The size of the group may influence the level of discussion and self-disclosure which takes place during exercises. Consider how a group could be divided up, e.g. participants could be invited to decide to choose who they want to work with or may be directed to work with a person they have not worked with before. Feel free to use and adapt the suggested outlines of exercises posted in this course (in annexe, format .PDF), according to your knowledge of your particular group, the prison circumstances and resources.

Brainstorming

This is a way of recording immediate thoughts on a subject. Everybody's contribution is written down as it is given. Only when everybody has finished contributing does discussion and analysis of the contributions begin.

Drawing

Drawing and collage are a useful way to approach issues which are intimate or personal and are useful in stimulating discussion.

Quiz or questionnaires

These are useful for establishing the information levels of a group but care must be taken not to create a sense of competition.

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Attitude continuum

This involves placing cards with the word agree-disagree, acceptable unacceptable, at opposite ends of a room and inviting participants to express their views or values. It is a very useful way for enabling structured discussion of participants' different opinions.

Video

Videos can be a useful catalyst for discussion or for giving information. TV programs popular amongst inmates can provide relevant material for discussing relationships, sex, personal development etc.

Newspapers and magazines

Literature, articles, drug users' magazines, photographs, prison magazines/newsletter, and case studies can be used as the basis for an exercise, too.

Drama, role play

Drama and role play can be used most effectively. Providing a case study and role playing it can help participants see a variety of angles on an issue. 'Freeze framing', where the action is 'frozen' and the participants are asked to suggest what has happened or what is about to happen is also a good technique. It is important to use a variety of presentations and interactive methods to help concentration and make learning as interesting as possible. Finally one should not forget to include regular breaks in the program.

Taking into account specific target groups/specific issues

From experience we know that generally there are good arguments for having safer-sex seminars for male inmates be conducted by male trainers and a female trainer for female inmates. This is due to the gender specific experiences, habits and risk exposure of both groups (e.g. prostitution, abuse etc.) and gender specific attitudes. Women frequently do not feel safe to discuss issues of sexual behaviour in the presence of men. Men might feel the obligation to play the 'macho', boosting their sexual achievements.

The ethnic, cultural and religious differences of inmates should also be considered, perhaps through running different training seminars with different approaches. In a predominantly Islamic culture it is not acceptable to talk as bluntly about sex as in Western countries. This point is important, as in most European prisons the percentage of foreigners is relatively high. This raises specific problems of culture and religion. Communication might also be hampered through language barriers. Having staff available who speak the language, or even better who come from the same country, culture or religious background can be very helpful.

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VII.5 Training seminars for inmates

Many inmates have not been reached successfully by health services before entering prison. So the time of imprisonment can be used effectively to inform them about risk reduction and other health issues. Here, one can contribute to making sure that the period of imprisonment is not simply 'lost time'.

Two types of training seminars for inmates can be distinguished:

- Training small groups of drug-using inmates in prison about risk reduction, possibly resulting in a snowball effect and
- Training drug-using inmates about risk reduction and as 'peer supporters' involved in further risk reduction activities.

Both kind of training seminars have their own perspective. The first type is meant for drug users who do not have any advance intention of becoming active in peer support activities. Nevertheless, our training seminar experiences showed an impact on both the participant and his/her peers. It is not hard to imagine that the training seminar will be discussed with friends and peers. This is where the 'snowball' starts to roll. This type of training seminar can be organised and conducted by both prison staff and community health or drug workers.

The second type of training seminar only makes sense in a broader peer support framework. It can be conducted as starting point for peer support activities in prison. In such a case it can be valuable for professionals to participate and bring along their knowledge and competence (e.g. nurses from the medical department). For example, when drug users are interested in contributing to a risk reduction strategy through a peer support initiative this kind of seminar can be fruitful. It is obvious that in these seminars attention is paid to organisational aspects and to the message, but also to how to get the message across.

When organising risk reduction seminars for inmates important things to keep in mind include:

- The need to clarify in advance that inmates who want to participate in the seminars will get the opportunity to do so (getting time off from work, schooling etc.). This should be discussed with the prison governor.
- Inmates should only participate on a voluntary basis to make sure that they are motivated to do so and to facilitate peer support, i.e. passing on the information to their peers.
- Drug using inmates, especially peer leaders prove to have a lot of valuable information and can contribute in many ways to training seminars.

Working with groups or individual inmates?

Training drug users should preferably be done as a group event. This is, of course, more efficient (less work, less money involved) than training on an individual basis. Moreover, it stimulates group discussion, facilitating group influences on attitude and social norms, making use of resources available among inmates.

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However, some prisons do not permit group work because it is regarded as a security risk. In that case it might be an option to train individual drug-using inmates to work as peer tutors. Working with individuals allows a very intensive and thus effective transfer of information.

VII.6 Training seminars for prison/drug service staff

"What creates health? It is the interaction of environment and people in the course of everyday life that creates a pattern of health in the individual, he family, the community and the globe." (Ilona Kickbusch, 1997)

Especially important issues for training seminars for prison staff include:

- Seminars that help prison staff to identify themselves with and support the objective of preventing infections
- Seminars in which prison staff acquire basic knowledge about drugs, drug use, infectious diseases and other drug use related health risks
- Seminars in which individual and collective needs for safety are discussed and agreed upon

Again the focus of these seminars cannot only be on knowledge but should also focus on:

- Skills, e.g. in the field of counselling;
- Raising awareness about the staff's attitude towards drug use, sexual behaviour, etc.

The training seminars should focus on adequate behaviour patterns as part of measures initiated to prevent the spread of infections in prison. A single training on behaviour change, however, will not be efficient without accompanying structural changes in the prison setting. According to interviews with prison staff, the three aforementioned goals need to be met.

Acquiring basic medical knowledge

The use of illegal drugs and the use of medical services and medication are often related to each other. However, frequently, drug-using inmates are reluctant to seek help concerning their use of illegal drugs directly from medical services. The situation is getting more complicated by the taboo under which drug use (in prison) operates.

Therefore it is crucial that prison staff learn basics of medical knowledge in order to:

- Avoid infections, especially viral infections often associated with drug use,
- Allow prevention and early treatment of health damage related to drug use.

Accepting and meeting individual and collective needs for safety
This is an important issue when training prison staff, as it has been shown that fear, insecurity and the wish to separate oneself from others have a negative effect on the atmosphere and on interactions and relations between staff and inmates. Although separation from others can be considered a method of protecting oneself against supposed or real threats, it should be overcome in order to establish a closer relationship between prison staff and inmates. This is a prerequisite for successful risk reduction activities, such as discussing safer behaviour.

A closer relationship can only be established if the prison staff´s need for safety is accepted and met. Seminars should focus on supporting prison staff, helping them to feel more secure in handling drug-related problems.

Besides extending their knowledge on drug and drug use related issues, seminars should also answer questions related to the risk to prison staff of getting infected, and inform participants on things like Post-Exposure Prophylaxis (PEP) after a needle stick injury, first aid in drug-related emergencies, adequate treatment of wounds and the availability of vaccinations. Often guidelines and protocols for avoiding risk exposure and adequate safety behaviour (such as wearing gloves when searching cells etc.) do already exist. These can be used, as basic material and problems in applying these recommendations then can be discussed.

VII.7 Training seminars for mixed groups

Combining the target groups of prison staff and inmates can be quite powerful with regard to the exchange of information, changes of attitude, etc. Exercises from the European Peer Support Manual have proved to be useful in this respect (Trautmann/Barendregt 1994). Here, again, a needs assessment might be a good thing to start with.

From our experiences working with peer support in prisons (Stöver/Trautmann 1998) we know that peer support can be an issue to deal with in seminars for mixed groups. Peer support and peer education can be useful approaches to contribute to risk reduction in prisons. To work out a plan for peer support one could organise a mixed seminar to present and discuss options of peer support as part of a risk reduction strategy. How and what can drug users contribute, how can they be supported by prison staff, etc. could be issues of discussion. Using exercises on safer use (such as how to inject safely, etc.) can show prison staff that drug users do have valuable information and know-how.

However, peer support in general should be first introduced to prison staff as part of an introduction of risk reduction strategies in prisons, for example, by seminars on drug use in general. It does not make sense to focus in a seminar or training seminar on peer support without having discussed first the basics of risk reduction. Our experience has also taught us that peer support initiatives are most successful when supported by professional or voluntary organisations (Trautmann/Barendregt 1994). In the closed setting of a prison, a risk reduction strategy would be impossible without the support of prison staff.

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