

INTRODUCTION

This guide has been drafted by the authors and the members of the Editorial Group between June 2007 and February 2008. Parts of the text (by Andrej Kastelic) have been modified from a chapter of the WHO Regional Office for Europe publication “Health in Prisons. A WHO guide to the essentials in prison health” (Møller et al. 2007). Essential parts have been taken from Annette Verster: Training Manual: Key aspects of substitution treatment for opiate dependence (Euromethwork 2003). An early version of this guide has been elaborated by the University of Bremen (BISDRO) for the European Commission, DG SANCO, Project No. 2003308, European Network on Drugs and Infections Prevention in Prison (ENDIPP; coordinated by WIAD, Bonn in Germany).

In many parts of the world, Europe, Asia, and North America opioid dependent people are over-represented in prisons. In these regions they represent about one third of the prison population and up to 80% in some countries such as in Central Asia. In sub-Saharan Africa, the problem is emerging, while in Latin America the main dependency is to cocaine.

Prisons are not the right place for treating drug dependent men and women, and countries should develop policies for alternatives to imprisonment. As long as these alternatives have not been developed and implemented, prison authorities are faced with this specific population, in need of treatment, care and support. Research has shown that substitution therapy is the most effective way to treat opioid dependence, to reduce the risk of HIV and hepatitis C transmission, and to reduce the risk of overdose.

Like all persons, prisoners are entitled to enjoy the highest attainable standard of health. This right is guaranteed under international law in Article 25 of the United Nations Universal Declaration of Human Rights and Article 12 of the International Covenant on Economic, Social, and Cultural Rights. The international community has generally accepted that prisoners retain all rights that are not taken away as a fact of incarceration, including the right to the highest attainable standard of physical and mental health. Loss of liberty alone is the punishment, not the deprivation of fundamental human rights. States therefore have an obligation to implement legislation, policies, and programmes consistent with international human rights norms and to ensure that prisoners are provided a standard of health care equivalent to that available in the outside community. (United Nations Office on Drugs and Crime, UNAIDS and WHO: HIV/AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response (2006)

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The need for access to treatment for opioid dependence in prison was internationally recognised more than ten years ago. In 1993 WHO issued guidelines on HIV infection and AIDS in prisons, stating that “Drug-dependent prisoners should be encouraged to enrol in drug treatment programmes while in prison, with adequate protection of their confidentiality. Such programmes should include information on the treatment of drug dependency and on the risks associated with different methods of drug use. Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opiate dependent individuals in the community, this treatment should also be available in prisons”.

The guide is based on the expertise of scientists and medical doctors/psychiatrists/healthcare professionals working in the field of substitution treatment in prisons. Relevant international literature and databases have been reviewed in order to develop the best evidence based guidance. The publication follows the guidance and recommendations of several international publications such as the WHO Regional Office for Europe: Health in Prisons. A WHO guide to the essentials in prison health, the UNODC/UNAIDS/WHO framework for HIV prevention, care, treatment and support in prison settings, as well as the WHO/UNAIDS/UNODC Evidence for actions technical paper: Interventions to address HIV in prisons – Drug dependence treatment.

Who this guide is for

This guide on opiate substitution therapy in prisons is to support prison doctors, contracted doctors, prison health care workers, prison administration, NGOs and others in delivering or supporting substitution treatment to opioid dependent prisoners.

Drug dependence has to be treated as a severe disease and everyone has a part to play to ensure the best treatment for prisoners and also to ensure that drug related harm is kept as low as possible. Applying the recommendations in this guide will contribute to a healthier prison for prisoners with drug dependence with satisfying roles for staff members and a marked reduction in the harm that drug use in prisons can create.



The essentials and important first steps

Although individuals committed to particular parts of the prison service can do much, we strongly believe that a healthier prison for drug dependent prisoners can only be achieved if all staff are involved, including senior staff members who determine the ethos of the prison as a whole.

Changes should be introduced with continuity in mind. Although single-issue and often externally funded initiatives and pilot projects can achieve much, projects will be more effective in the longer term if the prison health system is based on the principles of a sustainable approach, if sound policies are in place based on explicit principles that lead to effective practice by well-supported and trained staff.

Sustainability can best be achieved if strong links are created between prison health care services and the health services of the local community and if they work in close cooperation. Such collaboration will help to prevent prisons from being used as default health care services. Many essential components are required to achieve a healthier prison for drug dependence, including political leadership, management leadership and leadership by each staff member. Health care staff members have a special role to play, but prisoners also have a role, and community support is very important.

Experience in several countries of Europe has drawn attention to the problems that often arise if prison health services are provided separately from the country's public health services. These include difficulty in recruiting professional staff and inadequate continuing education and training. It is now strongly recommended that prison health services work closely with national health services and health ministries, so that the prisons can provide the same standard of care as local hospitals and communities. Indeed, as the WHO Moscow Declaration on Prison Health as a Part of Public Health acknowledged, the government ministry responsible for prison health should, where possible, be the ministry responsible for public health services.

Leadership by each member of the staff

A healthier prison for drug dependence cannot be created without the contribution of each member of its staff. Given the current health problems in prisons, staff members need to know and understand what the health problems are for drug users, how infections can spread, how they can be better controlled to decrease harm and how health and well-being can be promoted. Physicians, nurses and other professionals working in prisons have a unique leadership role in producing a healthier environment for drug dependent prisoners. They should start from a sound basis of professional training in which issues such as confidentiality, patient rights and human rights have been fully covered and discussed. They should also have some knowledge of epidemiology, of how diseases spread and of how lifestyles and socioeconomic background



factors can influence ill health. They should also be aware of human nutrition and of the importance of exercise and fresh air in promoting health. They should be alert to potential threats to health and able to detect early signs of mental health problems as co-morbidity is an often related condition for drug dependence.

Partnerships for health

One of the central pillars of health promotion is the concept of empowerment: the individual has to be able to make healthier choices and has to be allowed to do so. In health promotion in prisons, this approach is difficult to implement in prisons. It is therefore important that as much empowerment as possible be built into the prison regime.

One area that has been found to be important is providing health information to prisoners. Fact sheets should be made available for prisoners with drug dependence, explaining what the prison health service can provide and providing advice as to how the prisoner can best cope with such an illness while in prison. If written fact sheets will not be effective, because of language barriers or poor literacy, alternative ways of sharing information should be used, such as the use of videos and other visual aids or health discussion groups with a trained health worker. It is most important to encourage peer-based HIV prevention, education, counselling, and care initiatives. Increasing the role of prisoners in developing and providing health programmes and services increases the capacity of prisons to respond to HIV. The support to the development of peer-based education initiatives and educational materials designed and delivered by prisoners themselves is particularly crucial for populations with low literacy levels, where face-to-face educational interventions are critical. The development and support of self-help and peer-support groups that raise the issues of HIV, hepatitis C from the perspective of prisoners and drug users themselves should be encouraged.

Apart from availability of maintenance substitution therapy a number of harm reduction measures should be available such as clean syringes and needles and equipment for disinfection especially to avoid spread of blood borne disease from piercing and tattooing. A system for tattooing by professional tattooist should be considered.

Regular contact with local community services and the involvement of voluntary agencies can assist greatly in promoting health and well-being in prisons as well in ensuring the continuity of care, both when entering prison and upon release from prison. Where possible, prisoners should be connected to key community services before leaving prison, such as probation or parole, social services and the provision by a doctor of ongoing opiate substitute prescribing. For previous drug dependent prisoners this can avoid overdose related deaths after release.



Key points

- It is estimated that approximately one third of the prisoners are opiate dependent, and many more are experienced in drug use. In several prisons, this amounts to three quarters of the prison population.
- Prisons are extremely high-risk environments for blood borne virus transmission because of overcrowding, poor nutrition, limited access, continued illicit drug use (“hygienic relapse”), unprotected sex.
- All forms of drug dependence treatment have the potential to influence the risk of HIV and hepatitis C transmission, but substitution treatment programmes have the greatest potential to reduce injecting drug use and the resulting risk of spread of infection.
- *The position paper WHO, UNODC and UNAIDS* recently published on substitution maintenance therapy concludes that providing substitution maintenance therapy of opioid dependence is an effective strategy for preventing HIV/AIDS that should be considered for implementation as soon as possible in communities at risk of HIV infection.
- Opioid substitution maintenance treatment has expanded substantially in the European Union in the past 5–10 years.
- The prescription for substitution therapy and administration of opioid agonists to persons with opioid dependence – in the framework of recognised medical practice approved by competent authorities – is in line with the 1961 and 1971 Conventions on narcotic drugs and psychotropic substances. Given the existing evidence of the growing problems of injecting drug use, HIV/AIDS and hepatitis C in prisons in Eastern Europe and in the countries of the former Soviet Union, it is clear that the time to act is now. A failure to implement effective drug treatment and HIV and hepatitis C prevention measures could result in further spread of HIV and hepatitis C infection among IDUs, the larger prison population, and could potentially lead to generalized epidemics in the local non-IDU population.
- IDUs who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment.
- The death rate of people with opioid dependence in methadone maintenance treatment is one-third to one quarter the rate for those not in treatment.
- Similar to in the community, making substitution treatment available to prisoners has the potential of reducing injecting and syringe-sharing in prisons. In addition, prisoners participating in methadone maintenance treatment have lower readmission rates than those not participating.



- Recidivism among substance misusing prisoners: Between 70 and 98 % of those who have been imprisoned for drug-related crimes and not treated during the course of their incarceration relapsed within the year following release.
- The most common form of substitution treatment is methadone maintenance treatment. Methadone has been used to treat heroin and other opiate dependence for decades. The more recently developed buprenorphine is also quite common in some countries. Both have been proven to greatly reduce the risk of HIV infection by reducing opioid use, drug injection, needle-sharing and improving the health and quality of life of opiate-dependent people.
- Providing methadone maintenance treatment is therefore an effective strategy for preventing HIV and hepatitis C transmission that should be implemented as soon as possible in communities (including prisons) at high risk of HIV infection.
- Research has shown that methadone maintenance treatment is more effective than detoxification programmes in promoting retention in drug treatment and abstinence from illicit drug use.
- The health services for individuals in prisons or correction houses should be equivalent to those provided outside the correctional system.
- Continuity of care is required to maintain the benefits of methadone maintenance treatment.
- Before methadone maintenance treatment is started, participants must be provided with relevant information, especially on the risk of overdose and the potential risks of multiple drug use and interaction with other medications.
- Before starting treatment, the drug user should be informed about the primary physician's obligations to the state, to the prison and to the prisoner.



References

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