2.4 Effective drug interventions in prisons

Policy makers and prison authorities need to have a clear plan for making prisons as effective as possible in protecting the health and human rights of prisoners, including through the delivery of evidence-based treatment for drug dependence and harm reduction services to those who need them.

Why are effective interventions in prisons important?

Other sections of the Guide have argued that legal reforms should be pursued to minimise the numbers of non-violent drug offenders sent to prisons or other forms of custodial setting. In many countries, however, drug offenders, and particularly people who use drugs, make up a significant proportion of the prison population. In addition, attempts to prevent controlled drugs from entering prisons have persistently failed, and they continue to circulate amongst prisoners, with all the attendant health risks this entails in overcrowded and under-serviced closed settings. This means that effective drug policies are needed within the prison environment.

There are a number of further reasons why an effective prisons policy is essential for drug policy makers.

- **Public health** – prisons constitute an extremely expensive system for incubating health problems, because, by their nature, such institutions are difficult places in which to stay healthy. This is particularly so in the case of the use of controlled drugs, where practices such as the sharing of injecting equipment can pass on blood-borne viruses. Although life inside prisons is concealed from public view, prisons are not in fact sealed off from society, and they form an important part of the interconnected sphere of public health. Consequently, they remain the responsibility of governments. Health problems, infections and illness are not sealed away from the rest of the community, but pass across the prison walls as people enter and exit the institutional setting.

- **Economics** – responding to drug-related crime, overdoses and blood-borne infections both within prison and beyond the prison walls (amongst ex-prisoners, their families, etc) can be very expensive, in particular for illnesses such as HIV that are chronic and long-lasting conditions. This means that there is a powerful economic case to be made for measures that can effectively prevent these health problems in prisons.
• **Human rights obligations** – the right to the highest attainable state of physical and mental health is written into the goals of the UN and a number of international treaties (especially the International Covenant on Economic, Social and Cultural Rights). It is also a part of the Universal Declaration on Human Rights. These texts do not specifically mention prisoners, though many countries are signatories of other treaties that do explicitly extend this right to prisoners. The international treaties applying health-related human rights to prisoners are discussed below.

Prison authorities must comply with their international human rights obligations, and pursue strategies that minimise the health and social problems associated with prison-based drug markets and use. The pursuit of health-based policies in prisons, will lead to improvements not only in the health of the drug-using population, but also in the health of the wider population. In addition, it will impact positively on public finances as well as health outcomes.

**Health risks in prisons**

**People who use drugs who are detained in prisons and other custodial settings**

The best estimate of the current world prison population is 10.1 million, a figure rising to 10.75 million if the 650,000 individuals detained in China’s ‘detention centres’ are included. Because of the difficulties in obtaining data, and problems of comparability where data are available, it is not possible to provide an accurate global figure for the proportion of these detainees who use drugs. However, some indication of the size of the population can be given: in the European Union (EU), around 50% of prisoners have a history of drug use; in the USA, the figure is over 80%. People who inject drugs are vastly over-represented, often accounting for 50% of prison inmates, but only 1–3% of the broader community.

The number of people in prison, and of people who use drugs among them, has been growing fast in the past decades. In many countries, this has resulted from the widespread arrest and incarceration of people for minor drug offences – possession, consumption or small-scale dealing – while in others, the driving factors are drug-related offences such as theft, robbery and fraud committed to raise money to fund drug purchases. Drugs have become established at the heart of prison life, and are often now ‘the central medium and currency in prison subcultures’.

The presence of such a large proportion of people who use drugs, and risks related to drug use, in an environment where the maintenance of health is already difficult represents a serious challenge for policy makers, but one that they can meet by applying the growing evidence base referenced in this section.

**The prevalence of diseases among prisoners**

As a result of their lifestyles prior to imprisonment, the specific risk activities arising while detained, and poor healthcare services available in prison, drug-using prisoners are affected by high levels of general health problems, in particular infections such as HIV, hepatitis B and C, and tuberculosis. HIV and hepatitis C virus, in particular, can spread at an extraordinary rate in the prison setting, unless appropriate harm reduction measures are taken.
HIV is a serious health threat for the 10 million plus people in prison worldwide. In most countries, levels of HIV infection among prison populations are much higher than those outside of prisons. However, the prevalence of HIV infection in different prisons within and across countries varies considerably. In some cases, the prevalence of HIV infection in prisons is up to 100 times higher than in the community. In terms of HIV transmission through injecting drug use – the main concern in many countries – evidence shows that rates of injection are lower among prisoners than in the drug-using community outside of prisons. However, the rates of sharing needles, and the associated risks, have reached worrying levels: most countries report sharing rates in prisons of between 60% and 90%.

The levels of hepatitis C virus are also high among prison inmates. WHO estimates that about 3% of the world’s population has been infected with hepatitis C, whereas the prevalence of infection in prisons has been reported to range from 4.8% in an Indian jail to 92% in northern Spain.

Similarly, the prevalence of tuberculosis is often much higher in prisons than it is in the general population. A Thai study revealed that the prevalence of tuberculosis among prison inmates was eight times higher than in the general population. Another study demonstrated that the prevalence of tuberculosis in a prison in Victoria (Australia) had reached 10%, whereas a study in a prison in Bahia (Brazil) reported a prevalence of latent tuberculosis of 61.5%, with a prevalence of active tuberculosis of 2.5%.

Risk behaviours

Except perhaps in countries with high levels of heterosexually transmitted HIV, the major risk of HIV infections spreading in the prison environment stems from the sharing of injecting equipment. In prisons, large numbers of people are likely to share needles and syringes due to the lack of availability of sterile equipment via harm reduction services such as NSPs, and due to fear of detection of drug use. Some users resort to needle sharing for the first time while in prison, while others begin to inject drugs in prison. Such risky behaviour is at least in part a product of the prison context itself – drugs are often used to escape the misery, brutality, lack of privacy, anxiety and chronic insecurity that frequently characterise life within these institutions. The factors associated with the prison setting combine with the life history and subcultural practices of people who inject drugs, to provide a greatly heightened environment for health-related risk.

Rape and sexual violence are also vectors for the transmission of infection. Those prisoners at the base of the prison’s informal hierarchy are most prone to being victims of such assaults. In countries where people who use drugs are especially stigmatised, they may be particularly vulnerable to these types of risks.

Prisoners who use drugs are highly vulnerable to accidental overdose, particularly in the period immediately after release. Indeed, as people dependent on drugs reduce their use while in prison, they lose their tolerance to drugs. This means that their body can no longer cope with the doses they were taking before prison, and if they resume similar doses when released they face a high risk of overdose and death. A 1997 study in a French prison revealed that overdose death rates were from 124 times higher than in the general drug-using population for ex-prisoners aged 15 to 24 years through to 274 times higher for released prisoners aged 35 to 54 years. Prisoners are also at risk of dying in prison, whether from suicide, loss of tolerance or contaminated drugs. In another study of Washington state prisons, ex-prisoners were found to be 129 times more likely to die from drug overdose in the first two weeks after release than their counterparts in the general population.
Responsibilities for prisoners' health: international obligations

The concept of the right to the highest attainable standard of physical and mental health derives from the Constitution of the WHO. In recent years, WHO has been at the forefront of attempts to establish as a practical reality the right to health of prisoners, who represent an especially marginalised population group.\textsuperscript{14}

The right to health is also grounded in the UN Charter, the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights. Building on this universal right, the international community has gradually established the principle of equivalence, which argues that the right to health applies to prisoners as it applies to those living outside of prisons, and indeed to all human beings.

The first explicit reference to prisoners in international agreements came in the 1977 Minimum Standard Rules for the Treatment of Prisoners, which laid down a set of basic standards for the treatment of prisoners, including one relating to health. Agreed by the UN General Assembly, the resolution established a general principle of equivalence, stating that these basic standards should apply to all with no 'discrimination on grounds of race, colour, sex ... or other status'.\textsuperscript{15}

Section 9 of the 1990 UN Basic Principles for the Treatment of Prisoners made this principle of equivalence explicit: 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'.\textsuperscript{16} This resolution was also adopted by the General Assembly.

The EU agreed a further set of standards in 2006, known as the European Prison Rules, which reiterates the principle of equivalence and adds that, 'All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose'.\textsuperscript{17}

In December 2010, the UN General Assembly passed the UN Rules for the Treatment of Women Prisoners, usually known as the Bangkok Rules.\textsuperscript{18} These rules acknowledge that earlier instruments such as the Minimum Standard Rules are not sufficiently sensitive to the specific needs of women prisoners. Prisons were designed principally around the needs of male detainees, and the Bangkok Rules provide additional safeguards for women prisoners.

These and other guidelines do not represent legal provisions as such – they are non-binding recommendations, and there are no mechanisms for enforcement. However, their force lies in the fact that they have been agreed to by signatory states, UN members etc, and represent moral principles that states have publicly agreed to abide by.

These guidelines establish the principle that prisoners are entitled to equivalent healthcare services to those available outside prison; this stipulation applies to prisoners who use or have used drugs. Again, WHO has shown leadership in driving forward the agenda for the provision of effective healthcare services to incarcerated people who use drugs. In the course of providing guidance to policy makers on the provision of essential pain-killing medications, WHO has covered the issue of providing treatment for drug dependence in the prison setting. It states unequivocally that, 'Prisons should have functioning treatment programmes for opioid dependence'.\textsuperscript{19} These WHO guidelines on controlled substances have been endorsed by the INCB.
The INCB has likewise advised in its 2007 annual report that: ‘Governments have a responsibility to ... provide adequate services for drug offenders (whether in treatment services or in prison)’. 20

These standards of good practice relating to the treatment of incarcerated drug users are, therefore, firmly enshrined in international agreements that most states have signed up to.

Managing health risks in prisons
Although numerous research studies have examined policies and interventions relating to drug use in general, relatively few have focused on treatment of drug dependence and harm reduction services in prison. In many countries, limited resources are dedicated to prisons, and security is often prioritised over the health needs of people dependent on drugs.

Prison authorities have usually tried to tackle the power of drug dealers and limit the availability of controlled drugs through tough security measures or drug-testing programmes. These interventions have failed to achieve the intended goal of a drug-free prison, and have sometimes resulted in negative consequences. For example, drug testing in prisons can encourage people who use drugs to switch to drugs that are not being tested for, or are harder to detect and may be more harmful (e.g. prisoners can switch to heroin use from cannabis, as cannabis can be detected in the body for a longer period of time). Several studies have also revealed that drug-testing programmes were far from being cost effective. 21 UNODC itself declared that these programmes should be avoided in prisons. 22

A range of options are open to prison authorities, a combination of which is promoted as best practice by the WHO, UNODC and the Joint United Nations Programme on HIV and AIDS (UNAIDS).

• **Education and information** – many prisoners are unaware of the health risks they are taking. Simple information on these risks and the steps they can take to protect themselves and others should be widely distributed around prisons. Some prison administrations have also used educational videos or lectures to deliver the same messages, leading to higher levels of awareness. Used in combination with the provision of adequate healthcare and harm reduction services, education and information campaigns can be efficient in promoting safer behaviours.

• **Vaccination programmes** – effective vaccination exists to protect people against hepatitis A and B, and a period of imprisonment is an opportunity to encourage people to be vaccinated (many of them do not use preventive health services in the community). This consists of two injections, six months apart. Many prison administrations have targeted hepatitis A and B vaccination programmes at drug-using prisoners and report high levels of engagement and compliance.

• **Access to measures for safer sex** – many prison administrations have allowed the distribution of condoms to prisoners, offering them access to the same protection that is available outside of prisons. Early fears that the availability of condoms would lead to their use for drug smuggling have proved groundless. Further measures have also included providing information, education and communication programmes for prisoners and prison staff on sexually transmitted infections (STIs), consisting of voluntary counselling and testing for prisoners or measures to prevent rape, sexual violence and coercion.

A combination of options can address health risks in prison, which include:
• Education and information
• Vaccination programmes
• Access to measures for safer sex
• NSPs
• Prevention of overdose
• Needle and syringe programmes – programmes involving the distribution of sterile injecting equipment to people who inject drugs have been effective at preventing HIV infection. However, there has been great reluctance to introduce these public health programmes in prisons. Arguments against prison-based NSPs have included fears that prisoners would use needles as weapons against staff or other prisoners; that discarded needles would present an infection risk; and that the availability of sterile needles and syringes would increase the prevalence of drug injecting in prisons. In 2009, 10 countries had introduced NSPs in prisons. The outcomes have been very positive in reducing the sharing of injecting equipment and none of the fears outlined above have materialised in practice (see Box 1).

Box 1. Needle and syringe programmes in German prisons

A NSP was started in 1998 in two prisons in Berlin, Germany. A study was conducted in these two prisons to investigate the feasibility and safety of the programme and to assess its effects on patterns of drug use and health risks. The study found that rates of sharing injecting equipment had fallen from 71% of prisoners who inject drugs to virtually none, following the introduction of a needle-exchange programme. The study also concluded that the programme had had positive effects in reducing HIV and hepatitis B infections (see Figure 1). Hepatitis C infections did reduce but for NSPs to be efficient in reducing such infections, the study concluded that they should be coupled with additional programmes.

Figure 1. Prevalence of HIV, hepatitis B and hepatitis C infections among imprisoned people who inject drugs, according to year of first drug injection

[Graph showing prevalence of infections]

The Madrid Recommendation, made in October 2009 at an international conference of high-ranking prison health experts and attended by Spain's Ministry of Health, WHO and UNODC representatives, spoke of ‘the overwhelming evidence that health protection measures, including harm reduction measures, are effective in prisons ...’.

• Preventing drug overdose – programmes for overdose prevention, identification and management should involve information and awareness-raising, and practical measures such as training in expired air resuscitation and the distribution of naloxone (a medication that temporarily blocks the effects of opiates). The continuity of opioid substitution therapy (OST) through detention, prison incarceration and post release is also effective in preventing overdose.
Providing treatment for drug dependence in prisons

With a large number of people dependent on drugs held in custody, prisons can provide a useful location for delivering treatment for drug dependence, to break the cycle of dependence and crime. This requires that evidence-based treatment and rehabilitation programmes are made available within custodial settings.

There is evidence that a range of treatment interventions for drug dependence can be implemented effectively in prison settings. OST – in particular with methadone – is feasible in a wide range of prison settings for opioid-dependent people. Prison-based OST programmes appear to be effective in reducing the frequency of injecting drug use and the associated sharing of injecting equipment, provided that a sufficient dosage and treatment are provided for long periods of time (see Box 2). The risk of transmission of HIV and other blood-borne viruses among prisoners is also likely to decrease. OST has further benefits for participating prisoners, the prison system and the community. Evidence shows that re-incarceration is less likely to occur among prisoners who receive adequate OST. Moreover, OST has a positive effect on institutional behaviour by reducing drug-seeking behaviour, thereby improving prison safety. The challenges that had been experienced by prison administrations in managing some drug-dependent prisoners (e.g. security, violent behaviour) have been ameliorated by OST programmes.

Several studies have also acknowledged that other forms of treatment, such as psychosocial therapy, have been effective at reducing drug dependence in prisons. Structured therapeutic programmes using therapeutic community, 12-step or cognitive-behavioural models, have been shown to move a proportion of prisoners away from drug dependence, with resulting reductions in crime and health problems.

Effective treatment for drug dependence in prisons should therefore incorporate a range of options for detainees dependent on drugs. It maximises opportunities for rehabilitation and prevents a return to dependence and crime after release. The principles behind prison-based treatment are similar to those of drug dependence treatment in the community.

- Efficient mechanisms need to be put in place to identify those in need of treatment opportunities. As long as the treatment programmes provided are voluntary, humane and of good quality, prisoners will be likely to participate. Screening procedures on reception, and the provision of specialist assessment, advice and referral services, can identify and motivate prisoners to accept treatment.

- Various models of treatment in prisons are effective in improving health and crime outcomes in many countries. Prison authorities should aim to make available a range of detoxification, OST and psychosocial programmes in their prisons. These should be organised so that prisoners are able to move between services throughout their time in prison, according to their needs and when they choose to do so.

- Careful attention needs to be paid to the aftercare process, and continuity of treatment post release. Several studies have suggested that aftercare is needed to optimise the effects of in-prison treatment for drug dependence on reducing drug re-offending. This means that specific mechanisms are needed to link treatment in prison to that in the community.

If carefully designed and organised, compliance and success rates of treatment for drug dependence in prisons can be improved by linking treatment progress to prisoner incentives, such as consideration for early release.
Box 2. Opioid substitution therapy in Indonesian prisons

Indonesia has a fast-growing HIV epidemic, driven largely by the sharing of injecting equipment in injecting drug use. The state’s harsh response to drug use resulted in the incarceration of large numbers of people who inject drugs, with the result that prisons became a significant factor in escalating the epidemic. The Indonesian Network of People Who Use Drugs, and in 2008 UNAIDS, urged the country to begin treating people who use drugs as patients rather than criminals. The Indonesian government has initiated positive responses to these calls.

The Kerobokan prison in Bali, Indonesia, began providing OST with methadone in August 2005. It was the first Indonesian prison to do so, and as of 2009, the programme had treated 322 patients.

The institution combines OST with a range of harm reduction measures, including needle and syringe exchange, bleach for cleaning injecting equipment, and condoms. It is likely that these measures have led to the Kerobokan programme being much more successful than, for example, that based in Banceuy Prison, Bandung, where harm reduction is less integrated in the prison programme, and only nine patients had been registered for OST between 2007 and 2009.

Responsibility for prison health care

There is a growing call for the ownership of health in prisons to be transferred away from ministries responsible for justice to those responsible for health. A number of countries and states, including Norway, France, England and Wales in the UK, and New South Wales in Australia have already taken this step, with broadly positive results.

The reasons for this change centre upon questions such as whether healthcare staff who are employed by the prison are sufficiently independent, trusted by inmates and in touch with clinical and professional developments in the wider society – a set of logistical and ethical issues. Moreover, prisons lack effective monitoring and evaluation by the general public health system; this work is carried out instead by corrections or justice ministries with little expertise in health care. All of this tends to separate prison health from that in the rest of society.

Effective public health demands precisely the kind of integration that is often lacking in these arrangements, and governments should therefore consider the potential benefits of bringing prison health under the auspices of their health ministries.

Recommendations

1) An understanding of the level and nature of drug use and drug dependence among prisoners is needed to design appropriate policies.

2) A range of treatment and harm reduction services should be developed in custodial settings – if carefully designed and properly resourced, these services can have a highly positive impact on reducing the health and crime harms associated with drug-using offenders.

3) NSPs in prisons are needed to avoid the risks related to sharing injection equipment. The introduction of NSPs should be carefully prepared, including providing information and training for prison staff. The mode of delivery of needles and syringes (for example, by hand or dispensing machine) should be chosen in accordance with the environment of the prison and the needs of its population.
4) Additional harm reduction programmes – such as information and education programmes, naloxone distribution, etc – for preventing blood-borne diseases and drug overdoses should also be provided.

5) Evidence-based treatment for drug dependence should be offered to all detainees dependent on drugs, with the appropriate mix of substitution, psychosocial and mutual aid approaches. These treatment programmes should be stringently evaluated.

6) Better links and continuity of care should be established between prisons and community-based services, in order that individuals can continue treatment when entering prison or on release.

7) Governments should consider bringing prison health under the control of health ministries rather than justice ministries.

Key resources


Endnotes


17 European Prison Rules, para.40.4 and 40.5 https://wcd.coe.int/ViewDoc.jsp?id=955747
