

3.6

Health-based policies in prisons and other closed settings

Key recommendations

- Governments should consider bringing prison health under the control of the Ministry of Health rather than ministries of justice, interior or corrections
- An understanding of the level and nature of drug use and drug dependence among prisoners is needed to design appropriate policies and programmes; and services should be designed, implemented and evaluated with the meaningful involvement of people who use drugs
- A range of interventions and programmes should be developed and properly resourced in custodial settings, including treatment and harm reduction services. These programmes should be gender sensitive, and be stringently evaluated and adapted if necessary
- 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, syringes and other equipment (for example, by hand or dispensing machine) should be chosen in accordance with the environment of the prison and the needs of its population²⁰⁰
- Additional harm reduction programmes – such as information and education programmes, naloxone distribution, HIV testing and counselling, ART, crack pipe distribution, etc. – should also be provided
- A person's participation in drug treatment programmes should not be used as a reason to discriminate against them
- Effective links with community-based services should be established to ensure continuity of care so that the benefits of treatment started before or during imprisonment are retained.

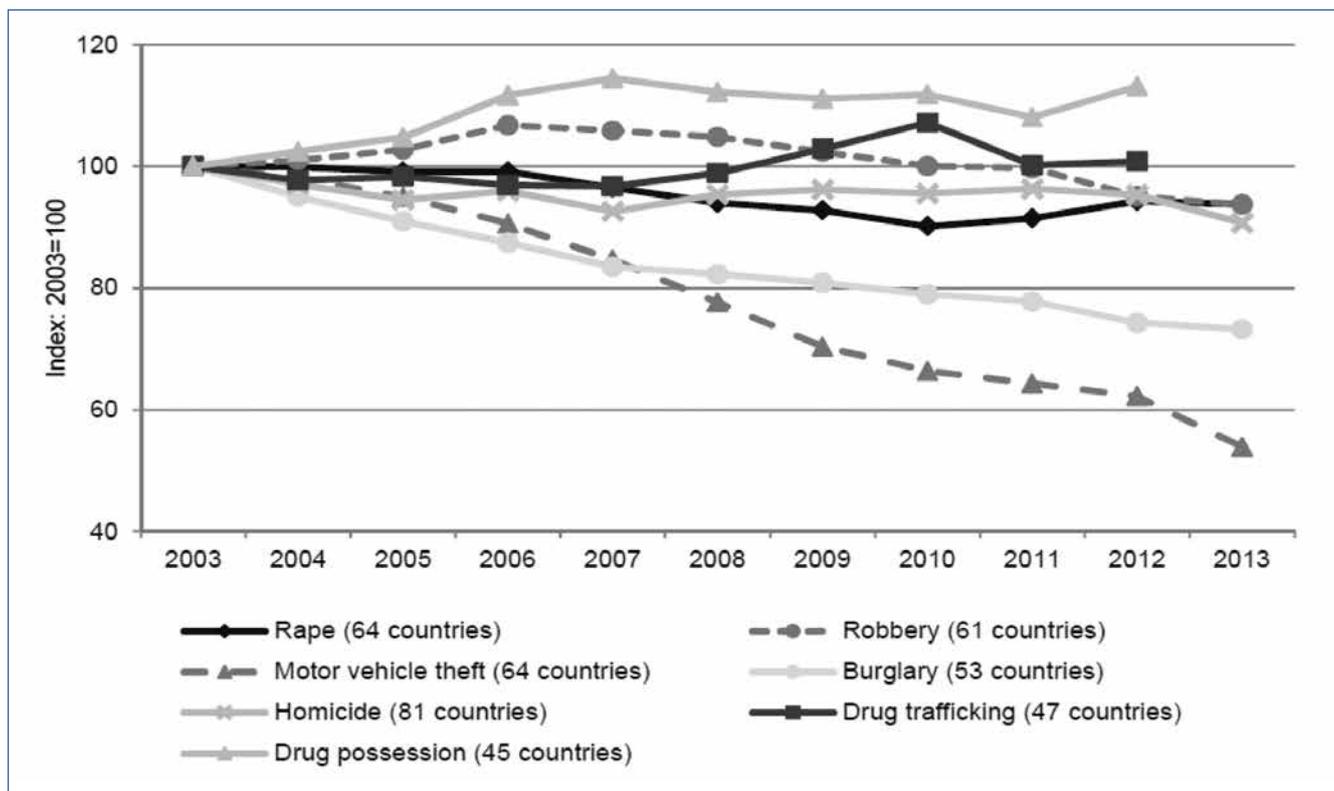
Introduction

The best estimate of the current world prison population is 10.2 million, a figure excluding at least 650,000 persons reported to be in pre-trial or 'administrative' detention in China and 15,000 in North Korea.²⁰¹ The number of people imprisoned for drug-related offences has been growing in the past few decades irrespective of imprisonment for offences such as theft, robbery and fraud committed to raise money to fund drug purchases. As already mentioned in previous chapters of the Guide, the global increase in drug-related crime is driven mainly by a rising number of offences related to drug possession – with offences related to drug possession currently comprising 83% of total global drug-related offences. Criminal offences relating to drug trafficking, however, have remained relatively stable over time (see figure 1),²⁰² and the vast majority of traffickers in prison are low-level offenders.²⁰³

The proportion of drug-related offences among female prisoners is typically higher than for their male counterparts.²⁰⁴ This trend has been attributed to the greater ease with which low-level crimes can be prosecuted,²⁰⁵ as well as gender disparities in the enforcement of drug laws and policies.²⁰⁶ Overall, however, the vast majority of prisoners the world over are adult men, although the number of women prisoners is increasing at a much faster rate than for men.²⁰⁷

In most countries, prisoners are drawn from the poorest and most marginalised strata of society, with low education, high unemployment rates, and histories of physical or sexual abuse, broken homes and relationships.²⁰⁸ Many prisoners may have used alcohol and/or controlled substances as a coping mechanism, including to 'escape' childhood abuse and violence. In prison, drugs are widely available, and are often used to escape the misery, brutality, lack of privacy, anxiety and chronic insecurity that frequently characterise life within these institutions. Boredom and lack of constructive activities in prison can also increase the likelihood of drug use.²⁰⁹

Figure 1. Global trends of selected crimes, 2003 to 2013²¹⁰



Although data are difficult to obtain and compare, studies indicate that approximately 50% of prisoners in the European Union, and more than 80% in the USA, have a history of drug use, and that this number is increasing.²¹¹ Estimates show that approximately one in three people detained have used drugs at least once while in prison,²¹² with the prevalence of drug use varying considerably from country to country. There is also evidence that many prisoners initiate injecting drugs for the first time in prison.²¹³ While the number of people who inject drugs in the community is only 0.26% of people aged 15-64, the rate is considerably higher in prison. For example, a study found that 23% of prisoners in Australia had injected drugs at some point in prison, as had 39% of male prisoners in Bangkok, Thailand.²¹⁴

While the rate of infections in prisons within and across countries varies considerably, the prevalence of HIV, sexually transmitted infections (STIs), hepatitis B and C as well as tuberculosis is much higher in prison populations as compared to the general population. HIV prevalence has been found to be 50 times higher in some prison settings than in the general population.²¹⁵ In Europe, the World Health Organisation (WHO) estimated that one in four detainees (an estimated 2.2 million people) are living with hepatitis C, compared to one in every 50 in the broader community.²¹⁶ Similarly, the prevalence of tuberculosis is 'multiple times higher' in prisons than it is in the general population.²¹⁷ While statistics are hard to come

by, in European prisons it was found in 2006 that tuberculosis infection was 17 times more likely in prisons than in the general population, and up to 81 times more likely in Eastern Europe.²¹⁸

The sharing of needles and syringes is a major factor for the spread of blood-borne diseases in prison, driven by the lack of availability of sterile equipment via harm reduction services and by fear of detection of drug use. Statistics show that a high number of prisoners who inject drugs share needles and other injecting equipment: for example, 56% in Pakistan, 66% in Russia, 70-90% in Australia, 78% in Thailand and 83-92% in Greece.²¹⁹ Other factors for the transmission of infections are rape and sexual violence as well as consensual unprotected sex. Where the use of drugs is particularly stigmatised, those at the bottom of the prison's informal hierarchy are most prone to being victims of such assaults.²²⁰

Based on these data, it is clear that prisons are an inadequate place to deal with drug use and dependence; rather, such settings result in additional health risks, even more so when facilities are overcrowded and under-resourced. There are therefore a number of reasons why an effective prison policy is essential, notwithstanding the need for broader drug policy reforms that seek to divert low-level drug offenders away from prisons in the first place (see Chapters 3.1 to 3.4):

- **Public health:** Prisons constitute an unsuitable

place for dealing with drug use and dependence,²²¹ but rather incubate health problems such as blood-borne viruses and overdose. Such health problems are not sealed away, they impact on the rest of the community as prison staff, service providers and visitors enter and exit the institutional setting, and prisoners are ultimately released. Consequently, effective healthcare in prison is in the vital interest of society.

- **Human rights obligations:** International human rights obligations include the right to the highest attainable standard of physical and mental health,²²² and prisoners retain their human rights while detained. Governments bear a particular responsibility towards those they deprive of their liberty.
- **Improve drug treatment and prevent recidivism:** Effective treatment for drug dependence in prisons – including opioid substitution therapy (OST) – improves health outcomes and can help to prevent a return to crime after release.²²³ Without treatment and a continuum of care, evidence shows a high rate of overdoses, relapse to drug use and recidivism among people who use drugs after they are released from prison.²²⁴
- **Economics:** Responding to drug-related crime, overdose and blood-borne infections can be very expensive, in particular for illnesses such as HIV that are chronic and may require life-long treatment. There is therefore a powerful economic case to be made for harm reduction and evidence-based drug treatment measures in prisons, as well as in community settings.

Legislative/policy issues involved

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is enshrined in article 12 of *International Covenant on Economic, Social and Cultural Rights*²²⁵ and reflected in Principle 9 of the Basic principles for the treatment of prisoners.²²⁶ The right to health cannot be curtailed because a person is caught using drugs or ends up in prison.²²⁷

States bear a particular duty of care for those detained, as prisoners have no alternative but to rely on prison authorities to promote and protect their health.²²⁸ The Special Rapporteur on torture has held that states 'must provide adequate medical care, which is a minimum and indispensable material requirement for ensuring the humane treatment of persons in its custody', and that 'omissions on the part of the authorities can amount to ill-treatment and even torture'.²²⁹

People in custody are entitled to the same standard of healthcare found outside of prisons, including with regard to prevention, harm reduction and antiretroviral therapy (ART).²³⁰ The Special Rapporteur on the right to health has clarified that the right to health is violated if harm reduction and evidence-based treatment programmes are available to the general public, but not to people in detention.²³¹

The most comprehensive guidance on healthcare in prisons is enshrined in the revised UN Standard minimum rules for the treatment of prisoners, also known as the Mandela Rules (Rules 24 to 35).²³² The



Bandung prison, Indonesia

Credit: International HIV/AIDS Alliance



Prison medical facility in Kazakhstan

revised Rules clarify that the provision of healthcare for prisoners is a state responsibility, free of charge and without discrimination on the grounds of their legal status (Rule 24).²³³ The same standards apply in prison as they do in the community (based on the principle of equivalence of care), and healthcare services in prison should be organised ‘in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence’ (Rule 24). The revised Rules also call for ‘particular attention to prisoners with special healthcare needs or with health issues that hamper their rehabilitation’ (Rule 25). The role of healthcare personnel is to evaluate, promote, protect and improve the physical and mental health of prisoners, through ‘an interdisciplinary team with sufficient qualified personnel acting in full clinical independence’ (Rule 25, see also the Dual Loyalty Guidelines,²³⁴ the Declaration of Tokyo of the World Medical Association²³⁵ and the UN Rules for the treatment of women prisoners – the ‘Bangkok Rules’²³⁶).

Healthcare staff in prisons are subject to the same ethical and professional standards as for patients in the community, including adherence to prisoners’ autonomy with regard to their own health, informed consent in the doctor-patient relationship, and confidentiality of medical information – unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others (Rule 32, see also General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights²³⁷). Information is a precondition for prisoners to be able to give their informed consent to

medical interventions. As the Special Rapporteur on the right to health emphasized, ‘informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision’.²³⁸

Professional healthcare requires the maintenance of medical files. However, the confidentiality of such information is reflected in Mandela Rule 26, including the prisoners’ access to it and the duty to transfer medical files to another facility along with the prisoner.

The lack of gender-sensitive provisions relating to healthcare provision in prison settings has been

Box 1 Principles for the provision of healthcare in prison²³⁹

- State responsibility
- Without discrimination
- Equivalence of healthcare
- Clinical independence
- Same ethical principles as in the community
- Medical screening upon admission
- Drug dependence treatment
- Mental healthcare
- Continuity of care

acknowledged and rectified by the adoption of the Bangkok Rules.²⁴⁰

While the Mandela Rules and the Bangkok Rules do not constitute legally-binding treaties, they carry the weight of unanimously adopted standards at the international level. At the regional level, provisions on healthcare in prisons have been incorporated in the European prison rules²⁴¹ and the Principles and best practices on the protection of persons deprived of liberty in the Americas.²⁴²

The WHO and the UNODC have been at the forefront of developing guidance relating to prisoner healthcare and the treatment of drug dependencies (see Key Resources below). The WHO guidelines²⁴³ on controlled substances have been endorsed by the International Narcotics Control Board (INCB), who also advised in 2007 that, 'Governments have a responsibility to (...) provide adequate services for drug offenders (whether in treatment services or in prison)'.²⁴⁴

Implementation issues involved

Prison authorities have usually focused on preventing drug use in prison through stringent security measures and drug-testing programmes, while dedicating little attention and resources to the provision of healthcare, drug dependence treatment and harm reduction programmes. Countries who focus on mandatory drug testing²⁴⁵ argue that this measure deters prisoners from using drugs in prison and allows them to identify individuals for treatment. However, the practice has shown a number of problems, including the diversion of financial and staff resources away from evidence-based treatment and prevention services, a negative effect on the prison regime²⁴⁶ and the risk of prisoners switching to more harmful drugs because these are not being tested for or are harder to detect (e.g. prisoners may switch to the use of heroin or new psychoactive substances rather than cannabis, as the latter can be detected in the body for a longer period of time).²⁴⁷

Implementing a comprehensive package of services in prison

A comprehensive package recommended by the UNODC, the International Labor Organization (ILO), the United Nations Development Program (UNDP), the WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) for HIV prevention, treatment and care in prisons and other closed settings comprises 15 key interventions (see Box 2).²⁴⁸

Box 2 The UN comprehensive package of interventions in prison²⁴⁹

The comprehensive package consists of 15 interventions that are essential for effective HIV prevention and treatment in closed settings. While each of these interventions alone is useful in addressing HIV in prisons, they have the greatest impact when delivered as a whole. Although by no means truly 'comprehensive', this package is a useful start to address HIV in closed settings.

1. Information, education and communication
2. Condom programmes
3. Prevention of sexual violence
4. Drug dependence treatment, including OST
5. Needle and syringe programmes (NSPs)
6. Prevention of transmission through medical or dental services
7. Prevention of transmission through tattooing, piercing and other forms of skin penetration
8. Post-exposure prophylaxis
9. HIV testing and counselling
10. HIV treatment, care and support
11. Prevention, diagnosis and treatment of tuberculosis
12. Prevention of mother-to-child transmission of HIV
13. Prevention and treatment of STIs
14. Vaccination, diagnosis and treatment of viral hepatitis
15. Protecting staff from occupational hazards

A combination of measures that address drug use, drug dependence and related health risks in prison includes:

Education and information – As prisoners typically come from the most marginalised groups of society and may have had limited access to healthcare before admission to prison, they are less likely to be aware of health and infection risks. However, the



Buen Pastor prison in Bogota, Colombia

spread of infectious diseases can only be prevented if prisoners are given information about means of protection and prevention in a diction that is appropriate to their language skills and education. Health education has also shown to improve adherence to treatment and rises in cure rates.²⁵⁰ Some prison administrations have used educational videos or lectures to deliver health education, leading to higher levels of awareness. Information material should be developed in consultation with prisoners and prison staff, as it 'makes the information more sensitive and appropriate to the prison context, increases the sense of ownership among prisoners and contributes to the continuity of the programme.'²⁵¹

Drug dependence treatment – With a large number of people dependent on drugs held in custody at any one time, prisons can be an effective setting for a range of evidence-based treatment programmes (for more information on treatment, refer to Chapter 2.5). OST – in particular with methadone and buprenorphine – has proven to be feasible and beneficial in a wide range of prison settings for people dependent on opioids. Yet only 43 countries provided OST in prison settings in 2014.²⁵² OST has proven to lower rates of heroin use, reduce drug injection, reduce the sharing of injecting equipment, lower rates of fatal overdose (especially post-release), increase adherence to ART, and lower re-incarceration rates.²⁵³ For example, a review of 21 studies on OST in prisons found that it provided an effective way to get people into treatment programmes, reduce risk behaviours, and lower overdose risks upon release. It also found that, where liaison with community-based programmes existed, the prison programmes ensured longer-term ben-

efits²⁵⁴ (see also the Madrid Recommendations²⁵⁵). Drug dependence treatment programmes showed additional positive effects on institutional behaviour and reduced violence.²⁵⁶ As in the community, however, more attention should be given to substitution treatment options for stimulant dependence (see Chapter 2.5 for more detail).

Several studies have also acknowledged that other forms of treatment, such as psychosocial therapy, are effective at reducing drug dependence in prisons.²⁵⁷ Structured therapeutic programmes have been shown to move a proportion of prisoners away from drug dependence, with resulting reductions in crime and health problems. Prison authorities should aim to make available a full range of evidence-based treatment programmes, based on the following principles:

- Screening procedures need to be in place to identify those in need of treatment, while respecting the principle of informed consent²⁵⁸
- As long as the treatment programmes provided are voluntary, humane and of good quality, prisoners will be likely to participate
- Programmes 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
- 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
- Careful attention needs to be paid to continuity of treatment upon admission and post release

- Treatment success and recovery should not be understood solely as abstinence from drug use. Individuals should be encouraged to identify and strive towards their own recovery, which may or may not require abstinence but will always include progressive steps to improve their health and well-being (see Chapter 2.5).

Needle and syringe programmes – While there has been great reluctance to introduce NSPs in prison settings, programmes involving the distribution of sterile injecting equipment to people who inject drugs have been effective at preventing HIV and hepatitis infection. Fears included the possibility 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. However, these concerns have not materialised in practice and the outcomes of such programmes have been very positive in reducing the sharing of injecting equipment.²⁵⁹ Yet, in 2014, only 8 countries provided NSPs in prisons (three less than in 2012), compared to 90 countries where such programmes were available in the community.²⁶⁰ The UNODC, the WHO and UNAIDS recommend that both NSPs and OST be accessible in prisons.²⁶¹

Access to measures for safer sex – A number of countries provide free access to condoms in prison settings, including in Western Europe, parts of Eastern Europe and Central Asia, as well as Australia, Canada, Indonesia, the Islamic Republic of Iran,²⁶² South Africa and the USA.²⁶³ Research in a Los Angeles county prison found that condom distribution prevented a quarter of HIV transmissions among sexually active inmates, and that the averted future medical costs far exceeded the programme costs.²⁶⁴ No security problems or other negative consequences have been reported, and evidence shows that the provision of condoms has not led to an increase in security issues, sexual activity or drug use.²⁶⁵ Further measures have also included providing information, education and communication programmes for prisoners and prison staff on STIs, consisting of voluntary counselling and testing for prisoners or measures to prevent rape, sexual violence and coercion.

Vaccination programmes – Effective vaccinations exist to protect people against hepatitis B, and incarceration does provide an opportunity to encourage people to take up these vaccinations. However, vaccination schemes should remain voluntary.²⁶⁶ The UK, for example, established an ‘opt-out’ testing programme for hepatitis B in prisons, whereby all prisoners are offered the chance to

Box 3 Moldova’s harm reduction programme in prison

In Moldova, OST for prisoners dependent on drugs was introduced in 2005, and recipients are provided with methadone each day in the prison pharmacy after signing a register. There is also an NSP in prison.²⁶⁷ Research documented a decline in overdoses²⁶⁸ and a positive impact of the treatment on the health and general well-being of prisoners.²⁶⁹ Initial challenges with the programme have been addressed, for example by providing staff with specific health and safety information including the type and scope of risks to staff.²⁷⁰ Concerns about methadone being used to bribe medical personnel or prisoners have been successfully addressed by administering the methadone under strict supervision, as well as by self-regulation by the participants of the programme.

As of 2009, more than two-thirds of adult sentenced prisoners had access to harm reduction services in Moldovan prisons and the results have been wholly positive. HIV and hepatitis C incidence have decreased, there has not been any recorded case of needles being used as weapons against prison staff or fellow prisoners, and drug use has not increased.²⁷¹

be tested for infection, and recommended that all prisoners be vaccinated against hepatitis B.²⁷² Most prison administrations that have targeted hepatitis A and B vaccination programmes at drug-using prisoners report high levels of engagement and compliance.

Establishing responsibility / prison management

It is now widely recognised that prison health services should be integrated into public national health policies and systems.²⁷³ It is also increasingly acknowledged that this can be done most effectively, and that continuity of care is best achieved, when the responsibility for prison healthcare is assumed by the Ministry of Health.²⁷⁴ Healthcare staff employed by prison services may not be sufficiently in touch with clinical and professional developments in the wider society, may lack independence, or may not be trusted by inmates.²⁷⁵ Countries such as Italy,

Norway, France, England and Wales and most parts of New South Wales in Australia have already taken this step, with broadly positive results.²⁷⁶

Ensuring gender sensitivity

Drug dependence has been consistently found to be over-represented in female prison populations, compared to the general population.²⁷⁷ This is linked to the background of these women, including the high rates of domestic and sexual violence they may have experienced prior to arrest and detention.²⁷⁸

HIV and other sexually-transmitted and blood-borne diseases are also more prevalent among female prisoners than their male counterparts,²⁷⁹ due to the combination of gender inequality, stigma and women's higher vulnerability to contracting STIs, limited access to information and inadequate health services.²⁸⁰ This background as well as physiological differences result in greater and different healthcare needs, and mean that drug dependence treatment and other measures need to be gender-sensitive in order to be effective. Treatment programmes need to take into account prior victimisation, diverse cultural backgrounds, any history of abuse or domestic violence, mental health problems common among female prisoners and the special needs of pregnant women and women with children. However, many prison systems discriminate against women when it comes to drug treatment and harm reduction programmes – i.e. by only providing them in male prisons.²⁸¹ Where these programmes exist, they are often not tailored to women.²⁸²

Rule 6 of the Bangkok Rules²⁸³ recommends that the health screening of female prisoners shall include 'the existence of drug dependency' and 'the presence of sexually transmitted diseases or blood-borne diseases'. Depending on risk factors, female prisoners should also be offered voluntary testing for HIV and other blood-borne diseases, with pre- and post-test counselling.

Gendered differences in drug use and dependence and related complications are acknowledged by Bangkok Rule 15, which highlights the need for 'specialised treatment programmes designed for women substance abusers'. The UN Committee on the Elimination of Discrimination against Women has also recommended that states provide gender-sensitive and evidence-based drug treatment services as well as harm reduction programmes for women in detention.²⁸⁴

With regard to HIV, Bangkok Rule 14 recommends programmes that are 'responsive to the specific needs of women, including prevention of mother-to-

Box 4 Spain's harm reduction programme in prison reduces HIV and hepatitis C infections

In the late 1990s, the rate of HIV infection among prisoners who injected drugs in Spain was reported to be around 30% – one of the highest in Europe. The country therefore launched a prevention and control programme for communicable diseases in prison, mirrored in the community. A comprehensive harm reduction approach was adopted based on voluntary testing, confidentiality, free distribution of condoms, OST, NSPs, health-related education, prisoners' training as health mediators, and parole for terminally-ill prisoners.²⁸⁵

The impact was significant. Spain has reported that HIV prevalence among prisoners fell from 22.4% in 1995 to 6.3% in 2011,²⁸⁶ and in one particular prison in the Ourense region, a 10-year review of the NSP found that between 1999 and 2009 the prevalence of HIV infection decreased from 21% in 1999 to 8.5% in 2009, and hepatitis C prevalence from 40% to 26.1%.²⁸⁷

child transmission', encouraging 'the development of initiatives on HIV prevention, treatment and care, such as peer-based education'. Further measures should include gender-sensitive support groups, drug education, and psychosocial programmes.

Preventing overdoses

Overdose is a common experience for many people who use drugs, in particular opioids, and is a leading cause of death among people who inject drugs. The period immediately following release from prison poses a significant risk of (fatal) overdose.²⁸⁸ This is because former prisoners may resume similar doses as prior to detention, when their body can no longer cope with these doses due to reduced tolerance following abstinence, reduced use or the use of other drugs while in prison.²⁸⁹ For instance, a UK study showed that male prisoners were 29 times, and female prisoners 69 times more likely to die from an overdose during the week following their release compared to the general population.²⁹⁰ In another study of Washington state prisons, former prisoners were found to be 129 times more likely to die from a drug overdose in the first two weeks after release than their counterparts in the general population.²⁹¹

Because of this elevated risk, prison services should seek to provide training and information on overdose prevention and emergency responses – both for people who use drugs and for prison staff. Upon release and/or while in prisons, people who use opioids should also be provided with naloxone – a WHO Essential Medicine which quickly and safely reverses the respiratory depression from an opioid overdose (see Chapter 2.4 for more details).

Addressing post-release issues

Upon transferral to or release from prison, continuity of drug-related programmes, in particular OST, is essential to ensure that people who stopped using drugs do not relapse into drug use or suffer from an overdose, that a former inmate does not suffer from opioid withdrawal, and that those on ART or other forms of medication do not develop resistance to such medications if their treatment is suddenly interrupted.

As set out by the UNODC, UNAIDS and the WHO, 'In order to ensure that the benefits of treatment (...) started before or during imprisonment are not lost, as well as to prevent the development of resistance to medications, provision must be made to (...) continue these treatments without interruption.'²⁹² This continuity of care is best achieved when community services can provide support to a prisoner in custody and after release and accompany his/her re-entry into the community.²⁹³ Several studies have suggested that aftercare is needed to optimise the effects of in-prison treatment for drug dependence on reducing drug re-offending.²⁹⁴ Continuity of care also requires that medical files follow the prisoner to the relevant public health service upon release (see Rule 26 of the Mandela Rules).

Key resources

- Penal Reform International (2015), *Global Prison Trends 2015 – Special focus: Drugs and imprisonment*, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>
- United Nations Office on Drugs and Crime (2004), *Drug abuse treatment toolkit, substance abuse treatment and care for women: Case studies and lessons learned*, http://www.unodc.org/docs/treatment/Case_Studies_E.pdf
- United Nations Office on Drugs and Crime (2014), *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings* (Advance Copy), <https://www.unodc.org/>

Box 5 Lichtenberg women's prison in Berlin, Germany

At admission to Lichtenberg prison, each woman is provided with a harm reduction kit, which includes a plastic case with ascorbic acid (to be used in the preparation of drugs for injection), alcohol wipes, vein cream, and a 'dummy' needle for use in the sterile needle dispensing machine (which requires a used syringe to be deposited before a sterile one is dispensed).²⁹⁵ These dispensing machines allow prisoners to obtain sterile syringes anonymously.²⁹⁶ Syringes stored properly in plastic cases provided are permitted by the prison. However, any prisoner found with an improperly stored or hidden needle or in possession of more than one needle is subject to sanctions.²⁹⁷ A review in 2013 found that there had been no increase in drug use or injecting drug use, and needle sharing had been strongly reduced.²⁹⁸

The prison also provides a holistic approach to drug dependence. There is a 'drug addiction unit' which is divided into a basic unit and the so-called 'motivated' and 'substituted' units. Usually drug dependent women move into the basic unit at admission. During the 'orientation' phase, they are encouraged to address their drug use. Women can apply to move into the 'motivated' unit – which is divided into two flats: one for women who are in the OST programme, and one for women who are abstinent from drugs (where all women have to participate in urine testing to prove their abstinence).

[documents/hiv-aids/publications/Prisons and other closed settings/ADV COPY NSP PRISON AUG 2014.pdf](https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/ADV_COPY_NSP_PRISON_AUG_2014.pdf)

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