European Network on Drugs and Infections Prevention in Prison

"Unlocking Potential: Making Prisons Safe for Everyone"

Report of the 8th European Conference of Drug and HIV/AIDS Services in Prison

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Budapest, 7th-9th July 2005

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ISBN : 1-902114-13-2

ENDIPP is a project co-funded by European Commission. Neither the European Commission nor any person acting on its behalf is liable for the information contained in this Report.

Introduction

This report details the proceedings of the 8th European Conference of Drug and HIV/AIDS Services in Prison, held at Corinthia Grand Hotel, Budapest, Hungary, from 7th to 9th July 2005. The event was entitled "*Unlocking Potential: Making Prisons Safe for Everyone*" and was attended by almost 300 delegates, from a wide range of professions and disciplines, including those working within prisons and in the wider community. In addition to delegates from the European Union, we were joined by colleagues from Bulgaria, Romania, Russia, other European and Central Asian states, the US and Canada.

The organizers are grateful to the Hungarian Prison Service and to all those who helped to organize this important event. We would particularly like to thank those who took the time to make presentations and to facilitate workshops, providing the material on which this report is based. Such information is reproduced as it was submitted with minimal editing. We hope it accurately reflects the content of the individual sessions. The terminology used in this report reflects the language used at the Conference. We have tried to be consistent wherever possible, but variations in expressions, titles, designations etc. may be apparent. Any mis-appellation in this report that causes offence is unintentional.

The 9th European Conference on Drugs and Infections Prevention in Prisons is scheduled to take place at the Grand Union Hotel in Ljubljana, Slovenia, from 5th to 7th October 2006. We hope to see you all there.

The European Network would like to thank the EC, EMCDDA, WHO, OSI, CEE-HRN, Heuni, WIAD, the AIDS Foundation East-West and Correlation. Our special acknowledgements go to the Hungarian Prison Service and the Hungarian Civil Liberties Union for their extensive support and assistance on site.

TABLE OF CONTENTS

Conference Program

"UNLOCKING POTENTIAL: MAKING PRISONS SAFE FOR EVERYONE"

Thursday 7th July – Afternoon

14:00-15:00 Welcome & Opening Session – Chair: Paddy Costall – ENDIPP

- **József Petrétei - Minister of Justice of the Republic of Hungary**

Keynote Address:

- **Jonathan Beynon – Co-ordinator Health in Detention, International Committee of the Red Cross**

"The health of prisoners, potential conflicts with security requirements and the role of independent monitoring in the process"

15:00-15:30 Coffee Break

15:30-17:15 Debate: 'Care and control - two sides of the same coin, or two ends of a continuum?'
Using a 'Question Time' format, with brief opening statements from participants, to examine the relationship between the concepts of both caring for prisoners whilst also maintaining control of the environment within prisons. Such issues as tension created by harm reduction and measures which might conflict with security concerns - e.g. needle exchange within prisons.

Chair: David Ramsbotham – *House of Lords - former HM Chief Inspector of Prisons* (UK)

- **Dasha Ocheret** – *Kolodetz* (Russia)
- **Alex Gatherer** – *WHO Health in Prison Project*
- **Andreas Skulberg** – *Prison Service* (Norway)
- **Fabienne Hariga** – *Modus Vivendi* (Belgium)
- **John Podmore** - *HM Prison Brixton* (UK)

19:00 RECEPTION HOSTED BY THE HUNGARIAN PRISON SERVICE AT THE *STEFÁNIA PALOTA (STEFÁNIA PALACE)*

Friday 8th Morning

9:30-10:45 Plenary Session "Integrated approaches to providing services: looking at live examples of existing good practice" **Chair: Steve Rossell** – *Cranstoun Drug Services* (UK) - **Mike Stoney** – *Prison Service* (Scotland) - **Alfred Steinacher** – *Prison Service* (Austria) - **Francesco Scopelitti** – *City Health Service – Milan* (Italy)
10:45-11:15 Coffee Break **11:15-12:45 Parallel Workshops**

GRAND BALLROOM *All Day*	*JÓKAI room* *All Day*	*KRÚDY Room* *Morning Only*	*PETŐFI room* *All Day*	*ARANY room* *All Day*
Harm reduction: what determines good policies and effective practices in prison? ***NB: Interpretation in ALL Languages*** **Chair: Matt Curtis –IHRDP-OSI (USA)** **Heino Stöver**- "Harm Reduction in European prisons", *University of Bremen* (Germany) **Ralph Jurgens**, "Reviewing the evidence about MMT and NEP in prison", (Canada) **Larisa Pintilei,** "Harm Reduction in Moldovan Prisons", *Innovating Projects in Prison* (Moldova) **Péter Sárosi**, "Harm Reduction in Hungarian Prison, challenging current practices", *Hungarian Civil Liberties Union* (Hungary)	**"It's not just heroin" Meeting the challenges of working with those who use other drugs** **Chair: Andy Stonard - Rugby House (UK)** **Andy Stonard** - "Services for alcohol users" **Tom de Corte** – "Meeting the challenges of Cocaine users" U*niversity of Ghent* (Belgium) **Janine Wildshut** – "Piloting work with crack and cocaine users in Dutch Prisons" *Mainline* (Netherlands)	**"Catch them while you can…." How do we engage and effectively work with young people?** **Chair: Joris Casselman - University of Leuven (Belgium)** **Laetitia Hennebel** – "Research study on services for juveniles" ENDIPP **Mark Llewelyn-Spooner**, "Services for juvenile offenders in England", *HM Prison Parc* (Wales) **Kathryn Leafe**, "Good practice from South-Africa", *THEMBA HIV/AIDS Organisation* (South Africa)	**Epidemiology: what does the evidence tell us?** ***Part I : International Perspective*** **Chair: Caren Weilandt, ENDIPP-WIAD** **Kralko Aliaksey Arkadievich**, , "Risk factors of distribution – HIV in Belarusian prisons", *Prison Service* (Belarus) **Peer Brehm Christensen**, , "Drug related deaths in Denmark – prison release and prevalence of BBI", *Odense University Hospital* (Denmark) **Akylbek Muratov**, , "Overview of HIV/AIDS in the Penal System of Kyrgystan" *GUIN* (Kyrgyzstan) **Fligauf Gergely**, "Gender based challenges in the Hungarian prison system", *Prison Service* (Hungary)	**Involving families and the wider community: early intervention and continuity of care** **Chair: Harry Fletcher - National Association of Probation Officers (UK)** **Petra Paula Merino**, "Overview of alternatives in Europe", *EMCDDA* **Shereen Sadiq** – *Home Office* (UK) **Gavin Lawson**, "Throughcare system in Scotland", *Cranstoun Drug Services* (Scotland) **Luisa Gandini**, *Probation Service* (Italy)

Friday 8th Afternoon

(Harm Reduction - continued)	*(Not Just Heroin - continued)*	*Afternoon only*	*(Epidemiology continued)*	**(*continued*)**
Parviz Afshar – "Scaling up Syringes Exchange in prisons and communities in Iran", *Prison Organisation* (Iran) **Natalia Vezhnina,** , "Harm Reduction in Central Asian prisons", *AFEW* (Central Asia) **Marat Akhmetov**, "HIV prevention in Prisons in Kazakhstan", *GUIN (Prison Service)* (Kazakhstan) **Holly Catania**, "The first US Prison MMT: evaluating a pilot, expanding an intervention", *Beth Israel Medical Centre* (USA)	**Jindra Voboril** – "Pervitin users in the Czech Prison system" *Sdruzeni Podane Ruce* (Czech Republic) **Balázs Dénes**, "Meeting the challenges of stimulant users in Eastern Europe" *Hungarian Civil Liberties Union* (Hungary) **Grantley Heines** "Crack-cocaine users: setting the agenda", *Birmingham DAAT* (UK)	**Developing and involving NGOs in states in transition** **Chair: Grzegorz Król - ENDIPP** **Irina Pillberg**, "The role and potentialities of NGOs in the penal system of Estonia", *Convictus Eesti* (Estonia) **Olga Škvařilová,** "Cooperation between NGO & Prison Service in the Czech Republic", *Sdruzeni Podane Ruce* (CZ) **Catalina Iliuta**, "Working with prisons: the Romanian experience" *ARAS* (Romania)	***Part II : National Perspective* - Dealing with Hepatitis C in French prisons: a measured approach** ***NB: EN/FR interpretation*** **Chair: Saâdia Yakoub - French Ministry of Health** **André-Jean Remy**, "National survey on HEP, HIV, and drugs in asylum seekers detention centres in France", *UCSA* **Philippe Sogni**, "Clinical and therapeutic aspects of viral hepatitis", *Cochin Hospital Group* **Sylvie Balanger**, "Screening and monitoring methods of prisoners with HCV", *La Santé Remand Prison* **Luc Massardier** "Psychiatric co-morbidity and psychiatric problems linked to HCV infection", *La Santé Remand Prison*	**Involving families and the wider community: early intervention and continuity of care** **Uday Mukherji**, "Continuity of Care: Prison Community Interface", *Glasgow Drug Court* (Scotland) **Andrej Kastelic**, "Community involvement with drug using offenders in Slovenia", *Sound of Reflection Foundation* (Slovenia) **Deborah Small**, *Break the Chains* (USA)

14:15 – 15:45 Parallel Workshops

15:45-16:15 Coffee Break
16:15-17:15 Plenary Session – Paolo Pertica Fellowship **Elena Grigoryeva (Belarus),** *first Paolo Pertica Fellow***:** " Gender sensitivity of existing strategies and activities on re-socialisation of HIV+ female prisoners in 5 Newly Independent States" ***Details of the second Paolo Pertica Fellowship*** **(Paolo Pertica, Edoardo Spacca)**

19:45 CONFERENCE DINNER ON BOAT ON RIVER DANUBE HOSTED BY ENDIPP

Saturday 9th Morning

9:45-11:30

Roundtable Discussion: How can we ensure quality and cost effectiveness in service delivery?

In the search to secure often scarce resources to provide services to 'unpopular' groups within society it has become necessary to justify expenditure in ways that go beyond moral notions of it being a 'good thing to do'. It is necessary to demonstrate other aspects of 'added value' for the wider community to ensure initial and continued support for initiatives. This session will see a variety of contributors, from different backgrounds and disciplines trying to unpick some of the issues and identify if and where common measures and determinants of achievement and effectiveness might be employed.

Chair: Mike O'Grady – *Glasgow High Court* (Scotland)

- **Deborah Small** – *Break the Chains* (USA)
- **Ralf Jürgens** – *International Prison Consultant* (Canada)
- **Dmitry Rechnov** – *AFEW* (Russia)
- **Kathryn Leafe** - *Cranstoun Drug Services* (UK)
- **László Huszár** – *Prison Service* (Hungary)

11:30-12:00 Coffee Break
12:00-13:00 **Closing & Feedback Session** **Paddy Costall** – ENDIPP **Caren Weilandt** – ENDIPP **Edoardo Spacca** – ENDIPP

13:00 Lunch and Departure

The following exhibited posters throughout the conference:
Alain De Bruyne – *De Eenmaking* (Belgium) **Irina Pillberg** – *Convictus Eesti* (Estonia) **Maria Grazia di Bella & Silvia Cocchi** – *Florence and Empoli Health Service* (Italy) **Marat Jamankulov** – *Prison Service* (Kyrgyzstan) **Serge Lastennet** – *ACT-UP* (France)

Thursday 7th July 2005
14.00 – 15.00

Welcome and Opening Session

The Conference was opened by Paddy Costall, Director of Services at Cranstoun Drug Services, with a warm welcome to all participants. In his introductory remarks, he reminded participants that the issue of drugs is not only linked to crime, but it is also an issue very clearly linked to public health. Prisons are a very significant part of our entire society and it is only whilst people are behind bars that they are separate from us. However, they do return to communities and thus the activities that occur with people and amongst people whilst they are in prison cannot be ignored. Harm reduction, therefore, should not be a polemic issue but rather an issue of pragmatism.

Amidst conflicting political views and different responses and policies to the issue of drug use around the world, some good signs are emerging. The World Health Organization has recently added to its essential medications list both methadone and buprenorphine, and the WHO Status Paper on Prisons, Drugs and Harm Reduction, which was widely discussed at the last ENDIPP Conference, has now been adopted and published. This not only reinforces the importance of the ENDIPP Conferences but particularly the real and powerful impact that they can have in shaping better policies, programmes and interventions at national, European and international level.

It was in this spirit that the 8th European Conference on Drugs and Infections in Prison was officially opened.

Welcoming Address

Mr József Petrétei, Minister of Justice of the Republic of Hungary

Mr. József Petrétei provided an overview of the issue of drugs and responses in Hungary and stressed the importance of wide cooperation to effectively respond to the drug problem.
With regards to Hungary, data on drug use indicates a lower prevalence than in other countries; nevertheless, it is reported to be on the increase, especially amongst youngsters.
The foundations for the Hungarian National Drug Strategy were laid down in 2002. At present, there is a debate over the issue of drugs, and there are contrasting pressures on the one hand to decrease tolerance, and on the other to offer drug users the opportunity to seek advice, help and treatment in medical and psychological facilities and avoid criminal procedures.

With regard to the issue of drugs in prisons, in 2004 there were 794 prisoners in Hungary, charged or convicted because of drug-related offences or facing trial because of drug-related charges. They represented 4.7% of the total prison population in Hungary, a rate fairly low when compared to the Western European average. This remains true for this year (904 prisoners, 5.45% of the whole prison population). This data covers only direct drug-related crime cases, and it is expected to increase.

The primary task of the Hungarian prison service is to prevent drugs making their way into the prisons facilities. As of January 2003 drug prevention sections and departments have been set up, and there are now thirteen of them operating across the country. Staff is continuously trained and there are not only post-release programs, but also drug prevention and drug treatment programs during the trial phase. The prison

service wishes to concentrate particularly on the re-integration of young and female offenders, emphasing prevention and reduction of drug use. There are two drug prevention centers in juvenile institutions and three prevention centers for females. Moreover, several programs for a larger number of prisoners will be launched soon.

As the work done by ENDIPP shows, effective harm reduction measures can be developed to tackle drug use in prison

Mr Petrétei concluded by noting that as the work of ENDIPP and its partners show, effective harm reduction measures can be developed to tackle the issue of drugs in prisons. The methods and experiences developed in other countries can be used in an efficient way through the cooperation of those involved in this work. The work and experiences shared through ENDIPP also clearly indicate that prevention and reduction of harm related to drug use is closely related to the prevention of infectious diseases.

The health of prisoners, potential conflicts with security requirements, and the role of independent monitoring in the process

Jonathan Beynon, International Committee of the Red Cross

The ICRC's approach to prison health issues focuses on establishing working relations with the ministries of justice and prison systems to build constructive dialogues towards resolution of problems. Other organizations are active in this field, such as NGOs, the Committee for the Prevention of Torture (which has the right of access to all places of detention, not just prisons but also psychiatric institutions, care homes for the elderly, centers for juveniles - with access

limited to member countries of the Council of Europe), the UN Special Rapporteur on Torture (who has the mandate to visit prisons around the world, specifically looking at issues of torture, including conditions of detention and ill treatment) the African Commission on Human and People's Rights Special Rapporteur on the Conditions of Prisons and so on. Moreover, under the UN Convention on Torture, an optional protocol is about to come into force (possibly in 2006) which will establish two broad visiting mechanisms: a country-based mechanism, that will empower national institution with the right to access to places of detention; and an international mechanism based in Geneva to mainly provide support and advice to national mechanisms.

The ICRC only visits places of detention in situations of armed conflict or internal disturbances, and is guided by the international humanitarian principles as applicable in situations of armed conflicts., Moreover, in situations where there are political disturbances without any armed conflict, the ICRC again can offer its services to 'political prisoners'. Finally, in both armed conflicts – international, non-international – and internal disturbances, the ICRC may also visit common law prisoners. Although the ICRC essentially concentrates on issues such as disappearances, torture and extra-judicial killings, the broader aims of the visits are to encourage the authorities to respect the moral and physical integrity of the prisoners and certain standards in the conditions of detention, including health. With regards to judicial guarantees, the ICRC monitors access to courts and lawyers and facilitates family links, particularly through the Red Cross Message Service – in essence a postal service routed through the ICRC and not through the normal postal service.
All the above scenarios fall within the objective of ensuring protection from ill-treatment, disappearance, torture and

killings. The modalities for the ICRC's visits - which include access to all the prisoners, access to all places of detention, the right to meet in private with the prisoner and to record his/her personal data (to allow continuous monitoring and follow-up in case of transfer, release etc), the possibility to repeat the visits - have all to be agreed with the state in advance. If breached in any way, the organization has the right to stop the visits.
Central to the work of ICRC is the rather debated concept of confidentiality, which ultimately allows the ICRC to gain access to places where other organizations simply are denied entry. Furthermore, the ICRC focuses on the principle of equivalence - where the equivalent is the healthcare in the surrounding community - and of equity - that is often prisoners have greater needs than other people in the community and hence may need more resources to deal with, for example HIV, TB and the like.

With regards to the issue of security, the underlying idea is that prisoners are sent to prisons *as* punishment, not *for* punishment. The punishment is the deprivation of freedom - not the poor conditions of detention. In countries of Latin America, South-East Asia, South Asia, Central Asia, Europe, nutrition in prison, for example, can be an issue because limited food may be available from the state to the prisons, and the prisoners may be dependant either on their families or on external organizations that provide them with food. The ICRC intervenes with feeding programs, support to the kitchens with food and kitchen material. The ICRC is also concerned with the conditions of work for the prison personnel. That is most evident in situations where tuberculosis is rampant. Prison staff is

Tackling problems like TB in prisons is clearly tackling problems of community health

exposed to it on a regular basis and often bring it out of the prison - to their families, to their community. Thus tackling problems like TB in prison is clearly tackling problems of community health. The ICRC sees an active role for health prisons staff in monitoring the actual conditions of the cells, the quality and quantity of the food, the amount and availability of water, the access to health and medication, and the quality, functioning and hygiene of the sanitary installations.
Still on security, the two extremes – overcrowding and isolation – both represent important issues. Overcrowding can derive from political decisions, such as criminal policies that increase the population of prisons, but also result from security problems, for example, a break-out can result in banning access to free-air. And related to overcrowding, further issues such as hygiene, sanitation etc, all contribute to providing a breeding ground for HIV and other infections. Isolation, on the other hand, can be a voluntary choice because of fear of reprisals from other prisoners, but also a punishment, which leads to a spectrum of physical and psychological problems ranging from simple restlessness to anxiety, to delusions, psychosis, and of course self-harm and perhaps suicide.

While the primary role of the ICRC is that of monitoring existing healthcare systems and making recommendations, the organization does monitor, advocate for and report on individual cases, in order to raise awareness of governments about particular situations, push for action in a non-confrontational way and assist individual prisoners, such as when access to specialists outside prison is needed, and/or when issues of discrimination (e.g. against foreigners) or security (for ex. against suspected terrorists) arise. In this latter cases, clashes can arise between security and medical priorities, particularly with regard to ‘dual loyalty’ – that is,

when a doctor, or any other health professional, has simultaneous obligations either expressed or implied towards a patient or a prisoner and towards a third party, which is usually the state.

The four pillars of ethical practice are: autonomy of the patient, confidentiality of the doctor-patient relationship, beneficence – that is to only act in the best interests of the patient - and non-malfeasance – that is to do no harm to the patient. These can however be sometimes influenced by obligations to the state, which can demand interference in a prisoner's access to healthcare, review of confidential medical records and medical information, impose segregation of HIV-positive prisoners etc.

In such cases, the ICRC sensitizes the authorities against such practices and about international standards and demands the cessation of such practices. It is clear that in some cases, obtaining a change of wrongful practices may require years.

Thursday 7th July 2005
15.30 – 17.15

Debate

Care and Control – two sides of the same coin, or two ends of a continuum?

Chair: David Rambsbotham (House of Lords – Former HM Chief Inspector of Prisons, UK)
Speakers: Alex Gatherer (WHO Health in Prison Project); Andreas Skulberg (Prison Service, Norway); Fabienne Hariga (Modus Vivendi, Belgium); John Podmore (HM Prison Service Brixton, UK); Paolo Pertica[1] (Blackpool Community Safety and Drug Partnership, UK)

The debate started with a brief introduction of the speakers, opening considerations and/or questions. *Fabienne Hariga,* felt that there is no competition between control and access to healthcare, and asked why what is possible within the community - in terms of prevention, harm reduction and different types of treatment - should not be possible within prison; *Andreas Skulberg* stated that it is important to bring public health thinking into the correctional services, because both are about intellectual, economic and moral poverty and thus good public health work is good work against poverty; *Alex Gatherer* acknowledged the crucial role played by last year's conference, by the Pompidou Group of the Council of Europe and by Cranstoun in the drafting of the "Status Paper on Prisons, Drugs and Harm Reduction", which has now been

[1] In place of Dasha Ocheret, unable to attend.

published, and highlighted that "The Lancet" devoted one of its lead articles to the Status Paper.

David Ramsbotham, shared his experience as former chief inspector for prisons in the UK, whose role is to monitor and influence the treatment and conditions of prisoners through regular inspections. These are followed by a report and set of recommendations, the implementation of which is consequently monitored. The philosophy adopted by David Ramsbotham is that prisons are an opportunity to provide help and appropriate assistance, to be identified through a need assessment of each and every individual and an examination of what prevents the person from living a useful and law-abiding life. Lack of education, lack of job skills, lack of what are often called "social skills", the ability to look after themselves, medical problems – both physical and mental – and substance abuse all rank highly. To implement appropriate responses, which were lacking at the time of his role as Chief Inspector, a 'healthy prison' model was devised based on three essential components - assessment, treatment and preparation for release. Fundamental aspects of a healthy prison were also identified. First of all, everyone – prisoners, prison staff, visitors etc – had to be and feel safe, because unless they were safe nothing could happen. Secondly, everyone had to be treated with respect, as a fellow human being. Under David Ramsbotham leadership, a report called 'Patient or prisoner?' was published recommending that the prison health service be made part of the national health service, so that exactly the same treatment would be available to people in prison and out of prison, which had previously being denied to them. Eight years later (in 2004) that has formally happened. Thus, there is now an opportunity to fully implement the principle of equivalence.

A key for success is the relationship between staff and prisoners, and an understanding by the prison staff of their twin tasks – namely that of keeping people securely and exercising control of the environment in which everyone has to feel safe, while recognizing that it is not their job to punish, but rather to provide 'duty of care'. Overall, and with regards to care and control, custody, care and justice may alternatively identify what lies behind this question.

Alex Gatherer stressed that the two elements – care and control - are obviously complementary and a healthy prison should have both in good balance. Within the WHO Health in Prisons Project, a consensus was reached on these. This consensus is articulated in the WHO HiPP "Prisons, Drugs and Society" which states that care, positive expectations and respect should be granted all prisoners', despite an insistence by many governments on the sole concept of security. Moreover, it must be born in mind that it is the public attitude on these issues that is really important, efforts should be made to enable the public to understand that these are complimentary aspects of an important public service.

Paolo Pertica supported the view that prisons and communities are inevitably interlinked and should be understood as 'one community'. On the issue of 'good care versus effective control', such expression seems to imply that it would be impossible to provide good care without compromising good control, or that it would be impossible to provide good care if there was effective control. On the contrary, however, it should be argued that good care will inevitably lead to better control. In this regard, it is important to remember that in England, most riots were started by prisoners not with the objective to escape, but to complain about the condition in which they were kept. Furthermore, and

in relation to control, the actual number of prisoners that require extensive control is generally minimal.

Andreas Skulberg stressed that a continuum, in mathematical theory, does not mean that the two ends extend endlessly, but on the contrary that they eventually meet. Hence, in the case of care and control, we may be talking around a circle. In the same way, a coin has actually three sides, the third being the rim. Hence, from a humanistic point of view, our continuum circle can be the rim. Therefore, it is not acceptable to believe that there shall be a conflict between care and control, although such can be experienced in real life. The key idea to obtain better care and control is through improved training of prison officers. It is important to individualize the needs and the risks for every prisoner and to analyze them, and security/control should not be any higher than it needs to be for any prisoner, because it would neither be just nor cost-effective.

In the case of care and control, we may be talking around a circle.

According to *John Podmore*, there are prison facilities across the world where there is control without care, and facilities where there is no control and no care. Many emanate from the 'economics of a madhouse', whereby it is assumed by some that large, cheap, overcrowded prisons will achieve something. In reality, true control can only come with care, in accordance to a concept known as 'dynamic security' whereby only caring environments can be safe, can be ordered, can be constructive and can be meaningful. Hence, care and control are inseparable.

Fabienne Hariga reiterated that there is not a competition between care and control. Examples from the implementation of peer harm reduction projects in Belgium or the evaluation

of needle exchange programs in Switzerland, show that pre-existing fears by guards and prison authorities before implementing these projects proved unnecessary and wrong, showing that there is no tension, no contradiction, and that it is possible to provide appropriate healthcare to detained persons with appropriate control measures.

The question of the compatibility between programs such as substitution treatment and/or needle exchange programs with security was raised. It was argued that one of the strengths of a Network such as ENDIPP is the sharing of different experiences which show that what is done in one country, can be done in another and can be learnt from. On the issue of substitution, while it has been argued that prison might be an opportunity, for many others it is a disaster, particularly if they are dependent on opiates. Substitution treatments should be available in the same way as they are outside prisons. Despite the principle of equivalence, in the UK there are needle exchange schemes in the community but no decent pilot scheme of needle exchange within prisons. In Norway, the basic rule is that prisoners have the same rights to healthcare in terms of prevention, diagnostics and treatment as everybody else; therefore, there are needle exchange programs in the general society and in prisons. After long discussions with the prison officers, it was realized that a clean syringe or a needle is a far less dangerous weapon than a HIV or Hepatitis infected syringe or needle. Substitution programs, which are also part of the ordinary treatment for drug users in Norway is also offered within the prisons.
On the question of security of needle exchange programmes in prisons, it is worth noting that razorblades, sharpened toothpicks, sharpened toilet-brush handles, boiling sugar and water, are other things that could potentially be used harmfully between prisoners or against staff. But any discussion about their removal is unrealistic and not even

considered. It follows that it is important to view things within their right context. A survey conducted in a number of countries, including Moldova, Spain, Belarus about needle exchange programs in prisons (over fifty prisons in these six countries) has shown thus far no conflict with security, and needles have never been used as weapons. With regard to substitution treatments, there is increasing evidence of their effectiveness from very good evaluations of such programs in prison systems, which show not only reduced sharing of injection equipment, reduced infections, but also increased security in prison, as prisoners previously dealing with very serious health problems have calmed down and have been able to participate in various programs. Prison staff themselves are very supportive of these.

Where healthcare standards are low, waiting to raise them in the community before they are raised in prison may not be the best approach…

Related to the principle of equivalence, it was noted that the standards are different in different countries Thus, in those countries where healthcare is particularly bad, should prison healthcare be equally bad? The answer may lie in prioritarization, where the most vulnerable, the most at risk, the most in need should get priority – and it so often happens that quite a number of these are be in places of detention. This may be a difficult political point to sustain, but the WHO Status Paper can be an excellent tool to support national arguments in this direction. Overall, where healthcare standards are low, waiting to raise them in the community before they are raised in prison may not necessarily be the best

There are a number of examples of good practices in different countries ready to be adopted by others.

approach. Good practices should be promoted within a country, both in the community and in prisons. At the same time, there are a number of examples of good practices in different countries ready to be adopted by others. Overall, it was pointed out that the concepts of prison health and public health should not be separated because the overall majority of people in detention today will eventually return to their communities. In the UK, e.g., the average length of time passing through prison is about twelve weeks.

From a different perspective, responsibility for healthcare should be that of the healthcare system, rather than the prison service. In many countries this is not the case and one of the most important messages to the public is that via transparency - care and responsibility can be improved because care should lie with the healthcare authorities, with law enforcement and the prison services having complementary responsibilities. Healthcare projects or programs can only be effective if they are implemented by people who actually wish to improve the health conditions of the detainees, and their independence (to be understood with particular reference to confidentiality) from the prison services should be guaranteed.
An interesting point was raised that in some countries, prisons may offer services that are less available in society, or services may be more advanced in prisons than they are in the community. For example, the fastest detox available in London is possibly inside Brixton Prison.

Still on the question of equivalence, it was noted that often the good work that is undertaken in prison is hindered by the return of the individual to his/her community of origin, where services may not be available because they do not exist, cannot be accessed because of discrimination or bias, or are not sought because of lack of information about their availability. Hence, an important question is how to ensure a

continuum of care, which should be complemented by assistance beyond health issues (for ex. housing, employment, education etc). Linked to this issue, is the question of continuum of health records, so that cures/treatments etc. administered to an individual while in prison should be recorded and available when the person is released. This would be highly beneficial and could be achieved through the setting up of one comprehensive information system.

It was noted that prison services targeting abstinence and relapse prevention, detox and rehabilitation can have negative consequences. Prison may not necessarily be the right setting for abstinence-based programs, especially when considering that in prisons there is lack of freedom of choice and people may be pressurized to take a very important life decision, such as to be abstinent. Overall, it was stated that different approaches work differently on different individuals and continuous creativity in design and delivery of services is indeed needed. Abstinence based programmes are often politically supported because they are 'sellable', and from a pure biological perspective, abstinence may be brilliant. But from a public health and practical perspective, it can be a very dangerous strategy if pursued alone. It should be available for those who choose it, although it should be born in mind that these programmes – as others – do stretch beyond the prison time and thus communities must be involved and able to provide assistance and services.

A point was raised on the role that prohibition policies play in maintaining the overall social and political construct, which encourages the use of prisons as a way of dealing with problems that are made outside prison, and which discriminates between type of drugs and ethnicity of drug users. It was stated that the whole question of control is related to the idea of drug prohibition, which has nothing to

do with the harmfulness of drugs and everything to do with the role of the state in controlling what people do and don't do. Hence, efforts should be devoted toward changing prohibition as the current prevailing international policy with pragmatic harm reduction, which should become the new leading international policy. Discussing the issue of legal versus illegal substances, it was pointed out that with harmful legal substances – such as alcohol and tobacco - the state response does not rest on punishment, stigmatization or deprivation of freedom. In the US, for example, major public education campaigns have been quite effective in reducing tobacco use amongst its citizens, and so have harm reduction strategies with respect to alcohol use (around drinking and driving).

If skills, knowledge and desire to care are among the fundamental elements that are necessary to ensure appropriate services in prisons, it follows that recruiting the right staff is a crucial step. Recruiting the right people, though, can be challenging because of the nature of certain marketing strategies and wide public perceptions associated with certain jobs. Hence, appropriate advertising strategies and right messages should be used. At the same time, it should also be remembered that recruiting people who care to work in prison but within regimes and requirements that don't require them to care, will likely mean losing them. The issue of ethics and values in healthcare is thus an important aspect of the overall discussion around cost-effectiveness, efficiency and effectiveness. Prison service should be recognized as a public service, with high standard in the quality of training and staff.

Prison service should be recognized as a public service, with high standard in the quality of training and staff

To conclude, it was felt that care and control are not in antithesis but are indeed interlinked and that working together - and not against each other - towards better and comprehensive services, equity and equivalence, more transparency and better quality of staff is absolutely crucial.

Friday 8th July 2005
09.30 – 10.45

Plenary session

Integrated approaches to providing services:

Looking at live examples of existing good practices

Chair: Steve Rossell (Cranstoun Drug Services, UK)
Speakers*:* Mike Stoney (Prison Service, Scotland, UK); Alfred Steinacher (Prison Service, Austria); Francesco Scopelliti (Health Service, Milan, Italy)

Mike Stoney presented an overview of the new computerized integrated case management system that is being introduced in the Scottish Prison Service. The system will rationalize information and data gathering and access, store comprehensive information on individual prisoners and their health history, and reduce bureaucracy in favor of improved service delivery. *Alfred Steinacher* offered a virtual tour of the prison service and of services available, which include abstinence therapy, drug-free units, substitution treatment and aftercare. *Francesco Scopelliti* presented an overview of the 'Dap-prima' project that is currently being piloted in five pilot cities in Italy.

Prior to illustrating the new system, *Mike Stoney* presented some data and information on the Scottish prisons. In 2004 the average daily prison population in Scotland comprised 6805 individuals; average daily remand population was 1253; long term population (four years and over) was 2637; and short-term population was 2814. 50% of the population usually return to prison within two years, with males being more likely than females to return (50% compared to 47%). Half do

so within 6 months of release and three-quarters within 12 months. Young offenders are far more likely to return than adults.

As a response to the increase in reconviction rates, in March 2005 the Scottish Parliament introduced the Management of Offenders Bill. The primary objective of this Bill is to improve the management of offenders through greater integration of activities within the criminal justice cycle and to reduce levels of re-offending. Among the actions to meet the objectives of the Bill, the Scottish Prison Service is developing an integrated case management and information-sharing system. The system will collect all pre-custody information and develop single entry and exit procedures for all prisoners (all sentence lengths). Improved planning will bring a number of indirect benefits, including saving of resources that could be re-allocated to interventions both inside and outside prisons, particularly in the area of aftercare as community resources are generally scarce.

The new system will focus on four main areas of offenders' development, namely health, life, work and leisure and will aim to integrate these into a holistic approach linking these areas together. This will mean that issues such as diet and nutrition, managing illness, addictions interventions, and broader health awareness, including basic health services access in the community, will all become part of the new management system. Moreover, support to establish stable lifestyles, budgetary control, improved relationships, positive social networks and behavioral change, basic education, IT support, employability preparation and

It is not always a question of 'what is being done' but 'how it is being done'

improvement of literacy levels will all be included in the system.
As far as leisure is concerned, the Prison Service intends to develop positive social networks and build self-esteem by using the facilities available in the prison, and introduce people either to new interests or enhance interests they already have and ensure they are continued in the community.

In a snapshot, the idea is to implement a holistic approach that links services together and ensures that proper planning is in place.

With regard to the integrated case management model, every prisoner will be assessed on admission using a core screening tool. There are presently a number of assessments undertaken on every individual, but information is often not even passed internally between agencies. With the new system, in each prison there will be mobile laptops and wireless access points, where inputs can be automatically uploaded into the main database. This will enable instant inclusion of information and instant access through electronic sharing, hence planning-time will be significantly reduced.
An annual single action plan will be developed, where every member of staff will be involved in delivering care in a sequence of interventions. An important component of this new approach is that every prisoner will leave the prison with his own community integration plan.

Overall, the new IT-based system aims at reducing bureaucracy progressively – through the reduction of paper-based files and replacement with a comprehensive and standardized computerized database system that contains information on all prisoners' records. A shadow database will be made available to external and internal agencies and will allow them to have direct access to the same information

(with the prisoners consent). Moreover, information will be kept over time, to ensure full records of everything that has happened to the person while in custody, including behavior and responses.

Through a virtual tour of the Austrian Prison Service, *Alfred Steinacher* presented the services on offer in Austria. Therapy is available in one institution in Vienna, mainly based on group therapy, with a capacity of approx 120 spaces. Primarily abstinence-oriented, it provides opportunities to learn how to handle drug addiction, also after release, and offers training on everyday life. It is important to note that since 1998, it is legally possible to join the therapy offered rather than undergo imprisonment (for drug users sentenced to up to three years).

Drug free units started in Austrian prisons in 1995. Treatment is not offered here as the decision to enter a drug free unit (through the signing of a contract) with voluntary drug testing and urine testing is seen as an act of self-responsibility. Substitution treatments have been on offer for twenty years now and there are no longer issues or resistance against them. Substitution treatments are used to treat severely opiate-dependent inmates to stabilize them emotionally, minimize drug related crime and reduce intravenous consumption within the venue. Long-term substitution treatments (for long-term sentenced prisoners) with methadone, buprenorphine, or retarded morphine are offered for several years or even for a lifetime. Controlling measures are set by the authorities, and there is care and support through psychologists and others. Prior to the introduction of aftercare, it was generally believed that prisons were responsible for prisoners only until they were inside the establishments. However, a few years ago, it became clear that it was necessary to continue the delivery of care beyond the incarceration time and to establish links with

external agencies to ensure that. Hence, the probation service and outside treatment providers were contacted and are now involved in providing aftercare.

Aftercare starts already within the prison before the prisoner is released, either by allowing external therapists into the prison, or by granting day-leave to attend therapy if the prisoner can be trusted. It is interesting to note that to overcome the problem of limited community resources, some private agencies have been set up with funds from the prison and community services. These provide housing, therapy, social support in getting back into everyday life and more.

Francesco Scopelliti, opened his intervention by remembering the exceptional contribution of Dario Foà, who was tragically killed in February 2005 and commemorated his commitment and devotion to work with the vulnerable and unprivileged. Dario Foa was an exceptional person and his vision, contributions and joyous personality will be missed.

For over twenty years the Health Service of Milan has been in charge of the treatment of problematic drug users inside prisons. A pilot project has been set up for non-violent sentenced drug users which allows them to choose to undertake treatment rather than going to prison. A specific centre has been set up for this purpose, and within it treatment plans are formulated. Prior to entering these services, the person is interviewed to assess his/her drug using habits, and to record whether he/she is already undertaking treatment. If so, he/she may be referred to the location of his/her treatment programme. The interview results are reported to the judge, who has the power to authorize the start or continuation of treatment (under the supervision of a 'tutor') and the granting of additional benefits, such as for ex. house arrest.

The judge is periodically informed about the treatment program (attendance, response, results etc). On average, 1600 individuals are approached in court annually. Among them, one-quarter may declare they are problematic drug user and are interviewed by health workers. Of these, approx. 300 are granted authorization to enter treatment programmes. In 2004, this system was accredited by the Justice Department.
The "DAP-Prima" project is funded by the European Social Fund and will last two years. The Health Authority of Milan is in charge of the training of workers, judges, police officers and other professionals in selected cities. It is also in charge of overall supervision and of facilitating cooperation among the different sectors involved.
In two of the four selected cities, the project is fully operational. Overall, judges are rather supportive of the programme, as it is perceived as an additional instrument at their disposal to be used at their discretion. Law enforcement is also increasingly supportive, and health workers are seeing direct benefits. With regard to monitoring, unfortunately it is only carried out for a period of three months from the exit of the programme. It was noted that longer term monitoring should be considered as it would provide a politically effective advocacy tool.

The project confirmed that the option to transform a negative event, such as committing a crime and being arrested, into a chance for a positive change - such as entering treatment - exists. Moreover, it creates a new experience that represents not only punishment but care and treatment and that will most likely positively influence future perceptions and relations with the institutions.

It creates a new experience that will positively influence future perceptions of, and relations with the institutions

Friday 8th July 2005
Workshop Session

Harm Reduction: what determines good policies and effective practices in prison?

Chair: Matt Curtis (OSI, IHRD Programme, US)
Speakers: Ralf Jürgens (Consultant), Heino Stöver (University of Bremen, Germany); Larisa Pintilei (Innovating Projects in Prison, Moldova); Murat Akhmetov (GUIN, Kazakhstan); Natalia Vezhnina (AFEW, Russia); Holly Catania (International Centre for the Advancement of Addiction Treatment, US).

The workshop reviewed practices in European prisons, examined evidences around prison-based syringe exchange programmes, methadone and other forms of substitution therapy, and looked at practical examples of such programmes at work in different countries – both from a political and practical point of view.

Heino Stöver provided an overview of harm reduction interventions in European prisons partly drawn on the results of research studies carried out within the ENDIPP framework. In many prisons in Europe, access to healthcare is very limited, and the healthcare itself is often poor and patchy. When comparing the prevalence of illnesses and diseases in prisons with prevalence of the same in the community, it clearly appears that mental illness is two to four times higher in prisons, suicide rates are up to five times higher, the spread of infectious diseases such as HIV/AIDS is twenty time higher, and Hepatitis C one hundred times higher than in the community. Nearly 10% of all HIV infections result from

shared needles, and substance dependence is on a phenomenon which is more widespread in prison than in the community. Between 30% and 50% of people incarcerated continue their drug use in prisons, while about 5% to 10% (and one English study even talks about 20 to 24%) start injecting while behind bars. In terms of prevalence, drug and alcohol use in prison is considerably higher - around 40% - than in the general society, and so are additional risks of contracting illness such as TB and STIs. Although less discussed, there is also alarming evidence of high risk of relapse and overdose after release.

A study carried out by the European Monitoring Center on Drugs and Drugs Addiction on the prevalence of drug use, drug using patterns and prevention and treatment responses, found that:

- between 15% - 50% of the total prison population is a problematic drug user
- the average annual turnover ratio in prison system is around 3.5, hence a lot of people go out from the system annually;
- many experience 'hygiene relapses' with negative immediate consequence on the spread of infections among inmates and prison staff.

With regard to responses to these challenges, and despite many national and international documents establishing the principle of equivalence, and stressing that prison health is public health, prison prevention programmes are often only abstinence oriented. Conversely, harm reduction in the community is acknowledged Europe-wide in nearly all of the 25 EU member states.

There are three important international instruments worth noting with regards to harm reduction in prisons: the WHO

Paper on Prison, Drugs and Harm Reduction; the Recommendation of the Prevention and Reduction of Drug-Related Harm of the EU Council; and, very important, the WHO Moscow Declaration. These guiding documents all support the implementation of harm reduction strategies in prisons. There is also an overall consensus that the time of imprisonment should be used to offer harm reduction measures, improve knowledge, and provide access to services. However, there are a number of obstacles preventing the full application of the principles contained in these documents, ranging from ideal aims of drug-free prisons to the denial of the existence of a drug problem in prison settings, to the illusion that drugs and communicable diseases can be easily controlled.

With regard to substitution treatments in European prisons, according to the ENDIPP study (the "STEP" research) conducted in eighteen European countries, evidence shows that: they can cause reduction of drug use and related risk behavior, particularly with regard to sharing needles and equipment, and morbidity; that they bring physical and psychological beneficial effects; and there are positive indicators on outcomes, including after release. At the moment there are more than half a million methadone patients in the community in the 25 member states and it is a question of time before methadone will be consistently available within prisons as well.

Prisoners are the community, they come from the community and they return to it. Protection of prisoners is protection of our communities

Currently, the high variety but also high inconsistency of treatments in prison represents a significant problem. Detox programmes can differ even within the same prison setting. Maintenance programmes are also very different, and their

length can vary from six months maximum to lifelong. Relapse prevention is done only in a few countries. One basic obstacle to a standardized substitution treatment is therapeutical freedom, which leads to practices that differ from prison to prison, and even from one prison doctor to another, within the same prison. These can lead to discontinuation of treatment, inadequate dosages and/or different medications than those previously taken, and to poor and patchy coverage and assistance.

Among the eighteen European countries analyzed through the STEP research, three countries provide no substitution treatment at all. some provide substitution treatment to problematic drug users.. Only one country, Spain, provides substitution treatment to 21,000 of the estimated 26,000 problematic drug users. While all in all, the average European coverage rate is 25%, without Spain, the coverage rate is only 7%. That means that only 7% of all problematic drug users in European prisons receive methadone or any other therapeutic substitution agent. There are different reasons for this. They range from prisoners choosing not to access substitution treatment; to the lack of developed treatment modalities in prison setting; to skepticism from doctors and medical teams; to limited availability of psychosocial care or access which can be restricted to target group like pregnant women, HIV infected prisoners; to lack of personnel to supervise the intake (particularly with regards to Buprenorphin); to political climates against substitution treatment in some countries. Furthermore, prisons are generally drug-free oriented, and there is the perception that methadone is a psychoactive street drug, not a therapeutic drug. Fabienne Hariga added that in some Belgian prisons further obstacles lie in the fact that often prisoners who are under substitution treatment are not allowed to work, to have visits and to enjoy other ‘advantages’ that are offered to others in prison. Moreover, medical doctors are

often afraid to prescribe methadone, because e.g. in the case of an overdose, they could be sued in courts.

When interviewed within the context of the STEP research, prisoners expressed dissatisfaction on several issues. First of all, the decision on 'who, where and how' to get methadone was seen as non-transparent and arbitrary and lack of choice with regard to substitution drugs was also generally felt. Detox programmes were implemented too quickly and not adjusted to the resources and the care capacities of the individual prisoners. Overall substitution was perceived as a reward for good conduct rather than an everyday medical intervention. A large number reported the 'yo-yo' effect – namely going from detox in prison to immediate relapse upon release - or entering into methadone programmes after release and then facing withdrawal once they returned to prison. Prisoners also reported being left alone, breach of confidentiality and anonymity, lack of psychosocial care, lack of clear information, a love-hate relationship with methadone, and the missing of links between prison and community. In some cases, prisoners on methadone were treated as a special and discriminated group.

Models of good practice should include: close cooperation between community medical services and prison medical services; training course on addiction and medicine (particularly therapeutic agents) for doctors working in prisons and nurses; staff information on the impact of substitution treatment; acknowledgement and involvement of patients and their needs and resources in designing and setting up substitution treatments; even and homogeneous availability of services; genuine implementation of laws and regulation; clear protocols and standards of clinical management of substitution treatment programmes oriented towards

individual patients needs; quality assurance; and, more broadly, health intervention in prisons.

Ralf Jürgens provided an overview of the Canadian HIV/AIDS Legal Network study on 'Harm Reduction in Prisons and Jails: International experience' which resulted from a thorough study of evidence on needle and syringe exchange and substitution treatment programs in prisons worldwide. A report on prison needle exchange has been produced with information about HIV/AIDS, Hepatitis C and injection drug use in prisons worldwide; relevant international and national laws; the experience of Moldova, Switzerland, Germany, Spain, Kyrgyzstan and Belarus, which have all introduced needle exchange in prisons, and what this means in terms of implementation of such programs in other countries.

The study shows that world-wide rates of HIV and Hepatitis C in prisoner populations are much higher than in the general population. World-wide also, illicit drugs are available in prison despite the sustained efforts of the prison systems to prevent drugs from coming into these institutions. People who use drugs prior to imprisonment often find a way to continue that drug use whilst they are in prison. Moreover a significant percentage of prisoners start using drugs in prisons and often start injecting. For these people, imprisonment increases the risk of contracting HIV and Hepatitis C. There have been a number of outbreaks of HIV infection in prisons as documented in Lithuania, Scotland, Australia and Russia. Proven measures such as needle exchange and substitution therapy can prevent further spread of HIV in prisons and, ultimately – to the public.

The first country to introduce prison needle exchange was Switzerland in 1992, thanks to a physician working in a prison who felt that he had an obligation to make needles available to

the prisoners. The programme has been in existence ever since. Other countries in which programs are implemented are Germany, Spain, Moldova, Kyrgyzstan, Iran, Norway and Belarus. A number of countries such as Ukraine have recently announced that they will also start prison needle exchange programs.

The prison systems where infections are prevented make them a healthier and safer environment for staff to work in, and ultimately it benefits the public

The review of the prison needle exchange programs in the six countries has shown that these programs can and do work in both well funded prison systems and in severely under-funded prison systems; in civilian prisons systems as well as in military prison systems; and in institutions with drastically different physical arrangements for the housing of prisoners – single cells to barracks with eighty to one hundred prisoners in one location. Needle exchange programs are operating in institutions for both men and women and also in prisons of all security classifications and all sizes.

A number of different methods are used to make needles available. In some prisons, needles are being handed out hand-to-hand by nurses or physicians; in others they are distributed one for one by automatic syringe dispensing machines; or they are made available by prisoners, who are trained as peer outreach workers. In others, external NGOs, already working in prisons and trusted by the prisoners, and/or health officials from outside, can enter the prison for the purpose of making needles available to prisoners.

The evaluation of needle exchange programs that have been undertaken in Switzerland, Germany and Spain have all

shown consistently positive results for the health of prisoners. They have shown that syringe sharing was strongly reduced in those prisons in which exchange programs were available. Moreover, in the five prisons where evaluation included blood testing, no new cases of HIV or Hepatitis C infections were detected. A decrease in fatal and non-fatal heroin overdoses was also observed. There was also a decrease in abscesses and other injection related infections. Moreover, it was noted that prison needle exchange actually facilitated referral to treatment programs. Very importantly, there was no negative impact on the safety and security in any of the prisons. Needles have never been used as a weapon in any of the prisons in which needle exchange programs have been established and there has been no reported increase in drug use and injecting, which is consistent with the evaluations of prison needle exchange programs outside. Support from the prison administration and staff has been crucial. In these prisons, .prisoners and staff state that these programs have increased their safety. Overall, needle exchange programs have proved to be safe in every jurisdiction in which they have been introduced. The evaluations have shown positive health effects and no increase in drug use, and hence it can be concluded that there remain no valid reasons not to introduce at least pilot projects (if not full scale programs) of needle exchange programs in other countries.

Prisoners and staff state that needle exchange programs have increased their safety

With regard to substitution therapy, community substitution treatment programs have expanded massively over the last ten years for a variety of reasons:

- there is overwhelming scientific evidence of the benefits of substitution therapy;

- substitution therapy is one of the best weapons in the fight against HIV, as substitution is a prevention measure - not just a drug treatment measure;
- there is scientific evidence that it reduces high risk injecting behavior and the risk of HIV and it is the most effective treatment available for heroin-dependent injecting drug users in terms of reducing mortality, heroin consumption and criminality; and
- it attracts and retains more heroin injectors than any other form of treatment.

The arguments for providing access to substitution therapy in prison are therefore compelling.

Evaluations of existing prison-based substitution therapy programs have been highly and consistently favorable and prison systems have been able to devise rules that have prevented the establishment of a black market for substitution therapy in prisons. Finally, it is important to bear in mind that any measures such as substitution therapy and prison needle exchange programs that are undertaken to prevent the spread of HIV in prisons benefit not just prisoners, but also benefit staff. Because of the rapidity of the spread of HIV in many countries and prison systems, postponing the introduction of these programmes is not an option.

In this regard, it was noted from the floor that eligibility criteria for substitution treatment should not be too strict – e.g. requiring several years of heroin addiction, or a certain minimum age – as to cause opportunities for prevention and treatment to be missed. The same is true for governments' regulations on substitution treatment. These should not be restrictive to the point that treatment programs cannot grow from small pilot projects to programmes serving all the people who need and want them

It was further noted that each prison is different and thus different approaches are needed. What works best is that each prison devises its own methods. For example, in Switzerland, machines were initially installed but it became clear that in some prisons there was just too much violence. Also some prisoners who were really opposed destroyed the machines regularly. Thus, a new system was introduced in which needles were given out by healthcare staff. In resource-poor prison settings, on the other hand, peer outreach has worked very well. With regard to cost effectiveness, when asked about it, the management of one prison stated that 'we didn't undertake a cost-effectiveness study, because we simply know that this is cost effective. It is sufficient to take the abscesses into account that we don't have to deal with in terms of healthcare anymore.'

We didn't undertake a cost-effectiveness study, because we simply know that this is cost effective. It is sufficient to take the abscesses into account that we don't have to deal with at healthcare anymore.

Overall, costs are different as for example machines are quite expensive, while educating peers about how to do this is very inexpensive. However, the biggest costs to date have really been related to the evaluations undertaken at the start of the programs by some countries, rather than the actual running of the programs.

Moldova, along with Kyrgyzstan, has been a huge pioneer in developing harm reduction services in the former Soviet Union. *Larisa Pintilei* discussed the harm reduction programs that are being implemented in Moldova. In the early stages, there was resistance from authorities to the introduction of harm reduction services in prisons as there was denial over the

existence of drug use there. Therefore, some monitoring of the situation in selected prisons was carried out and the report, sent to the government, showed the existence of a drug use problem in prison and related spread of infections and complications. It was found, for example, that in some cases glass was used as a base material to produce drugs. In the face of this, harm reduction interventions were approved by the Government in five prisons (two others are in pipeline). It transpired that needle exchange services, particularly from an economic point of view, were good because they were cheap and hence the most cost-effective method in order to prevent the spreading of HIV infection.

Currently, the harm reduction program targets 10,800 prisoners and 2,800 staff working in the system. In the needle exchange stations, access is voluntary and confidentiality applies. The stations work 24 hours a day. There are prisoners whom have been trained and, in addition to distributing information, they also distribute condoms, are involved in training projects, and also exchange used needles for sterile ones. Condoms, disinfectants, bleach are all available.
The result of a monitoring research project show that 21% reported not having shared needles for the past two months and only 4% reported that they continued sharing.
The pilot needle and syringe exchange programmes were introduced in 2000; in all of the 18 prisons 24.000 condoms were handed out, with an increase of 11,000 in the year 2004. Similar results can be observed with regards to the prison needle exchange programs. In 2004, 3,650 needles were exchanged. In 2001 and 2002 the needle exchange ratio grew by 50% in one institute; in another the increase was three-fold and reached a level of 37,000.

One of the most important components of the Moldavian work is information support. Different leaflets and publications are

distributed, including books and instructions and professional literature. In every prison, trainings and seminars have been organized. Presentations on HIV infections and AIDS as well as Hepatitis C have also been delivered, together with sessions on different risks involved with drug use. Psychological rehabilitation has also been introduced, in recognition of drug users as human beings with particular psychological conditions.

In April 2005, an Hepatitis C assessment on 200 prisoners was implemented in the prisons where needle exchange programmes were running and it revealed that in 64% of the cases, in addition to being HIV positive, prisoners were also positive to Hepatitis C. With the assistance of statistical data from WHO, the Innovating Prison Project has developed a program of healthcare, which includes medical care to be provided to HIV positive prisoners, and voluntary testing for Hepatitis C. A number of surveys and evaluations with regard to this particular area have been undertaken. As economics plays a significant role in determining what is done, a number of prisoners work as volunteers in prisons, including HIV positive prisoners themselves, for example in data collection, both thorough questionnaires and interviews.
With regard to inter-institution mobility, for example from low security facilities to high or medium security facilities, this creates problems as programs cannot be introduced overnight in all prisons. An amendment to the penal code on extending these programs came into force on 1st June this year and according to it, there is now an opportunity of handing over packages to the prisoners unlimitedly. On access to anti-retroviral treatment in prisons, in Moldova this is currently available for 18 people, and thirty more will be soon added. Overall, from a human rights perspective there are worries that in some countries prisoners are simply not on the radar screen and, while there are efforts made to scale up access to

treatment, the prison system is not part of the picture. This is felt particularly when receiving assistance from the Global Fund (GFTAM) which has no prison-specific components.
The reverse has also happened. That is, in a number of countries prisons are seen as an easy setting for scaling-up with captive populations, where one can quite easily ensure compliance with treatment and where the prison system has hand picked certain prisoners for treatment access. This also raises important human rights issues. From a public health perspective, continuity of treatment is a fundamental issue, particularly in countries where the HIV epidemic is driven by injecting drug use. A large portion of people who will be on anti-retroviral drugs may enter prison at one point, hence the issue of continuity of treatment upon arrest, incarceration and release is key.

Péter Sárosi, of the Hungarian Civil Liberties Union spoke about the challenges which the Hungarian Prison System faces and the drug problems in prison.
According to the latest Hungarian national survey, published by the government in 2005, more than 11% of the adult population has used some kind of illicit drug at some stage in life.
The most popular drug is cannabis. The estimated number of IDU's is around 10, 000 to 15,000 people and most of them are concentrated around big towns, especially Budapest. As it is often the case, low prevalence data might not reflect actual figures but rather limited, partial and/or poor surveillance systems, such as in the case of Russia. According to WHO, there are between 2,000 and 3,000 people living with HIV/AIDS in Hungary. Officially there are no registered cases of IDUs living with HIV/AIDS, because there is no national survey on the prevalence of HIV/AIDS among IDU. However, research on prevalence of HCV indicates prevalence rates of more than 30%.

Drug-related crime is also on rise in Hungary. In the last seven years there has been an eleven-fold increase in drug-related cases and in 2004 there were almost 5, 000 people arrested for use of illicit drugs. Of these more than 80% were arrested because of simple possession. In 2003 there was a legislative reform in Hungarian Drug Policy, which introduced a system of alternative treatment to imprisonment, so that the person caught using a small amount of an illicit drug can be referred to a six months treatment or prevention course instead of being imprisoned.

With regard to drug use in prisons, there are several risk factors in Hungarian prison, such as, overcrowded cells, lack of access to clean needles and methadone maintenance treatment, limited access to condoms and lack of confidentiality of the HIV/AIDS testing system. Despite international recommendations and the 2000 National Drug Strategy, which contains clear recommendations on harm reduction, the service coverage is very low.
Out of estimated 10,000-15,000 intravenous drug users in Hungary, less than 400 receive methadone treatment and the same can be said of the needle exchange programs. After the 2003 political reform, the prison administration established fourteen new drug-free units, called prevention units and modeled after the Dutch drug-free units, which stipulate that people who enter these drug-free units should sign a contract that they will abstain from drugs for six months. The common form of treatment in these units is abstinence.

NGOs are not really involved in prevention and treatment in Hungarian prisons, and there is clearly a need to involve more NGOs in prison treatment and screening.
The HIV/AIDS and Hepatitis C screening system was mandatory before 2003, so all prisoners who entered prison were tested for HIV on a compulsory basis. After 2003,

voluntary and anonymous HIV screening in the prison system was introduced but it resulted in a dramatic decrease in the number of prisoners who applied for testing, possibly because of low motivation and lack of confidentiality. Moreover, HIV screening is only available for blood donors in prisons. All prisoners tested positive for HIV/AIDS are sent to a special unit which is a segregated wing in a prison hospital. The HCLU has recently submitted a proposal to the constitutional court to investigate the practice of segregation of people with HIV, because it is believed that this provision is unconstitutional.

There is the crucial need for a stronger political commitment to implement international recommendations and effective HIV prevention in prisons

There is a need for closer cooperation between professionals and NGOs and the prison administration, in order to implement diversified treatment services in Hungarian prisons. Furthermore, there is the crucial need for a stronger political commitment from the government to implement international recommendations and effective HIV prevention in prisons, which appears to be currently weak.

Replacing *Parviz Afshar,* Director of Medical Services for the Iranian Prison Organization, who was unable to attend the Conference, Edoardo Spacca provided an overview of the situation in Iran on the basis of Parviz Afshar's notes.
Imprisonment is one of the most harmful events that can happen to a human being and the first priority, even before talking about harm reduction, should be to reduce incarceration levels, especially in a country like Iran where overcrowding is a serious problem.

Throughout history, from the time of the Prophet Muhammad, there were no prisons. People were given punishments but they were not incarcerated, and it is only in the last centuries that prisons were actually built in Iran to control those individuals for which punishment was not enough.

A few years ago, the Minister of Justice, a religious leader in Iran, identified as a priority the need to search for alternatives to imprisonment and reduce incarceration rates.
In Iran, legislation pertaining to drugs is very repressive; however a new draft, supported by the majority of the Parliament, is being prepared to review present drugs law. Drug use is a crime, possession for personal use is also a crime, and trafficking is punished by death penalty. Nonetheless, there is a very large political movement inside the parliament – hence not just coming from the society - and the new draft law aiming at decriminalizing drug use and possession for personal use is well supported. In the last few years, the use of parole for prisoners has increased, as well as the use of pardons on the occasion of religious and state celebrations.
Restorative justice and victim-offender mediation, which is called 'satisfaction', is also widely applied. Essentially the prison authorities, in cooperation with judicial authorities, organize meetings between victim and offender. If the victim or the family of the victim accepts some form of compensation – often a financial one - the offender is released and is free. Due to these new provisions, in the last four years the overall prison population in Iran has been significantly reduced.

With regard to the specific issue of drugs and prisons, the authorities recognize this problem, as well as the difficulties of stopping drug use in overcrowded conditions where drugs cannot be prevented from entering and are widely available.

Bad actions are better than worse actions

Authorities were able to use the religion of Islam to advocate successfully for harm reduction in the country. Two rules in the Koran in particular are supportive of a pragmatic approach to drug use in prison. According to the first one, a person should not be in harm and should not make harm to others; the second one is that bad actions are actually better than worse actions.

The Iranian religious leaders have acknowledged that these rules are simply telling professionals to implement harm reduction interventions because between the spread of infections and the use of drugs, it is better to prevent the worse of the two, which is the spread of the infections. With regard to data from the prisons, there are over 200 prisons all across the country; the incarceration rate is still quite high (210 for 100.000 inhabitants); there is a very high turnover ratio; and in an average year the number of people entering prison is between 600.000 and 700.000. However, because of the extensive use of restorative justice and victim-offender mediation, the prison population ratio is falling now.

Thanks to restorative justice measures, the overall prison population in Iran has decreased from 170.000 to 130.000

On average, almost half of the offences are drug-related. With regard to prevalence of drug use, little research has been implemented. In those areas that have been studied, up to 30% of prisoners were found to be using drugs.

In terms of responses, the Triangular Clinics model was introduced in 2002. WHO has identified this model as one of its best practices. The Triangular Clinics specialize in HIV, sexually transmitted infections and drug treatment. Services

include prevention and support, treatment and harm reduction. A very intense HIV/AIDS education is provided to the staff through a number of trainings across the country. Currently there are 44 Triangular Clinics. The goal is to introduce them in 80 prisons. Within the triangular clinics, voluntary counseling and testing is carried out confidentially and results are not disclosed to prisons authorities. In terms of STIs, the Triangular Clinics provide information on safe sex practices.
Through the Triangular Clinics, prisoners are referred to other services inside the prison establishment, which include detoxification facilities and drug treatment including individual and group psychotherapy especially for medium and long term prisoners. A methadone maintenance therapy was also started three years ago. At present there are 1,400 prisoners on MMT, but this number will be increased to 6,000 prisoners by the end of 2005. It is worth noting that methadone is also available in community centers in Iran, but waiting lists are often significant and cannot cover the needs of released prisoners. Thus, prisons are working also as a community service, because prisoners that have started MMT in prison can come back to prison on a daily basis to get methadone. Disposable blades and bleach are also distributed, and information is given on how to use bleach to clean needles. A needle exchange program is being introduced as a pilot by the end of the year in four sites in four different regions throughout the country.
All prisoners in Iran have the right to see their wives once a month and private meeting rooms are available for this purpose. Prisoners can stay in these meeting rooms up to 48 hours and they contain a number of items, including condoms, which can eventually be brought back into the prison and distributed further.

To conclude, health is a human right, and prisoners too must enjoy this right. The principle of equivalence should be a

given. Within the Ministry of Health, dedicated and well funded offices for the healthcare of closed settings should be established. Infection services should be integrated into the prison healthcare services. The Triangular Clinics model should be expanded. Finally local networks of professionals working with drug use in prison and those working in the community play essential roles and must therefore be created and/or strengthened.

Murat Akhmetov provided an overview of the situation in Kazakhstan. There has been a steady decrease in the prison population in Kazakhstan. In 1998 the President of the Republic adopted a resolution on the implementation of measures to examine the general health condition of the population in Kazakhstan and on the launching of a fight against tuberculosis through the DOTS strategy. Since 1999 this strategy was implemented throughout the entire country and there are now fewer reported cases of illness, a ten-fold decrease in mortality rates and an overall improvement of the situation. In spite of this, however, infection rates are much higher in the prison population than in the general population and in 2001, the number of HIV positive people suddenly increased.

With regard to HIV and AIDS, an information campaign targeting the wider public was launched against the widespread belief that drug users are all HIV positive.

Prisoners themselves have been involved in the fight against HIV/AIDS

Fighting AIDS is an important topic and prisoners themselves have been involved in this fight. They produce articles and write articles in newsletters. Competitions with prizes are also organized. Seminars and presentations to prison staff on appropriate behavior and

responses are also being conducted. Because of the implementation of significant measures by the government, including the distribution of information and the provision of access to protection instruments, the situation has radically changed in Kazakhstan.
Since 2002 there is mandatory HIV testing, to be conducted with the consent of the prisoners. There is currently no access to ARV. However, financial assistance has been received and, in cooperation with the Anti-AIDS Center under the auspices of Ministry of Healthcare, ARV will be introduced.

Epidemiological monitoring to analyze the effectiveness of prevention programs is in place. For example, in 2004 nine regional committees were set up and through their monitoring of existing projects, it appears that most prisoners do have access to condoms and disinfection instruments and most of the inmates do receive information on prevention.
A combination of strategies, policies and central co-ordination, scientific research projects and prevention programs have all contributed to the success of actions in Kazakhstan. There remains the need to expand the actions not only to control HIV but also the spread of tuberculosis.

Holly Catania, project director of the International Center for Advancement of Addiction Treatment, within the Chemical Dependency Institute of the Beth Israel Hospital in New York City, highlighted that Beth Israel in New York runs one of the oldest methadone programs in the world, with about 6,000 patients being treated. Despite more than 40 years -history of methadone treatment, there are not - with the exception of this program - methadone maintenance treatment programs in any state or federal prison.

Puerto Rico is a territory of the United States with a very big heroin addiction problem, high unemployment and the highest

HIV rate in the country. In 2001, the governor of Puerto Rico established the first drug control office, which is a coordinating body of different government agencies that are involved in healthcare, criminal justice, law enforcement, vocational education and other welfare agencies on the island. In the summer of 2001, the office issued a comprehensive plan that included a call for substance abuse treatment for inmates in the island's prison. It should be noted that there are about 50 prisons for a population of four million and the incarceration rate is very high. However, instead of a mere criminal justice response to the problem of drug use, the need to treat people who are using drugs was recognized - including the need to address this problem within prisons, where a significant risk factor is the drug trade controlled by organized groups. An in-prison methadone maintenance treatment program was introduced and a protocol drafted with the cooperation of five different government agencies - namely health, corrections, vocational rehabilitation, mental health and anti-addiction services – which are now responsible for treatment services in Puerto Rico. An agreement with the United States federal government agencies – the Drug Enforcement Administration and the Substance Abuse and Mental Health Administration who control any drug treatment within the United States – was needed. It was agreed that a pilot project serving 24 inmates at a time, would precede. It was decided that in order to control the possible diversion of methadone, prisoners participating to the pilot would be separated from the rest of the population. There was a lot of fear among the corrections administration that if methadone was introduced into the prison, it would leak

Instead of a mere criminal justice response to the problem of drug use, the need to treat people who are using drugs was recognized

out into the general population as there would be a black market for it.
In order to be selected for the pilot, prisoners had to have a history of heroin abuse (no specific amount of time) and urine tests had to show the presence of heroin used within two years from the end of their sentence. The average participants' length of sentence was 19.4 years, and some were up for release. The main idea was that this program would help the transition to treatment programs outside prisons.

It should be noted that this approach is unique in the United States. It does exist at a micro scale level in prisons in New York, but it is a short term facility. The programme was evaluated in 2003, which was a bit early as none of the prisoners who were participating in the program had yet been released. Hence it became more of a process evaluation, which, albeit with some limitations, highlighted a number of positive findings. There were only twenty men participating in the methadone program at that time, because four of the cells that were built to house them were under construction. The evaluation was conducted under complete anonymity and included twenty participants from the methadone program and forty participants from the general population.
One of the most important findings was that heroin use in prison, particularly by injection, is not uncommon. In the survey, use was reported by 23 of the 40 non-program participants; use in the past 30 days was reported by 15 people of the 40 who were not in the methadone program. Of the 20 patients from the program, 18 were there for more than 30 days and two were new to the program. Only one of the patients tested positive to heroin, they all tested positive for methadone and none of those participants in the group of 40 tested positive for methadone. When comparing use among the pilot group with the general population, in the first group

there was a steady decrease, while trends remained rather stable in the general population
The second major finding was that the program was selecting the appropriate participants. Their heroin use was greater than that reported by the sample of inmates not in the program. With regards to frequency of use, almost all of the people in the program were reported to use heroin daily in the prison; just over 50% of the general population reported the same use. A third set of major findings was that participation in the program was associated also with a greater likelihood to accept treatment after release. Although 90% of the patients were satisfied with the program, they did feel a need for more activities and their isolation from the general population was a problem for almost everyone in the program.
There was no evidence of any methadone diversion in either the self-report or the urine testing. As a consequence of the evaluation all five participating government agencies reaffirmed their support to the program The Department of the Corrections and Rehabilitations announced a plan to expand the treatment from 20 to up to 300-500 in the next year. The study is in publication, and will be included in the next edition of the Correctional Healthcare Journal, which is the review journal for correctional healthcare providers. A more descriptive, qualitative paper is going to be published possibly in the Journal of Addictions, possibly early next year.

From the floor, it was noted that although this programme is certainly important – and even more so as it is implemented within the US - the fact that there are separate units built in prison for people on methadone and that this is probably quite an expensive way to make methadone treatment available, may need some re-thinking. It should be noted that other prison systems have introduced substitution therapy - without experiencing any diversion - by implementing other measures that are not costly and do not lead to the segregation of

prisoners. In this regard, it was clarified that the pilot model was conditioned by the fears of the administration and the biases of traditional healthcare providers. However, the planned expansion of the program is not based on a segregated residential treatment community as there are no longer barriers in the correctional healthcare services. A Buprenorphin trial, in a minimum security facility, will also begin in August. A common problem with the two programmes – methadone and buprenorphine – is the lack of community treatment, which represents a challenge in terms of ensuring continuity of treatment. To overcome it, the agreed short-term solution is that prisoners who are being released from these programs will get priority places in community treatment programmes

On the question of reluctance of authorities in the US, but also in Europe, to introduce methadone substitution treatment in prisons, there seemed to be a shared view that a combination of fear, misconception and moralism dictate restrictive approaches in these countries. As far as the US is concerned, there has been a shift in mental health services away from offering community based institutionalized care and some of the prisons are used as a way of housing severely mentally ill people, creating huge problems in terms of staff security. Secondly, the whole concept of prisons in general has changed over the last hundred years and has moved away from the idea of rehabilitation. Thirdly, staring from the 1980s, the increased attention on arresting people and locking them up for drug possession has swelled the US population to two million people between state, federal and local prisons. This of course creates a huge drug using population in the prison system that the public morale is unable to deal with.

Overall, the importance of disseminating the results from innovative projects as widely as possible was reiterated,

particularly when evaluations show not only good health outcomes, but also good outcomes for staff in the prisons. This is particularly important with regards to Eastern Europe and Russia, where there are incredible risks of epidemics, but seemingly a total reluctance to consider substitution therapy.

Medical care providers and doctors should also be invited to express their views and support to the treatment of addiction as a medical problem and to continuity of care. Cooperation between NGO and the medical professionals should also be further strengthened,

Workshops session
Friday 8th July 2005

"It's not just heroin". Meeting the challenges of working with those who use other drugs

Chair: John Podmore (HMP Brixton,UK)
Speakers: Jindra Voboril (Sdruzeni Podane Ruce, Czech Republic), Dénes Balázs (Hungarian Civil Liberties Union, Hungary), Tom DeCorte (Univesity of Gent, Belgium), Grantley Heynes (COCA, UK), Janine Wildschut (Mainline, Holland)

It is common for discourses around drug use in prison to focus on opiates and on interventions mainly directed towards heroin users. However, there are a variety of other substances that are used in prison In the UK, for example, methamphetamines are the second drug of choice after cannabis, but these substances are hardly ever included in services and interventions targeting drug use. Noting the different psychological and physical consequences associated with the use of these synthetic drugs, *Jindra Voboril* highlighted that targeted services need to be introduced, particularly in countries with high prevalence of ATS use such as the Czech Republic.

Cranstoun/ENDIPP has launched a qualitative research project focusing on stimulants use, users and services in prisons in nine European countries. *Tom DeCorte* coordinates the research, which is investigating what services are on offer and the policies in place to address the needs of stimulant users in prison. The research is conducted in nine countries (two prisons will be visited in

each) through interviews with incarcerated users, prison staff, governmental and non-governmental staff and reviews of national data and policies.

With regards to the situation in Hungary, *Dénes Balázs* observed that one main reason for the absence of differentiated services is to be found in the legislation which does not distinguish between different types of drugs. This leads to users being wrongly treated (for example, there are situations where cannabis users are hosted and treated in centers dedicated to opiates dependents) and to a lack of integrated approaches to drug use. Current legislation, public misinformation and media campaigns that generalize 'drug use' as one category contribute to poor and ineffective approaches. It is therefore essential to differentiate between substances and between substance users, as different, tailored responses – in particular with regards to treatment – are needed.

Treatment is the answer. What was the question?

Grantley Heynes presented an overview of the city of Birmingham Crack Cocaine strategy 2005-2008. In order to devise an appropriate strategy, a crack problem analysis on markets, users, prevention and treatment options is currently being conducted.

To be effective, the strategy has to be rooted into the communities. Hence, a fundamental element of the approach chosen is to focus on ensuring that communities are effectively engaged in addressing crack cocaine issues. This means influencing Local Area Agreements to make sure that crack cocaine issues are addressed within regeneration approaches and are integrated with housing, anti-social behavior and other strategies. It also includes supporting local communities with information and leadership in tackling crack issues and learning from the

User Involvement Project in order to roll it into relevant policy and decision-making, and to lobby Birmingham to receive appropriate funding.

There are a number of myths and inaccurate stereotypes around the issues of crack and cocaine use, users and consequences. To improve awareness and understanding of the issues, work is being done to build an evidence base on crack cocaine and its impact on the lives of individuals, with particular focus on related harms. It is also envisaged that a Pan - Birmingham Outreach Engagement forum, seeking to influence the wider substance use agenda specific to crack cocaine, will be set up.

There are a number of myths and wrong stereotypes around the issues of crack and cocaine use, users and consequences

To ensure that all crack cocaine using offenders receive swift, appropriate and co-ordinated interventions at every point of the criminal justice system, the city of Birmingham Strategy ensures that interventions under Criminal Justice Intervention Programmes are accessible to all. The enhancement of the capacity and skills of workers in the Criminal Justice System to work with all drug using offenders is recognized as a priority and is addressed in the Strategy.

With regard to the enhancement of treatment, support services and effectiveness of working with crack-cocaine users from all community, the strategy will support the development and delivery of effective crack cocaine user treatment and offer continual support, in particular for those groups such as young people and offenders who are not currently accessing services. It will seek to influence initiatives to recruit and retain staff with the skills to work effectively with crack cocaine users, in particular with the

cultural competence to work with crack users from black and minority ethnic communities. Furthermore, it will identify gaps in data collection and encourage the dissemination of information relating to effective treatment responses to crack cocaine use.

Janine Wildschutz discussed the experience of the Dutch NGO Mainline, which started to work directly with drug users in 1990. Mainline implements a number of programmes: international projects; outreach work and production of written materials; training, policy monitoring and innovative projects aimed at professionals. Mainline's health education project in prisons started in 1997 as it was perceived to be a good opportunity to deliver health education and to ensure continuity of contact. The project started in 't Schouw, Amsterdam, in 1997 and was extended in 1999 to Schutterswei, Alkmaar. Since 2001, the interventions are funded by the institutions themselves.
With regard to cocaine in Holland, its entry dates back to the 80s. Today, there are approx. 55.000 users of base cocaine and approx 26,000-30,000 heroin users. The average age is 32 years. Cocaine base is normally smoked rather than injected and creates a strong psychological dependence. Mainline implements a prison project for users of crack cocaine. The main objective is to produce a protocol on "how to work with users of crack cocaine". The project runs a programme for users in detention, including health education for this group. A training programme for prison staff is also being run. With regard to the results and conclusions that the project has observed so far, the following are of particular relevance. First, problems caused by crack are generally underestimated. Users are reluctant to talk about their crack use and there is little knowledge amongst

professionals. There is an urgent need to improve counseling skills and to initiate programmes targeting risks and consequences of relapse.

In the discussion that followed, a number of issues were raised. The question of whether integrated approaches, incorporating different expertise within the same services, should be preferred to different services providing specific expertise was discussed, and it was argued that to avoid disjointed services, an integrated approach may be preferable.
An important point was highlighted by Andy Stonard concerning individuals' assessment upon admission to prison. It is true that normally an individual is assessed against the services that are available and that services delivered are the ones 'available on the menu', such as MMT. It should be pointed out however that methadone based treatments have little to offer to crack-cocaine users and different responses need to be invented. With regard to financial resources, political decisions around funds to be allocated to drug interventions seem to be lacking any minimal hint of creativity. Better training of staff for the identification and understanding of different substances and their consequences on individuals was also highlighted as a priority.

Friday 8th July 2005
Workshop Session

"Catch them while you can ..." How do we engage and effectively work with young people?

Chair: *Joris Casselmann* (University of Leuven, Belgium)
Speakers: *Laetitia Hennebel* (Cranstoun Drug Services); *Mark Spooney* (HMP Wales); *Kathryn Leafe* (Cranstoun Drug Services)

Laetitia Hennebel provided an overview of issues related to juveniles[2] and young offenders[3] in secure settings, which is the focus of one of Cranstoun/ENDIPP's current research studies. Juveniles and young offenders fall under the category of vulnerable prisoners as they face, by nature, particular risks with regard to their safety, security and/or well-being as a result of imprisonment.

The Cranstoun/ENDIPP qualitative research project focuses on juveniles with problematic use of alcohol and other substances (heroin, cocaine, licit drugs, glue etc.). It investigates the services offered to them and the policies to address their needs. The research will be conducted in nine countries (two sample settings will be visited) through interviews with incarcerated juveniles, prison staff, governmental and non-governmental staff and reviews of national data and policies. A preliminary literature review and

[2] Defined as < 18 years old
[3] Defined as 18 -21 years old

meetings reveal some interesting information. According to data currently available, juveniles under 18 in Slovenia represent 1% of the total prisons population (09/2002); in Belgium 1.1% (09/2000); in France 1.4% (04/2003); in Scotland 2.8% (09/2002); in England and Wales (04/2003) and in Spain 0.3% (12/2000).

Imprisonment of a child shall be used only as a measure of last resort and for the shortest appropriate period of time'

Convention on the Rights of the Child

Juveniles and young offenders in prison have a higher prevalence of substance misuse problems. Juveniles tend to experiment and engage in chaotic drug use, which includes a range of substances. Frequently they show a rather low level of motivation to deal with problems, and even lower capacity to recognize severe problems. They are often characterised by having a sense of invincibility. Secure settings may be an opportunity to break the cycle of criminal behavior, act on drug issues and provide good services, including basic education as illiteracy and innumeracy are rather common.

Mark Spooner provided an overview of the Juvenile Substance Misuse Services in Wales. In April 2004, the Youth Justice Board introduced the National Specification for Substance Misuse. In accordance to it, each juvenile establishment has a Specialist Substance Misuse Team with specific services for young people and addressing all substances. The Youth Justice Board has a vision that young people should be able to access similar levels of service provision within the juvenile secure estate as in the community. The Substance Misuse Teams aim to ensure that young people can access resources to meet their individual needs**.**

The core activities are broken into five key areas as follows:

- Identification, assessment and planning;
- Detoxification and clinical management;
- Education and prevention;
- Support and programmes and
- Through-care and resettlement.

The proposed approach is tier-based. Tier one focuses on meeting universal substance-related needs, providing information and advice. Tier two addresses the targeted prevention needs of those defined at risk of developing substance misuse; tier three deals with assessing substance misuse and meeting the needs of young people who are substance mis-users and coordinating other interventions. In tier four the needs of young people who require an intensive highly focused piece of work or settling for a fixed period, are central.

A child is NOT an adult!

Within identification, assessment and planning, all young people are to be screened for substance use on admission. They will receive full substance misuse assessment within five days for remands and within 10 days for DTO's. A care plan is then identified to access appropriate interventions.

With regard to detoxification and clinical management, it is stipulated that each clinical intervention will respond to individual needs. Each establishment needs to ensure that there is access to a range of clinical interventions that cover both detoxification and on-going treatment of substance misuse.

Education and prevention concentrate on a variety of topics including: the impact of substances on individuals' families and communities; the prevalence and acceptability of substance use amongst peers; the short and long-term effects and risks of substances on health; laws relating to substance

misuse; making more informed choices to stay safer and healthier; accessing information, help and advice; exploring one's own and other peoples' attitudes towards substances, substance use and substance users; challenging stereotypes, and exploring media and social influences.
Within the area of support and programmes, the Specialist Substance Misuse Team provide one-to-one support to young people with more established substance misuse problems, or other complex needs. Moreover, it provides a range of group work interventions to meet substance misuse and psychological needs, avoid and manage risk taking, (including problem-solving by developing coping strategies), improvement of self-awareness and self-esteem and effective communication.
Through-care and resettlement focuses on establishing contact with community based substance misuse treatment services prior to release, sharing information about the young person's sentence plan and the progress made. Responsibility is joint in order to ensure that this change is managed positively, and disruption is reduced as much as possible.

In conclusion:
- All young people will have access to interventions that meet their individuals' needs.
- All young people will be screened for all substances at admission.
- All young people will receive a full assessment.
- All young people will receive Tier 1 Education and Prevention intervention.
- All interventions will be delivered within a harm minimisation framework.
- All services will be young person specific.

Katryn Leafe introduced the Themba HIV/AIDS Project, which is being implemented in South Africa. The project is a

health education tool, a youth training project and an interactive theatre company. It has been training young people and delivering performance-workshops and interactive theatre to schools, community based organisations and businesses in Gauteng (South Africa) since February 2002. The focus of the interactive Themba theatre process is on influencing behavior to prevent the spread of HIV/AIDS, as well as providing skills to all participants, whether in the performance group or in the audience.

Themba primarily targets young people, who are the high-risk group for contracting HIV, and gives them tools that help them make safe decisions around sexual behavior. Themba's secondary target groups are adults - parents, teachers and workers. Themba works with four different groups to enable behavior change: (i) The performance group, which is made up of young people from (at present) Soweto, Alexandra and Tembisa. They are trained in a range of areas, providing them with the opportunity to work towards competencies in performance skills, life-skills, HIV/AIDS awareness, peer support and education, facilitation skills and language development. All these skills are transferable to the workplace when the young people finish their training with the Themba Project. (ii) The plays, which are performed to audiences (in schools or in corporations and other organisations) who become involved in the action, and practice negotiation and decision-making alongside the characters in the play. The effectiveness of the prevention message occurs in the participation of the audience. While engaged in the performance-workshops audience members learn skills which they are then able to use in their social, educational and working lives. The average size of the audience is 160. (iii) The Themba 'follow-up' workshops

If I can prevent one person from becoming HIV+ my work is worth

which are held in schools with smaller groups of learners, and facilitated by the Themba actor-educators. These reinforce the messages through a range of interactive activities based on ITT, while at the same time the participants in the workshops are trained in a similar range of skills (though not to such a highly developed level) as those learnt in the training of the actor-educators. (iv) Training workshops for young people – both school learners and unemployed youth. These workshops range from two hours to two days in duration, and the participants learn about HIV and AIDS as well as becoming actively involved in the ITT process. The culmination of the workshops is the creation of plays around issues to do with HIV and AIDS. These plays carry messages which include the importance of knowing one's HIV status, living positively, stigma and discrimination, being an HIV+ role model in one's community, as well as encouraging the delay of first sexual encounter, engaging in safe(r) sex, and negotiation around different sexual activities.

The project is rather small. However, small changes are needed before big ones can take place.

Friday, 8th July 2005
Workshop session

Epidemiology: what does the evidence tell us?

Chair: Caren Weilandt, (WIAD-ENDIPP, Germany)
Speakers: Kralko Aliaksey Arkadievich (Prison Service, Belarus); Peer Brehm Christensen, (Odense University Hospital, Denmark); Akylbek Muratov, (GUIN, Kyrgystan)

Caren Weilandt introduced the first speaker of the session, *Aliaksey Kralko*, who presented the results of a sociological study on risk factors related to the spreading of HIV in the Belarus prison system.

There has been a steady growth in the number of HIV infected people in prisons in the Republic of Belarus, in recent years. The first HIV infection was registered in prison in 1988, and by January 2005 there were already 1098 HIV infected men in prison. The majority of HIV-infected people arrived to the penitentiary system with an already established diagnosis. For the others, this was established upon admission. Most of these prisoners are hosted in high security structures because of a history of criminal behavior, mainly linked to drug related \offences. Most of them have low levels of education and high level of drugs consumption.
The level of awareness on methods of transmission is much lower among prisoners older than thirty years and among people with low educational level. The majority of respondents identified ways of transmission of the virus as follows:

- common use of drugs -93%;
- sexual contacts without use of condom - 91%;
- blood transfusion - 91%;
- drawing tattoo with already used needles - 90%;
- contact with blood through a wound, 89%; and
- sharing shaving blades-88%.

About 10% of the interviewed prisoners admitted having had homosexual contacts. Only 13% of them reported using condoms; the number is low primarily because condoms are not widely available. Homosexual contacts seem to increase for people re-entering prison several times. For example only 2% of male prisoners were ready to have sexual relations with men when in prison for the first time. This number grew to 12% for people having already spent different periods of time in prison.

50% of the respondents declared using common blades for shaving (both men and women) and 7% of them did not disinfect it in any way. 28% used water for disinfection, 21% hot water and soap, 21% pour boiled water over the tool and 11% immersed it in a solution of disinfectant.

As far as tattoos are concerned, 20% of respondents made tattoos in prison. Tattoo needles are disinfected in 67% of cases by warming them up on a flame, in 64% of cases by using a disinfectant, in 16% of cases by using boiling water. 16% of the respondents reported the presence of drugs in their prisons. 13% witnessed cases of drugs injection in prison with sharing of syringes or other injection equipment. 24% think that it is necessary to distribute condoms in prisons, 42% believe that it is possible but not necessary and the remaining 30%, do not think that it is necessary at all.

According to the data presented, there are real risk factors for the spread of HIV in prisons in Belarus, by drawing tattoo, using drugs and common tools for shaving, and through

sexual contacts. Considering that it will be difficult to eliminate risk behaviors, there is a clear need to minimize risks associated with them. This will be possible only with the wide introduction of harm reduction measures and through the increased availability of condoms and syringes in prisons.

In the discussion that followed, the questions of whether tattooing should be prohibited in prison and/or whether clean needles for tattooing and razorblades should be provided were raised. According to Dr. Kralko there is an historical tendency to get tattoos and because of this existing tradition, it would be very difficult to forbid these practices in prison. In Germany, tattooing in prison is forbidden, but it takes place anyway. It is important to develop HIV prevention programs focusing on existing risk behaviors.
The problem of overcrowding in Eastern European countries prisons was also brought to attention. No single cells are available in Hungary and the same can be said for Belarus, where there are on average 10 prisoners per cell.

Dr. Peer Brehm Christensen presented a study which is being carried out in Denmark on drug-related death after release from prison. Denmark has a population of 5.3 million and an estimated hard drug using population of 25,000. The average number of drug related deaths is 250-300 and it has been stable for 10 years. The prevalence among IDUs tested in Denmark is as follows: HIV 0-3%, HBV 65%, HCV 75-85%. Mortality rate is also rather high (1-2% per year) and this has been related to recent release from prison. Drug users are a socially stigmatised group that are difficult to access by health surveys. Drug related deaths are important in this respect as this group has less contact with the public health care than drug users in treatment or in prison.

The primary aim of the study is to investigate the prevalence of antibodies to HIV and hepatitis B and C among drug related deaths over a five-year period starting from 2004. An anonymous post mortem sample is obtained at autopsy (mandatory performed for DRDs) and is tested for HIV, HBV and anti-HCV by standard serology assays. The deceased is looked for in three national registers, which are: a) reported acute or chronic viral hepatitis and AIDS; b) drug treatment register and c) prison register. The study has been approved by both ethics committees and the national data protection agency.

The study is carried out in cooperation by the Ministry of Health, the coroners of Denmark and the public registers. The study has been approved by the ethic committees and data protection agency of Denmark. The preliminary 2004 results from this study showed that the methodology was feasible and reliable: half of those tested were positive for hepatitis C and one quarter for hepatitis B. Overdose deaths due to methadone were increasing and heroin deaths decreasing compared to previous years. Also, a decrease in death after release from prison and a low coverage rate by national registers for viral infections were found.

During the discussion that followed, the issue of aftercare programs was raised, in terms of methods to put prisoners in contact with health structures in the community once released in order to avoid deaths due to overdose. Indeed, since the setting up of a methadone treatment register in prisons in Denmark, prison administrations have to inform treatment centres that a prisoner who was under methadone treatment in prison is being released. This is actually the only way for the released individual to

The problem of waiting lists to be admitted to a treatment centre after release is affecting the effectiveness of this referral system

obtain methadone straight after release and is also a way to put the person under the medical surveillance of a health service in the community. The problem of waiting lists to be admitted to treatment centre after release is however affecting the effectiveness of this referral system. This seems to be the case in several countries in the European Union. With regard to a question raised on the legalization of drugs in Denmark, the current government is bending toward a harsher approach on drug use, proposing to criminalize even minor possession of hashish.

There are no mandatory health tests for prisoners when entering the structure, including TB. When prisoners were offered medical tests, the rates of uptake in different prisons and different countries varied greatly. The way in which the policy of testing is proposed can therefore greatly influence the number of prisoners who accept to be tested.

Akylbek Muratov gave an overview of the HIV/AIDS growth in the penitentiary system of Kyrgystan, where the responsibility for health in prison has currently moved from the Ministry of Interior to the Ministry of Justice.
Kyrgyzstan is a transit country for the trafficking of drugs; HIV prevalence is quite low, but is growing very fast. About three years ago, programs were set up on HIV, TB and other diseases prevention within the penitentiary system. There are 35 penitentiary institutions in Kyrgyzstan, including 11 prisons, 6 pre-trial detention centers and 18 colonies. There is a medical department at the main department of corrections, thirteen medical units, five smaller local medical units serving one institution and thirteen bigger, serving several colonies each. Finally there are four in-patient hospitals for prisoners. On HIV, in the country, in 2000 there were two registered cases in the penitentiary system in Kyrgyzstan. In January 2005, there were already 124, which have become 130 by

today. The cumulative number of HIV positive prisoners who were imprisoned within the last six years is 272. In the whole country there are 750 registered cases of HIV. Therefore, more than 30% of all known HIV-positive people are now in prisons.

It was a one year pilot and in 2004 a new order was issued to cover ALL institutions with needle exchange programs

In order to face this rapid growth, a program of needle exchange was initiated in prison. A second program, to be started is related to methadone maintenance treatment, and a third program, 'Atlantis' is based on the twelve-step methodology. The first needle exchange program in prison was implemented in one big prison hospital in Kyrgyzstan, under the special order of the Minister of Justice, with the support of the Open Society Institute and one local NGO. Four prison staff members were running this project and were trained in Poland on how to implement needle exchange programs in prisons. 10.000 syringes were exchanged within this project.

After this one year pilot a new order was issued in 2004 to cover all the institution with needle exchange programs. There are now twelve medical professionals running these programs in prisons; 45.000 needles were exchanged during 2004. The number of syringes which were exchanged clearly shows that there is drug use and illicit drug trafficking in the prisons of Kyrgyzstan. It is important to highlight that this needle exchange program in the Kyrgyz prison was the first pilot project in all of the former Soviet Union countries and especially the first project within the region of Central Asia.
Dr. Muratov underlined the regional dimension of the HIV problem, and particularly the fact that there is a lot of migration between Central Asian countries. Proposals have

been advanced to set up a regional mechanism to promote needle exchange in prisons and other similar programs. The mechanism already started in Kyrgyzstan could be a working mechanism for the whole Central Asia region. A first regional meeting to arrange the setting up of such a mechanism will be held at the end of September 2005 and will discuss the problem of needle exchange and adopt a regional position on how to deal with the needle exchange program in prisons in Central Asia.

In 2002, Kyrgyzstan also started a first pilot project on methadone maintenance treatment, under a special order issued by the Ministry of Justice and the Ministry of Health, for which the first positive results were also registered.

With regard to rehabilitation, the "Atlantis" Program came from Poland and was offered to Kyrgyzstan by the Stefan Batory Foundation. It is a 12 step program, with a duration from four to six months, which now is implemented in two prison settings with 45 clients in one colony and 20 in the other. The clients who graduated from the program became peer consultants for their mates. In his concluding remarks, Dr. Muratov argued in favor of introducing HIV tests for the prison system in Kyrgyzstan, of further developing the "Atlantis" program into a rehabilitation program available to all prisoners in all the institutions, and of providing training for prison staff. Another challenge to be faced soon is the problem of co-infection and co-morbidity of HIV and TB.

Responding to a question from the floor on how syringes are distributed in prison, Dr. Muratov explained there are several mechanisms. In some cases they are distributed in a deliverance area, through a peer consultant. In other cases medical doctors and nurses distribute the syringes. Sometimes there is a special room where people can go in to exchange

syringes, which is also used for counseling sessions, distribution of information and materials, etc. It is important to have this mechanism in place, especially for newcomers. Another question was raised with reference to the living conditions of prisoners with HIV. There is no segregation in the prisons in Kyrgyzstan for HIV positive prisoners. At the moment people coming from "high-risk groups" are mandatory tested while in the pre-trial detention centers, but the prison service of Kyrgyzstan is about to introduce express testing for HIV and switch to voluntary testing.

Kyrgyzstan is one of the few countries in the world where needle-exchange programs are implemented in all prisons

Kyrgyzstan is one of the few countries in the world where needle-exchange programs are implemented in all prisons. No incidences of attacks with needles or security problems have occurred with the introduction of needle exchange. The needle exchange program in fact helps to build a "healthy culture" amongst prisoners and this helps also to avoid accidents and attacks in prison.

Mr Gregely Fligauf discussed gender based challenges in the Hungarian prison system. Eastern-European, and especially Hungarian prisons, face increasing challenges, particularly with regard to overcrowding and low budgets. There are 33 prisons in Hungary, with more than 16.000 inmates. The drug-related crime rate is currently 5.45% percent, slightly higher than in 2005. The main objective of drug related policies in Hungarian prisons is supply reduction the second objective is the demand reduction. There are special units for prisoners with drug related problems, called Drug-Prevention units. The first priority of these units is to reach a drug-free status for prisoners and facilitate cooperation between them and the prison staff. These units work on a voluntary basis and the

prisoner has to sign a statement and be tested before joining the unit. The staff composing the Intake Committee collects information on histories of drug use from prisoners upon admission. Positive answers have been increasing since 1995.

The prison service target group in terms of prevention and demand reduction policies is not the offenders who have been charged with a drug related crime, drug kings for example, but rather the users - those who were users before incarceration, and those who use in prison or are potential users in prison. There is very little information available in prisoner databases and registers about drug use in prisons. However, if a prisoner enters the institution for a drug related crime, he is proposed to join the Drug Prevention Unit, thus having higher reintegration chances. If a prisoner presents withdrawal symptoms, there are special care units in forensic hospitals. If the prisoner was using drugs before incarceration, he can also join the DPUs. A sociological survey was recently carried out in Hungarian prisons with a sample of 6% of all prisoners. To the question: ‘do you think that drugs are reachable in the prison?' 60% of the interviewed answered positively. This year there were 33 cases of people reporting having used heroine before incarceration, 23 prisoners who said they used cocaine, 28 amphetamine or methamphetamine and 46 cannabis.

With regard to gender and drugs in prison, there are also fewer females in prison in general and they are hosted in structures in distant geographic locations. It is therefore difficult for female prisoners to contact their families. In some of these institutions, female prisoners can receive anti-stress or anti depression medication, but some of these medicines, like other sedatives and anti-epileptic medication, are often diverted and abused. Male inmates obtain drugs in illicit ways, for example in parcels or by corrupting the staff. Female

prisoner, on the contrary, get legal drugs from the healthcare units. Women normally take drugs in a social context: they need positive social feedback for their drug use behavior. This aspect is really important for them. The family contact is also really important. Stigmatization causes more difficulties to the female prisoners than to the male ones, because of the negative effects of reintegration. The main reasons for male prisoners joining the Drug Prevention Units is to 'win a power battle' with other prisoners. The main aim for the women is to reintegrate into positive group norms and a positive prisoners' climate in the cells.

Stigmatization causes more difficulties to female prisoners than to male ones because of negative effects on reintegration

Discussions followed on the best methodology to collect information from prisoners. Caren Weilandt briefed the group on a methodology developed by WIAD which is based on anonymous surveys, particularly important for prisoners. It was tested during a study in Armenia and gave quite high participation rates and reliable results. This is a successful methodology to get good information on what is happening behind prison walls, in terms of infectious diseases, risk behavior, and prevalence of infectious diseases. It has been approved and is currently applied in several European countries.

Friday 8th July 2005
Workshops session

Involving families and the wider community; early intervention and continuity of care

Chair: Harry Fletcher (National Association of Probation Officers, UK)
Speakers: Petra Paula Merino (EMCDDA); Gavin Lawson (Cranstoun Drug Services, UK); Shereen Sadiq (Home Office, UK); Luisa Gandini (Department of Penitentiary Administration, Italy) ; Uday Mukherji (The Glasgow Drug Problem Service – Drug Courts, Scotland); Andrej Kastelic, (Center for Treatment of Drug Addiction, South Eastern Europe-Adriatric Network, Slovenia); Deborah Small (Break the Chain, USA)

Petra Paula Merino presented the European perspective on alternatives to imprisonment for drug using offenders. She highlighted that in the face of dramatic problems such as overcrowding and the potential collapse of criminal justice systems across Europe because of drug related offences, a set of new developments focusing on alternatives to prison and prosecution, such as mediation and social work are emerging in many member states. Drug use in prisons in the EU is difficult to quantify and authorities respond unevenly throughout the Member States. However, there is a general agreement that drug users are over-represented among the 350,000 people in prisons that can be encountered in a single day throughout Europe – with a minimum of 180,000 and perhaps as many as 600,000 drug users passing through the system each year.

With regards to diversion programmes, different formulas have been used across the EU to divert drug dependent offenders away from the criminal justice system and into an appropriate treatment modality. Most often an alternative to incarceration is offered, usually with the 'threat' of incarceration if treatment requirements are not met. Among the existing diversion programmes in Europe, the following are worth noting:

- Formal police diversion: senior police officers formally caution offenders; record of the offence is usually kept;
- Informal police diversion: individual police officers; discretionary powers;
- Statutory diversion: offenders are directed towards various interventions in an effort to avoid their progression into the criminal justice system;
- Prosecutorial diversion: prosecutors intervene and direct offenders away from the criminal justice system if they believe the community is best served by treating offenders rather than subjecting them to court action including sanctions such as fines, bonds or imprisonment;
- Juridical diversion: based on the discretionary power of magistrates and judges, courts may order a range of dispositions and interventions.

With regard to drug courts and alternatives to imprisonment or prosecution out of tribunals, it was stated that drug courts do not reduce (at least in the short run) the number of drug related cases in tribunals, but on the contrary require additional efforts from criminal justice systems. On the other hand, alternatives to prison or prosecution lead to a decrease of drug related cases in courts. A perverse effect, however, could be an over-control by justice systems (out of tribunals) of non serious offences. With regard to common problems encountered by drug courts and alternatives to

prison/prosecution (non court based), they can lead to a more intensive control of drug users by criminal justice systems in different settings than prisons (community, treatment facility etc…). Both encounter problems in finding adequate treatment facilities, and both encounter resistance from treatment professionals in treating drug users offenders, especially when coerced by the court.

Shereen Sadiq outlined through-care and after-care for drug using offenders and provided an overview on the Drug Intervention Programme, on how these contribute to aftercare and on challenges and solutions for local delivery.
The Drug Intervention Programme was established to respond to problems that had emerged with the previous system. These included the fact that drug workers in the criminal justice were working in isolation from others. Moreover, drug workers in prison were also experiencing difficulties in referring released prisoners back to the community and the involvement of families, housing services, training and peers' support groups was not consistent across the country. Assessments were repeatedly taking place in prison and in the community with no system in place to support workers and improve continuity of care for clients. Communication between the community and prisons was good in certain cases but not consistent across the country, and funding restricted.
The Drug Intervention Programme was set up in 2003 and it currently links together various programmes and plans.
The principle of the Drug Intervention Programme rests on engaging drug-misusing offenders in treatment at every stage in the criminal justice system and beyond. Throughcare is thus defined as continuity of approach from arrest, to court, through to sentence and beyond. Aftercare, on the other hand, is to be understood as the package of holistic support needed to address assessed needs and sustain engagement.

Some of the practical solutions envisaged within the new programme to support delivery and promote continuity include a Drug Intervention Record; the promotion and development of examples of practices which support closer working between drug and housing workers (e.g. rent deposit schemes); a single phone line for new/existing clients, available 24 hours/day; and the promotion and development of peer led support particularly for those who have left treatment (community and prisons). Overall, while the principle of through-care is not new, a systematic approach is essential to promote and support continuity of care. In the same way, aftercare should not happen as an 'after thought', but planning needs to be part of the treatment pathway, which involves and includes families and individuals. In order to establish and maintain effective partnerships it is however important to: be responsive and coordinated (prison and communities); establish single points of contacts to promote continuity; and provide access and support with wrap-around services and support at the 'vulnerable times'.

Aftercare should not happen as an 'after thought'

A question was raised with regard to MMT in prisons. As treatment will soon come under the National Health Service, this should help to address the question of equivalence of healthcare, although it will take time to change current practices. With regard to the inadequacy of information systems in England and Scotland, the Drug Interventions Record is a tool that has been developed to respond to this problem. However, there are issues of data protection which have to be taken into account.

Gavin Lawson provided an introductory overview of the Throughcare System in Scotland. Throughcare services available in the Scottish prison system include the National

Addiction Throughcare Service (NATS); the Homeless Addiction Team (HAT); the Community Addiction Teams (CAT's); and the Signposting and Referral Service. The NATS offers pre-release meetings in prison (including care plan review); community appointment (including review of needs assessment); support services to motivate clients to remain/become drug free and to help them from re-offending; and a family liaison service. The HAT offers assessment of clients pre-release who are at risk of homelessness in the community; support with maintenance/detox medication and health issues; referrals to housing services and support from community addiction teams. The CTAs offer; assessment via Care First; counseling support one-to-one; access to medical services; referral to residential/day-care rehabilitation services; on-going review of clients' needs; and family support. Finally, the signposting and referral service provides for: a literature service; information on harm reduction; referrals to general practitioner services; appointment with statutory/non statutory community services; and family and liaison support.

During the discussion that followed, the issue of those falling through the net was raised. Generally speaking, the re-offending rate has dropped because people remain on prescribed medication. An electronic system means that people are tracked better and will therefore be less likely to slip through the net. With regard to varying cultural and socio-economic systems in Europe, there are cultural differences which are reflected by the type of system in place in different countries. The arrest referral scheme in Scotland, for example, is not only a medical model, it also serves as a social model. In other countries, such as Italy, the approach is also multidisciplinary.

Luisa Gandini provided an overview of the situation in Italy. There are currently approx. 60,000 prisoners in detention in

Italy, the highest number in the last ten years. It is estimated that about 15,000 have a drug addiction problem, 1,000 have a problem with alcohol and 2,000 are part of MMT programmes. 30% of prisoners in detention are foreigners.
Among convicted offenders, approx. 63% are active heroin users. Since 2005, treatment falls under the responsibility of the national health services at regional level, which is also responsible for contacts with GPs in the community. Hence, health services in prisons are directly linked with local health services at community level. House arrest can be granted to individuals awaiting trial and this is common for drug user offenders with HIV, who are mainly heroin users. Alternative measures currently in place include: assignment to the probation service; semi-liberty; and home detention. In 2004, 7,000 people were assigned to the probation service for 'special reasons', mainly related to drug/alcohol problems.

Uday Mukherji presented a summary of the 'Continuity of care: prison-community interface', an organisational model in Scotland.

Prison-Community Interface

PRISON	OUTSIDE COMMUNITY
Increasing Prison Population	Increase in Drug Misuse
Lack of Resources	Limited Resources
Limited Capacity	Limited Capacity
Lack of Therapeutic Environment	Better Therapeutic Environment
Frequent Transfer of Prisoners	Mostly Static Population
Relatively Short Stay in Prison	Stable Population
Many Treatment Programmes without Validation	More Validated Programmes
Variable Treatment Standards	Variable Treatment Standards
Limited Range of Treatment	Wider Range Of Treatment Programmes
Limited Training Prospects	Better Training Prospects
Isolation from the Mainstream Treatment Services	Not Isolated

The organisational model characteristics include:

1. Single Multi-agency organisation (including the Prison Service; Health Service/Joint Partnership Addiction Service; Probation Service/Social Service; and Voluntary Organisations);
2. Single Multi-agency management structure;
3. Single Multi-agency planning for prison and community drug service; and
4. Joint funding.

With regard to key strategic issues in service delivery, these include the importance of joint needs assessments on a variety of issues (drug misusing prisoners' needs, family support needs; range of interventions; work-load assessment; staffing needs in all disciplines; and staff training & support needs); the establishment of alternatives to prisons programmes; and the planning of suitable services (capacity/range/quality). Operational management issues rest on the following: unified operational management structure; set professional standards for all staff; single shared assessment of clients in prison and in the community; a suitable range of treatment programs; evidence-based guidelines and protocols; established care pathways; case management; regular critical incidence review; robust clinical incidents review; robust clinical governance; unified data collection system; on-going staff training and development; and regular audit of all areas of service delivery.
With regard to the hurdles of this system, at the organisational level they include: difficulties in achieving consensus over aims and objectives; organisational differences; the need to clearly identify roles and responsibilities; the need to ensure commitment and support; and the resource constraints. At a professional level, certain factors such as stereotypes, respect and trust, different philosophies can represent difficult

challenges. Finally, contexts also play an important role as issues such as political environments, rapid/constant reorganization, and funding inadequacy or uncertainty can all impact upon the smooth operation of this model.

Andrej Kastelic presented an overview of some of the most significant problems facing drug users in Europe today, followed by a summary of the Guidelines for the Treatment of Drug Addicted Prisoners, with emphasis on the Dublin Declaration. The Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia is a consensus document on the rights of prisoners to HIV prevention and treatment and on the responsibility of governments to meet these agreed standards. It is a framework for action to address the HIV crisis in prison based upon best practices, scientific evidences and human rights.

Despite such Guidelines and international commitments, significant problems in their adoption still exist in some countries, while in others where they have been adopted, their implementation is lacking.

Recidism among drug using prisoners remains high. Between 70% and 98% of those who have been imprisoned for drug-related crimes, and not treated during the course of their incarceration, relapse within one year following release. Harm reduction lowers the threshold so that people who are unsure of what to do about their drug and alcohol use can have access to treatment. There are recurrent violations of drug users' human rights. These can be found in drug laws and policies that help spread disease; drug laws and policies that deprive users of their human rights by denying them access to some forms of treatment, by imprisoning them in high-risk prison environments that increase the risk of spread of disease, by denying access to syringe exchange programs and by denying honest education about safer drug use practices.

Moreover, despite the wealth of scientific data and experience showing that treatment and harm reduction measures work, there are a number of barriers preventing harm reduction in prisons. They range from: zero-tolerance/abstinence based approaches, to seeing harm reduction as an admission of failure; to discrimination against prisoners; to criminal laws and punishment; to lack of appropriate legal framework, and to staff safety concerns/perception of danger. In Slovenia, the Network of Centers for the Prevention and Treatment of Drug Addiction implements international guidelines and good practices by offering the following services: prevention; individual, group and family therapy; counseling for addicts, relatives and trainers; community health services; substitution programs; preparation for hospital treatment; rehabilitation and social reintegration; consultations for health, social, education services and police; cooperation with NGOs, TCs, self-help groups; and education and research through the publication of the magazine "Addiction". .Within the Centre for Treatment of Drug Addiction in Slovenia, there is: an outpatient clinic; a detoxification unit; a day center; an intensive treatment unit; an adolescent program; crisis intervention unit; and training and research. Coordination of all services is ensured by the Centre. The Centre operates under a number of general principles and instructions, inspired by a public health/human right approach to drug users. More informations can be accessed at www.seea.net.

Deborah Small discussed the US approach, which differs significantly from the European one. There are now around 2 million prisoners in the US, one-quarter of who have been arrested for drug related offences. If probation and other sentences are included, the number rises to 8 million, mostly for drug related offences. A great range of activities are included under the 'drug-related offence' tag in U.S. law. These carry a minimum of sentence of five years and up to

life. Even first time drug offenders can get a sentence of 10 to 15 years. Since the sentences are so long, there is little government interest in treating drug offenders. Treatment may start a year or two before release. Paradoxically, according to U.S. law, violent-crime offenders are treated far better than drug offenders. Race tends to play a great role in prosecution, arrest and conviction. Poor African, American and Latino citizens form the majority of prisoners, which is vastly unrepresentative of the general population of drug users. Whites are, in fact, the main drug users in the general population. New York State, but 96% of apprehended drug offenders are black.

Drug laws are a form of state persecution, as it is easier to imprison such people than to find them a place to live and work. The average imprisonment cost in the US is approx. 30,000-35,000 USD a year - the average outreach therapy 12,000-15,000 USD a year. There is no free treatment available in the community – one needs to pay or be imprisoned in the right place to get treatment. This is however very slowly changing. There is a large distinction, often ignored, between those addicted and sentenced for drug related offences and those sentenced but not addicted. Moreover, issues related to poor level of public schooling and the changes in welfare laws now cause problems for young people entering the job market. In some communities the only 'equal chance job providers' are the drug bosses.

The average imprisonment cost in the US is approx. 30,000-35,000 USD a year. The average outreach therapy cost is approx. 12,000-15,000 USD a year.

Break the Chain is working towards policy reform, starting with a review of current often offensive language, and with emphasis on the need for increased and improved treatment services, including staffing. Currently, the majority of drug

treatment service users are people of color, while the main service providers are usually white.

Friday 8th July 2005
Workshop Session

Developing and involving NGOs in States of Transition

Chair: Grzegorz Król (ENDIPP, Warsaw)
Speakers: Irina Pillberg (Convictus Eesti, Estonia); Olga Škvařilová (Sdruzeni Podane Ruce) and Jiri Richter (Sananim ANO, the Czeck Republic); Catalina Iliuta (ARAS, Romania); Nikolay Gagarkin (Ukrainian Network of Drug and AIDS Services in Prison)

Irina Pillberg offered an overview of the focus and work of Convictus in Estonia, which was established in October 2002 with the help of Convictus Sweden.
Convictus Eesti offers psychosocial help, consultation and harm reduction services for HIV-positive drug addicts in the Tallinn region. Since 2000, the beginning of the HIV epidemic in Estonia, out of a total of 4662 registered HIV positive cases, 34 % (1602, as of May 2005) have been reported among Tallinn residents. Based on the reported data, the HIV prevalence is 0.8 % among the adult (aged 15-49) population of the city.

Convictus currently concentrates on the following:

- Psychosocial support to HIV-positive people in Tallinn and nearby regions;
- Stationary and mobile syringe exchange program and counseling for drug users;
- Psychosocial work and counseling for HIV-positives in prisons of Estonia (female, male and youth prisons);
- Psychosocial help for HIV-positive drug addicts in Tallinn;
- Former drug users lectures for school children and youth; and

- Support groups for HIV-positive drug addicts.
- Preventive and informational booklets and books

Since 2000, more than 850 HIV positive cases were diagnosed; all had been infected before entering prison. As the result of quick rotation, approximately 600 infected inmates are present in prison at any given day (total number of inmates: 4500).
The epidemic in prisons has shown a rather sharp and aggressive character. From the very beginning, HIV positive people were completely isolated from other prisoners. At the start of 2004, 160 HIV positive prisoners were still isolated in a separate wing and could not use the common canteen. The prison administration did not know how to deal with them and other prisoners were afraid of having physical contact with them.
In December 2002 Convictus Eesti received permission to work in the largest and oldest prison of Estonia - Murru Prison - with the most traditional infrastructure and the most difficult contingent. From February until July 2003, the project, Murru Prison HIV+, funded by FHI, managed to create three support-groups within the prison estate that met twice a week. More than 50 % of HIV-positive prisoners participate actively in the project. Although the project itself was very efficient, tolerance of prison staff and prisons administrations was very low. Thus, Convictus decided to act in two parallel directions, namely advocacy work with the Ministry of Justice and prison department, and in prison administration.

In early 2004, an agreement on support services by Convictus was signed. Also starting from 2004, new support-groups started in a number of other prisons. Seminars are being held inside prisons with the joint participation of administration and prisoners. The goal of the seminars is to draw the attention of the administration and prisoners to the problem of HIV.

The specificity of the seminars lies in participation of different group members on an equal footing: prisoners and physicians, ministry representatives and volunteers, project staff members and guests from the city. This represents an innovative path for Estonia, namely that of working with high risk groups and organizing prisons' round table discussions, where all the participants can speak freely. After several successful seminars in different prisons, heads of the prison, representatives of the Ministry of Justice responsible for HIV problems and drug addiction, and the head of Global Fund in Estonia started to attend these events. An important element for the success of these seminars was a mass media campaign, organized before and after these event. Up to today, seven seminars have been held.

The specificity of the seminars lies in participation of different group members on an equal footing: prisoners and physicians, ministry representatives and volunteers, NGOs staff and guests from the city

Co-operation with the medical health department and social department in prisons is another essential element of the work of Convictus. The organisation participates in monthly meetings of the heads of prison social departments, which shows that administration treats Convictus as an equal partner. This is also evident by the fact that the Ministry of Justice issued a state order to Convictus to publish books concerning HIV and drug addiction prophylactics in prisons. One book was published with the direct participation of inmates, who were members of the support groups in prisons. The organization now plans to expand from the provision of support to the implementation of harm reduction interventions. Starting from autumn, the Institute of Health will conduct research on infectious hepatitis in larger prisons.

After the research, all inmates with more than half year sentences will be vaccinated for HBV.

Olga Škvařilová and *Jiri Richter* gave a presentation on the cooperation between NGO´s and Prison Service in the Czech Republic.
The current National Drug strategy dates back to 1993. It has since included harm reduction approaches which have been implemented open-mindedly and relatively successfully. There are 35 prisons and remand prisons, hosting about 19, 500 prisoners (first quarter of 2005), 900 of whom are women. This is one of the highest rates in Europe. There are 140 NGOs actively providing services to drug users, five of which are actively involved in prisons.
With regards to drug use, cannabis, pervitin (methamphetamine), heroin and subutex are the drug of choice in the community, while in prison medicaments, cannabis, pervitin, subutex, opiates are used. With regard to routes of intake, smoking, sniffing, intravenous and oral uses are all common in the community and in prisons alike. HIV reported cases in the community total 300, less than 5% of which are related to drug use. According to the prison service, there are few such cases in prison. 64% of Hep C cases in the community are found among problematic drug users. In prison the rate is over 40%.There are 30,000 problematic drug users in the community, while in prison the numbers range from 25% (official) to over 45% (estimates).
Within Czech prisons, there are six specialized units for drug treatment with a capacity of 324 prisoners (crowdedness: 82%); drug free zones in 22 prisons with a capacity of 938 prisoners. Each prison has a drug prevention centre but overall harm reduction is still not seen as a relevant approach within prisons settings.
A.N.O (Association of NGO´s) was founded in 1995. It is an apolitical, expert and independent umbrella association with

75 members, including key service providers. It serves as an expert network and cooperation platform and represents NGOs in policy planning.

There are five expert sections, of which the youngest one is the 'Drug Services in Prisons'. This serves as an expert platform, ensures coordination; promotes cooperation and capacity building, quality assures services provided; implements education for programme workers and ensures continual cooperation with the Prison Service.

Cooperation between NGOs and the prison service in the Czech Republic has grown over time

Cooperation between NGOs and the prison service in the Czech Republic has grown over time. It started in 1995 – 1997 with an exploration of how to approach the lack of willingness and trust from the Prison service. In 1998 irregular contacts with drug users in prison started. In 1999, a legal regulation established cooperation as a principle without, however providing any direction as to its possible forms. Since 2000 – 2002, cooperation between prisons and the NGOs Podané Ruce, Sananim and Laxus has been slowly building. In 2002 – 2003, communication improved and the Twinning Project „Drug Policy" saw the joint participation of representatives from NGOs and Prison Service. In 2003 – 2004, the Phare Project "Drug Services in Prison and Aftercare" (SPR) brought the development of mutual cooperation and originated the network "Clients in conflict with the law". A professional section „Drug services in Prison" has now been established within A.N.O., with the aim to support, networking, coordinate drug services in prison and negotiate with the Prison Service. Cooperation is advanced in eight prisons (and it is based on written agreements), while it is starting in other seven prisons. 17 prisons do not cooperate with any NGO of which approximately ten are not interested in any cooperation.

Services available include: individual counseling and therapy (including motivational interviewing and crisis intervention); harm reduction in a form of advice and information; group therapy and counseling; social and legal services; mediation of treatment and aftercare services; references to courts, probation and treatment services; and counseling for family members.

Current problems encountered by NGOs are of various nature. They can be legal, (such as when the law enables cooperation but does not specify the form); there are missing standards for drug services in prison; the legal position of NGOs and drug services is also generally rather low; and there are still issues around NGOs workers' status in prison. Moreover, there are often different conditions in each prison and funding remains a problem.
Overall, it is advised that NGOs involvement in prison needs to be made explicit as it may be threatening for the prisons and/or viewed as an offer of services that prison service employees should do. Unfortunately, harm reduction is often tabooed by the Prison Service.

Catalina Iliuta provided an overview of the penitentiary system in Romania. The Romanian Prison Department is part of the Ministry of Justice. There are 43 prison institutions (34 prisons, 6 hospital prisons and 3 centers for young offenders). At the end of 2003, the prison population comprised 46,789 inmates. Results from research conducted by penitentiary system showed that less than 1% of the prisoners use condoms on a regular basis and 67% declare that they never use them. However, around 1/3 declare that they have multiple sexual contacts in prison. Other risk factors are associated with the low level of hygiene, sharing and re-using razors, tattooing and auto-mutilation. Prisons are significantly overcrowded – depending on the prison, the rate of occupation is between

150% and 700%; 14% of prisoners do not have their own bed. One shower is used by around 30 persons and a single toilet chair is used by around 20 persons.

With regards to cooperation, the partnership with civil society started in 1995, when the penitentiary system was part of the National AIDS Commission, made up by an informal group of NGOs and GOs (mainly infection disease hospitals and the penitentiary system) who advocated for availability of HIV treatment. The collaboration continued over the years and, in 1999, the penitentiary system started, with financial support from OSI, their first peer education program. Technical assistance for developing and implementing the program was offered by ARAS. In 2002, they joined the Romanian Harm Reduction Network.

Several projects were conducted at national and local level in partnership with ARAS. Most have as primary goal the capacity building of the penitentiary system to provide services related to HIV and drug dependence. In Romania there is no "partnership history" between NGOs and GOs. This has a number of repercussions as most of the services developed by NGOs in prison are voluntarily-based. The Romanian system is not used to sub-contract services to NGOs and there is a gap between the prisoners' needs and the capacity of prison systems to offer specific services. Furthermore, prison staff is overloaded, hence prisons do not have the human resources to offer all needed services.

Those who should benefit from the partnership between NGOs and penitentiary system (both inmates and community) are affected by the heavily centralized system!

In general, those who should benefit from the partnership between NGOs and the penitentiary system (both inmates and community) are affected by the heavily centralized system.

With regard to HIV prevention services in prison settings in Romania, the following are available:

- Peer education and peer counseling (including training and IEC materials);
- VCT for HIV/STIs (The HIV testing services increased in the last three years, but access to pre and post test counseling is limited. In 2004, out of 947 inmates tested, one was HIV+);
- STIs diagnosis and treatment;
- HAART therapy for all inmates who are HIV positive; and
- Information program on adherence and compliancy to treatment.

However:

- Condoms are not available inside prison. Inmates receive these only upon release;
- There are no needle exchange programs;
- Even if more and more inmates have a history of drug addiction and/or are in prison for drug related crimes, there is no adequate drug dependence treatment (one detox center, no substitution treatment, no self support groups);
- No bleach distribution/availability;
- The services are not linked with those in the community;
- No self support groups exist; and
- Confidentiality is often broken.

Nikolay Gagarkin and *Ludmila Kononenko* provided an overview of the partnership between NGOs and penitentiary institutions in Ukraine, from the perspective of the Ukrainian

Network of Drug and AIDS Services in Prison established in 2002. The Network groups together leading NGOs working in prison, the heads of the Ukraine State Department of Corrections, staff of Regional Directories of the Department of Corrections, staff of correctional facilities and the Regional Centers for Social Services for Youth.

The goal of the Network is the implementation of international standards and programs in prison. Its main activities include: experience sharing; cooperation between NGOs and GOs; training NGO personnel; HIV prevention in prison and social-psychological support to PLWHA and IDU prisoners. The Network is implementing two projects: the "Partnership in Effective HIV Prevention and PLWHA Support in Prisons" project, funded by the European Union, and the "Harm Reduction Development in the Global Fund Priority Regions of Ukraine" funded by the International HIV/AIDS Alliance in Ukraine and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In 2004, over 10 all-Ukrainian seminars were conducted. An informational Network was established, including a website (http://www.prison.aids.ua). The Penitentiary Initiative bulletin was also launched, together with an electronic newsletter service. Outreach work and support groups for IDU and HIV+ prisoners were set up in eight regions covering over 10, 000 prisoners, including IDUs and HIV+.

A common issue for NGOs working in Eastern Europe is how to ensure the continuation of activities and projects when international funds become less available. It was generally thought that there is still a two to three year opportunity for international funding. Beyond that, governments will have to share the burden by co-funding certain initiatives, possibly together with the private sector. It was noted that in the UK, 40% of support comes from the private sector.

Friday, 8th July 2005
Workshop session

Dealing with Hepatitis C in French prisons: a measured approach

Chair: Saâdia Yakoub (Ministry of Health, France)
Speakers: Philippe Sogni (Cochin Hospital, France); Sylvie Balanger (La Santé Remand Prison, France) Luc Massardier (La Santé Remand Prison, France)

Saâdia Yakoub gave a general introduction on Hepatitis C in French prisons. Viral hepatitis is a considerable public health issue, not only in France but at global level. WHO data shows that 370 million people have HepB and 170 million have HepC. In France, a recent survey shows that 300,000 people have HepB and this figure has doubled in the last ten years. Around 600.000 people have HepC – with
5,000 more cases every year. The rate of HepC co-infection cases has increased by 25% and HepB co-infection has increased by 6% those with HIV. The most affected people are intravenous drug users: in France 70% of new HepC cases are among them, but this is the case also in general within the European Union.
The evolution of this disease is particularly fast in the case of poly-drug use. HepC for poly-users, are four to five times higher than in the general population. According to a study published in France in 2005 evaluating 6,000 new prisoners in over 134 prisons, 33% of the interviewed had used drugs and 30% were alcohol users. Screening carried out before incarceration gave a rate of 40% for HIV, 30% for HepC and 20% for HepB. There have been 2572 new detainees this year, of which 30% have been arrested for violating the possession

of drug law. They have all had at least one consultation with the psychiatry unit or the addiction unit. More specifically, out of the patients that have been monitored by the addiction unit (329 subjects in 2004), the results showed that mostly used heroin (25%), cocaine (24%), especially crack, and alcohol (14%). 16% of these patients formerly used to inject drugs although only 2% were still injecting up to one month before imprisonment.

Among the problems faced by the French prison administration there is the particularly vulnerable economic and social situation of most of the prisoners, further worsened by their use of drugs and alcohol, and the lack of staff to do screening and patient follow up. In 2003, less than ten detainees per year were treated in selected prisons. Some medical staff is still reluctant to prescribe substitution treatment. There is also a lack of vaccination campaign for Hepatitis C and B, both among prisoners and among the general population, and there is a lack of information and awareness among prisoners. While France has national anti-drugs plans and strategies against Hepatitis B and C, these plans have been implemented very late, with very small budgets dedicated to health programmes in prison.

In 2003 in some French prisons, less than ten detainees were treated

Philippe Sogni spoke about Hepatitis C, with particular reference to its natural history and treatment. Acute hepatitis is, in most cases, not even recognized and in 80% of the cases becomes chronic. 20% of the chronic cases develop cirrhosis over a period that can vary from 20-30 years in a healthy person to much less in people presenting other risk factors like obesity, high levels of alcohol consumption etc. There is a risk of developing liver cancer in 2 to 5% of the cases per year and

the similar risks of other complications. In the cases of HIV-HepC co-morbidity, the evolution towards cirrhosis is even faster. Risk factors for Hepatitis C are mainly injection drug use and blood transfusion, although since 1992, blood has been controlled before transfusion. There are also risks related to organ transplants from infected donors, unsafe medical practices, for example piercing and other types of exposure to infected blood and birth from infected mother. There might also be sexual transmission, but there are quite low probabilities of being infected in this way.

One of the major problems in dealing with Hepatitis C is that those affected show few or no symptoms apart from fatigue. On the other hand, Hepatitis C is very easy to test - through a blood test or other tests, up to the liver biopsy if there is suspicion of lever inflammation and cirrhosis. This procedure is very expensive and quite intrusive, and alternative tests have been developed such as fibro tests, which are non-invasive and is quite commonly used and based on blood sampling or fibro-scan. As far as Hepatitis C treatment is concerned, there are preventive treatments, but there is no vaccine. It is very important to limit the consumption of alcohol, in order not to accelerate the development of the disease. There are factors which diminish the response to anti-viral treatment, such as the fact that the virus is of genotypes one and four which are, more resistant to treatment, and HIV co-infection. In case of a poor response, treatment must be prolonged to 48 weeks instead of 24 and higher doses are needed. The treatment is, unfortunately, very expensive, (the full dose for 48 weeks costs about 20.000 Euros) but in France it is covered 100% by social insurance. Hepatitis C is a frequent and potentially lethal disease, screening is easy and important progress in treatment has been

Hepatitis C is a frequent and potentially lethal disease. Yet is very easy to test

made. Despite this, it is predicted that in the coming years in European countries death-rates will remain high. It is therefore important to go on developing prevention strategies, to develop screening strategies and to promote access to treatment for patients.

In response to a question on testing of prisoners and whether the fibro-test should be chosen instead of a liver biopsy, which requires hospitalization, Dr. Sogni reported a high use of non-invasive tests like fibro-test in his practice. Biopsies are carried out in the healthcare facility of the prisons. Another question was raised with reference to prisoners' access to treatment. The answer is positive in terms of the possibility of receiving treatment, however the problem is how to make sure the infection is diagnosed and medical treatment combined with follow up and psychological and psychiatric help if needed.

Sylvie Balanger gave a presentation about the health care provided to prisoners in the prison La Santé. At 1 January 2005 there was a prison population of 59,272 in France.
Within La Sante', there are 1450 prisoners, 60% of whom are under the age of 40 and 60% of whom foreigners from up to 80 different nationalities. The average stay is 21 weeks, which is quite a short period of time. La Santé prison has a big medical heath unit, composed of 46 people with a consistent budget, more than 700,000 Euros per year, which is not common in France. A minimum of 450,000 Euros of this budget is dedicated to medication. The medical unit is fully independent from the prison administration, but depends on the Cochin Hospital. The unit carries out around 16,000 consultations per year, out of which 606 were for HIV, Hepatitis C and B during 2004. This figure is constantly increasing. As for the legislation, only one consultation which is compulsory, and it is done upon admission together with

screenings for HIV and Hepatitis C and B. This is offered on an anonymous basis and is free. Healthcare is provided for free and in total confidentiality to all prisoners. Confidentiality is fully respected. As for health services available to prisoners, Hepatitis C screening is done by an independent center. Results are received within 18 days and are transmitted to the patient only upon his agreement. The first consultation with Hepatitis C patients is done within 15 days, followed by a psychiatric consultation, if needed. The file is then discussed at Cochin Hospital and a decision is taken within 9 to 14 weeks on whether to start therapy or not.

A study is been carried out in La Santé prison, in cooperation with Shering-Plough**,** covering the period September 2004 to September 2005. According to data collected in the course of this study, in 2004 there were 179 cases of Hepatitis C examined by the medical unit, of which 12 underwent treatment. 57 patients have been diagnosed HIV-positive, of whom 39 have been treated. 89 patients had Hepatitis B and three of them have been treated. Prevalence rates were different from the ones in the general population, but also different from national data on prisons. HIV prevalence is 1.79%, Hepatitis C prevalence is 7.78% and 5.1% for Hepatitis B. For HepC, patients had been infected mostly through drug use. Among these 9% have been co-infected with HIV and 18% with HepB. 32% of the HepC infected people were French nationals, and 40% were from North Africa – Morocco, Tunisia and Algeria, with few patients from other geographical areas. As for the virus genotypes, the situation is not very good, since there is mainly genotype one, which is more difficult to treat. There is absolutely no correlation with the geographical origin of the genotype.
One major problem is related to the short duration of imprisonment in “La Santé”. When trying to find prisoners who had left the medical centre, it was realized that over a

period of seven months, trace had been lost of around 46% of patients.
For an establishment like La Santé, with short imprisonment periods, the main problem is the delay in getting the biological results, as it takes about seven to eight weeks. There may then be refusals of treatment, because patients are afraid of secondary effects of treatment, and lack awareness of the seriousness of the disease. Particularly for Muslim detainees, being treated for Hepatitis means recognizing their status as problematic drug users. Finally, there is some reticence among foreigners on accepting treatment. They know that, if they are not treated and can still claim to be sick, they will be granted permission to stay on French territory. However, upon liberation there are some very immediate problems, as they have to eat, they have to have somewhere to sleep, they need a job, and there is also the problem of drug users' relapse.

Luc Massardier, provided an overview of the characteristics of patients being treated within a prison environment. The presentation focused on stigmatization of these patients, which makes it even more difficult to treat them. Generally speaking, the main offences resulting in incarceration in France are related to sexual aggression. Individuals incarcerated for drug use represent approx. 30% of the overall population. The latter can be difficult patients to treat, because of the negative perception they have of themselves and the fact they often think they cannot be treated. Patients are confronted with the phantom of death and that represents a severe trauma for most of them. They also fear the treatment will be life-long and they would become invalid if they accept

60% of the patients in prison show acute personality disorders Many have found in delinquency and drug use an escape from depression

it. A psychiatrist team tries to help patients realize that treatment is needed to avoid aggravation of the present status. 60% of the patients in prison show acute personality disorders, and these patients have found in delinquency and drug use an escape from depression. In these patients, depression can reach the level of identity-trouble with narcissism and problem of self-confidence and confidence in others. These patients are often aggressive, intolerant and unstable. The intervention of the psychiatrist is normally requested when the virus is discovered, but that psychiatrists see these patients for, at maximum three consultations, not enough to get to know them and to express a psychiatric opinion. The problem of lack of psychiatrists is well known in many prisons. Hence it is important to set up networks and share information to be able to respond to everyday challenges.

In answering to some questions from the floor, Sylvie Balanger stressed that one of the major problems linked with the care of prisoners presenting Hepatitis C or other infections is the rapid turnover rate. Treatment for Hepatitis C lasts at least six months and up to one year for patients presenting genotype one Hepatitis. How is it possible to ensure therapy if the prisoner leaves the establishment or is released or transferred after few weeks? Agreements have been established with the Cochin hospital for treatment follow-up after releases, but it is up to the released prisoner to decide whether to follow it. Many do not. In relation to this point, a question was raised on whether it is ethical to start a treatment when there is little chance that this will be carried to the end. Wouldn't it be better just to screen the prisoners upon arrival and give them information on where to get treatment once they are out?

Sylvie Baladier highlighted that evidence of denial of the disease is quite common amongst prisoners and leads to denial of treatment. Sometimes the denial of treatment comes from foreign patients, who can stay in the territory because of their medical situation and to receive care. If they are treated too well, they fear they will be sent back to their home countries as a result. She reported having witnessed cases of voluntary transmission of the virus among foreign prisoners, in order to get an excuse to stay in France for the treatment.
Others were in favor of starting treatment anyway, because the prisoner is in any case a patient needing help for drug use conditions or liver problems linked to Hepatitis C status. Active drug users have the right to access treatment as well. Moreover, regular medical treatment facilitates stabilization of one's personal life and may lead to dealing better with the problematic drug use condition. The effect of treatment started during incarceration has been shown to be positive. Among the patients who are referred back to the hospital after release, those who have spent more that six weeks in prison and have started treatment, tend to come back to hospital – surely more than those who have received a shorter period of treatment in prison.

On the issue of general conditions of prisons, staff and budgets remain problematic issues in most French prisons. In many, there are no consultations concerning infections and there are insufficient financial allocations to deal with the regular increase of Hepatitis C cases. This represents a major obstacle for care and many physicians in prisons are obliged not to treat and to postpone treatment for when the patient will be released. In cases where laboratories for analysis are simply too far away from the prisons, no screening is done.

Friday 8th July 2005
16.15 – 17.15

Plenary session
Paolo Pertica Fellowship

The Paolo Pertica Fellowship was established in 2004 on the occasion of the tenth anniversary of the creation of the European Network on Drugs and Infections Prevention in Prison. The aim is to provide opportunities to young researchers, from the EU and from the countries of the Former Soviet Union, to contribute to the continuous development of evidence based research in the field of drugs and infections prevention in prison.

Elena Grigoryeva, the first Fellow of the Paolo Pertica Fellowship, presented the results of her research on 'Gender sensitivity of existing strategies and activities on re-socialization of HIV positive female prisoners in 5 Newly Independent States', where re-socialization is understood as the process by which individuals learn new norms, rules and patterns of behavior, that allow them to get their needs met without violating the existing norms, rules and rights of others

The study aimed at researching one of the most vulnerable social groups amongst prisoners – women living with HIV in prison and after release. It aimed to identify specific factors, through comparative analysis, which could improve the gender sensitivity of re-socialization programs. The countries where the study was conducted were Armenia, Belarus, Moldova, Ukraine and Russia.

It was found that the target group faces daily stigma in the society, even more than in prison, because of their HIV status, their criminal background, their drug use - either current or

past - and their gender. These factors together continue to cause their re-entry into prison.

Moreover, the study showed a number of limitations in criminal legislation that create great obstacles to the improvement of gender sensitivity in prisons. First of all, there is the absence of a conceptual approach to the understanding of gender issues in criminal legislation. Within the hierarchy of values created by criminal law, violence against women is not given sufficient attention, often because violence against women is not perceived as a violation of basic human rights and it is not viewed as the responsibility of the State to prevent and address it, including domestic violence.

There is the absence of a conceptual approach to understand gender issues in criminal legislation

Drug use practices, in almost all cases, determined the behavior of the target group and led to committing a crime. Almost all were imprisoned for drug-related crimes. Almost 70% of them came from rural areas or small towns, and 25% percent from big cities. Around 6% were homeless. Because of registration problems, particularly in Belarus and Armenia, many of those released have no place to live, cannot find a job, cannot obtain proper documents, and thus end up living a homeless life. With regard to the reason for committing a crime and for being incarcerated, 34% of the interviewed women (out of a total of 627) identified problems in the family as the first reason; 30% of them identified drug and alcohol abuse and only 18% financial problems – which, on the contrary, was identified as the first reason for committing crimes and consequent incarceration by over 65% of interviewed men.

The research highlighted an extremely low level of awareness of women living with HIV in prison on HIV issues. There are

still many who believe that HIV is transmitted through towels, through insects, and so on.

The main problem experienced by women living with HIV in prison is overcrowding. There are many cases were women spend their entire sentence lying on the floor, without any space for sleeping. In several countries there are more than 100 women in one room. Most buildings require major repairs; in several sample prisons there are no shower facilities available and HIV positive women have to go to take a shower (once a week) to a different department. A very limited variety of food is provided to prisoners, including HIV positive prisoners. There are insufficient personnel to provide training and psychological services in prison; on average one psychologist serves 500-700 prisoners. One tutor serves 100-150 prisoners.

In several prisons, at the time of conducting research, there were no HIV testing systems. With regards to treatment, the situation is different in each country. In Belarus, for example, there was no treatment in prison. In Armenia it was not possible to get this information. In Ukraine, there were treatment opportunities in prison and a good connection with outside prison services. In Moldova treatment in prison was also available. The research further found that women had severe difficulties in socially adapting after having spent time in prison because of lack of: skills for efficient communication, mainly caused by their drug abuse practices; fear of stigma from the society due to HIV/AIDS status, ex-drug abuse and ex-imprisonment; the absence of supportive environments; the negative influence of their marginalization during imprisonment; depression and absence of trust from the surroundings. Most women had no professional skills and many had no experience of being employed. They often lacked motivation to improve the knowledge required for

getting certain professions and a better social status. Professional training (when available) is generally provided with no consideration of the economic situation in the country nor of the demand for specific skills.

Major psycho-sociological reasons influence re-socialization progress. Over 65% of the women indicated that they were not able to see a future since they became aware of being HIV positive. This is partly due to the fact that women more often blame themselves for having HIV. This view is often much supported in prison by prison personnel and often also by close relatives and other people. The level of knowledge of women about their rights, including how to get registration or how to avoid discrimination, is also very low. Counseling on HIV/AIDS issues is provided without pre-testing and post-testing counseling, and hence needs to be improved, together with access to medical and psychological services for prisoners living with HIV.

In conclusion, in all target countries HIV in prison is closely related to drug use. In all target countries women living with HIV, when released from prison, face substantial stigma from the society on a daily basis. In Belarus, Ukraine, Moldova, some pilot initiatives of gender sensitive re-socialization have taken place and could be used as examples of practices. Moreover, in all target countries there is the need to establish initiatives from the community and create self organized groups of women living with HIV, as well as assistance for their relatives, to enable them to provide specific services to the target group.
Furthermore, it is urgent to develop qualitative social and psychological services in prison and to involve NGOs in the provision of assistance and services as well as in developing a solid link between prison and state services and community based activities.

Saturday 9th July 2005
9.45 – 11.30

Roundtable discussion
How can we ensure quality and cost effectiveness in service delivery?

Chair: Mike O'Grady (Sheriff and High Court Judge, Scotland)
Speakers: Deborah Small (Break the Chains, US); Ralf Jürgens (Consultant, Canadian HIV/AIDS Legal Network, Canada); - László Huszár (Deputy DG, Prison Service, Hungary); Kathryn Leafe (Cranstoun Drug Services, UK); Dmitry Rechnov (AFEW, Moscow)

In the past few years, at every level and in every area, there have been increasing concerns over the question of public resources spent vis-à-vis results and impacts achieved. Governments, public opinion and the media seem to demand that when resources are spent, results follow – and that they follow fast and big. In the field of interventions for drug users in prisons, the pressure is often greatest. On the one hand, this is because these groups are largely perceived as 'unpopular' and undeserving. On the other, because final judgment on impacts is often imbued into a combination of superficial understanding of the issues, bias or limited knowledge about their complexity, external pressures and influences, and morality. It is however known that in this particular field of work, contexts, diversities, personal histories, backgrounds, cultural and socio-economic environments all significantly impact on results. People and their problems cannot be reduced to a formula or a set of numbers, and the word 'success' does not have an absolute value.

Following these introductory remarks by *Mike O'Grady*, the roundtable speakers contributed a number of ideas and perspectives. From a US point of view, *Deborah Small* discussed the implication of political, social and racial discrimination and stigmatization as obstacles to the enjoyment of universal rights and as barriers against access to services to particularly marginalized populations in the US. *Ralf Jürgens* emphasised the availability of a number of cost-effective and successful initiatives on prevention and suggested that more attention should be devoted to these approaches against the predominance of responses focusing mainly on treatment; *Dmitry Rechnov* highlighted the difficulties in choosing and implementing quality services with limited resources in countries of transition; *Kathryn Leafe* discussed the relativity of, and difficulty in defining 'quality' when applied to very different socio-economic and cultural contexts and individuals; and -*László Huszár* argued that the drug problem is a social construction and as such it is important to inform and educate public opinion if rational responses are to be pursued successfully.

Should we focus on policy change or on increasing services to people? *(Deborah Small)*

I'm faced with the dilemma of whether it is more important to focus on increasing services to people or instating policy change

One of the recurrent dilemmas facing those who work in the 'unpopular' fields of drugs and prisons is whether to concentrate efforts on policy and legislative changes or to implement better services for the immediate benefit of individuals and communities within the framework of existing legislation. While at a first glance, these objectives would not appear to be in contrast, pursuing them both can in reality be

rather tricky. For example, arguing for a distinction between people charged with non-violent crimes and violent crimes can be helpful in changing the legislative mind, but it reinforces the public perception that these are legitimate distinctions to make and thus undermines the goal of providing treatment and support to all the people who need it, irrespective to what their background may be.
In the American context is often easier to argue for more programs and delivery of more services rather than to change the underlying policies that make it difficult for drug users to live productive lives and to have the same benefits that other people enjoy.

In the last five years, there has been progress made in many states across the country in reducing the length of mandatory sentences that are imposed on drug offenders. This has however affected only those charged with possession, not those charged with sale (the majority of which are people of color, representing approx 50% of those incarcerated for drug/drug-related charges). The budget crisis that many states have faced may have forced legislators to acknowledge and redress the imbalance between resources devoted to criminal justice and prison building, and those devoted to more popular programs, like health and housing and education. In places where voters have had the ability to choose directly, they have overwhelmingly favored providing treatment over incarceration for low level drug offenders, clearly showing an awareness of the fact that it is more cost-effective to provide treatment to people than lock them up in costly jail cells for long periods of time.
Unfortunately, while the current administration has envisaged the implementation of 're-entry programmes' to facilitate reintegration into the community, none of the federal policies that act as barriers to these programmes – that is, all those laws that prevent people convicted for a drug offence from

accessing public housing, welfare benefits, food stamps, educational student loans, etc – have been amended or changed.

(When) Will we ever learn that prevention is better than cure? *(Ralf Jürgens)*

Prison systems around the world are faced with an HIV epidemic, with rates of HIV infection peaking from 5% to 20%. Paradoxically, however, the majority of resources invested both outside and inside prisons is primarily devoted to HIV/AIDS treatment rather than to prevention measures that have been documented and proven to be cost-effective in preventing the HIV infections. While many prison systems seem to be happy to accept funds to provide ARV treatment to prisoners, the same systems refuse to implement HIV prevention measures in prison. This is clearly not a good allocation of resources, and it demonstrates that prevention needs to be valued more than is currently the case.

I just want to point out the irony of refusing to undertake prevention measures and at the same time accepting monies to provide care and treatment

Interventions and priorities need to be driven by science and not by prejudice. Science has shown the effectiveness of different measures - from methadone maintenance treatment and other substitution therapies, to prison needle exchange programs - in the prevention of the spread of HIV and in bringing other positive health consequences for prisoners. Evidence further exists that these measures are cost-effective, and ultimately that these measures are beneficial to the public, because prisoners are members of the public and most will be eventually released and return to their communities. Hence,

what is or is not done in the prison system has an impact on the public as a whole.

How do we make a choice? *(Dmitry Rechnov)*

The dilemma is how to allocate very limited resources

When discussing these issues from the prospective of 'countries in transition', there are further elements that need to be considered. An overall scarcity of public resources in many countries of transition imposes more severe choices over their allocation and it often may come down to choosing to devote them to a particular group or sector of society – say HIV positive single mothers - rather than sharing those among different groups or sectors – say HIV positive single mothers, HIV positive prisoners or drug using prisoners. Moreover, overall conditions are often so harsh that those released from prison may be back the next day, in search for food, assistance and help that is nowhere else to be found. In the face of such hardship, the overall issue of quality of services acquires a different dimension. Despite many policy-makers being convinced and oriented towards harm reduction programmes, the very limited resources available in many transitional countries leads to poor quality of services, often so poor that they may even cause 'harm promotion' rather than 'harm reduction'. This in turn has an effect on the evaluation of those services, which become perceived as non-effective or, worse, as bad practices. Hence, the issues of quality versus quantity pose, in countries of transition, fundamental structural and systemic questions.

Quality may cost more, but delivers better *(Kathryn Leafe)*

A fundamental starting point in the discourse over quality and cost-effectiveness is to define what it is meant by 'quality'. Is

it a bare minimum or is it a best practice? Considering that services exist for the benefit of service users, quality should probably be understood as a cycle of continuous improvement, and as such best practices at a given moment should always be questioned versus better options that could exist. Different approaches, and/or a combination of elements from different approaches may work better than the established ones. This may somehow clash with current pressures over the need to demonstrate standard outcomes for service costs. On a related point, the best insurance for quality of services is quality of staff, which comes with certain costs and responsibilities.

Quality is a cycle of continuous improvements

Moreover, the notions of equal opportunity and anti-discrimination should not be understood as the provision of exactly the same services to all clients. On the contrary, it should mean that service providers have a responsibility to offer the best services to those who have most difficulties in accessing them. This implies making services widely accessible and providing additional support even if this means additional costs. Ensuring quality and delivering best practices should be the imperative, and to respect this and be ultimately cost-effective, the price may rise. It is important, in this regard, that clear arguments are put forward to demonstrate why quality services may cost a bit more, but ultimately will deliver much more.

The drug problem is a social construction *(László Huszár)*

South-Eastern European countries are sometimes faced with external pressures to prove that foreign and/or best practices, brought from other countries, are understood and implemented at home. It often happens that these countries are exposed to different pressures and very well argued approaches – be it supply reduction, demand reduction, harm

reduction – all of which, they are requested to adopt, or on which they are compared and judged. This surely is not beneficial, and can force responses that are not cost-effective. Instead, the problem and the responses should be analyzed from a different perspective, namely by recognizing that the drug problem is a social construction and that the notion of cost-effectiveness is determined by that social construction, and not by the individual or by the reality. In Hungary, it is not known how many drug users there are in prisons, because there is not a notion of 'problematic' user. Within society, there is the idea that a drug user is someone who is sinful, guilty, and weak, someone to be rejected, and that drug users are a small and invisible minority. This perception is not conducive towards rational responses but rather to emotional ones. This is true for the overall Hungarian society, and also for the prison service. If the problem is not perceived or known to be a burden either for society or for prisons, no real amount of money will be spent on treatment or prevention, even though scientifically this would be the rational response. Public opinion thus needs to be informed and educated to respond rationally.

Prevention and harm reduction are more effective approaches than any other, but one must know that these measures need understanding, empathy, rational choice

In general, it is essential to bear in mind that responses to problems like drugs in society and problem in prison are culturally embedded, that cultures are different and that therefore responses must be different. Recognizing that 'public opinion is the culture', it is imperative to educate it, in order to change culturally generated constructions and be supported in the implementation of rational responses.

The issues and perspective presented by the speakers generated a lively and interesting discussion.
On the issue of prioritization of interventions – prevention on the one hand, substitution therapies on the other – it was noted that in some countries substitution therapies are only available to a minuscule percentage of the population that needs them. Therefore, the issue of priorities remains controversial as it risks being interpreted as a question of exclusive choice between the two.
With regard to resources, these seem to always be limited for services and treatment, but almost always available for the building of new prisons. It was however pointed out that, although prison officers may individually believe that prisons are not always the best response to certain offences, in the face of overcrowding they may still advocate for new prisons in order to at least improve the immediate conditions of some prisoners.
Still on the issue of resources, it was argued that the question is not how many resources are available but how they are allocated. In many countries, a significant proportion is still allocated to expensive supply reduction activities – urine tests, drug dogs - while less expensive measures are not undertaken for political or "moral" reasons. Very often, there is a lack of knowledge from governments themselves over their budget allocations for drug issues. In Belgium, for example, a 2002 research found that 53% of the total government drug budget was spent on repression; 38% on treatment and 2% on prevention. This is an area where research can be very useful in and advocating change. Overall on research, it was highlighted that there is a shared responsibility to make research findings and facts widely known.
With regards to choice, it is essential to remember that drug users and prisoners generally continue to suffer fundamental disrespect of their human rights. It should not be forgotten that a child and a drug user have the same right to access to

treatment, which is unfortunately not an equation that the public recognizes. Hence, the importance of advocacy in this area, which needs to continue to emphasize that what is done in prison has a direct impact on overall community health.
Given that the judiciary can commit unlimited public funding every time a person is sentenced to go to jail, and given that that conviction may originate from prejudice, lack of knowledge, lack of information, a case was made for seeking to educate the judiciary about harm reduction. In some countries, such as the UK, training programmes for judges have been introduced, which include regular contacts with services and 'ground' people. In others, like in Australia, the judiciary has played a very active role in responding to requests from prisoners. In the same way, the medical profession also needs to be engaged.

On the question of quality of services, an accreditation system for services is being pursued in the UK. But, only those interventions that research has proved to work can be accredited. However, the accuracy and/or comprehensiveness of the research are often questionable, as it often fails to acknowledge diversity and socio-economic and cultural contexts, and the need for flexibility and adaptability.
Finally in some countries like Hungary, the issue of assistance in prison is tricky because there is the expectation that users would have to be punished rather than helped as drug use is a criminal offence.

Closing remarks

The Conference was attended by over 260 participants from 41 different countries in representation of more than hundred governmental, international and non-governmental organizations.

In a vibrant atmosphere, the Conference closing remarks by Edoardo Spacca, ENDIPP Coordinator, reiterated the shared embracing of the notion that it is crucial to work with problematic drug users in prisons because it makes human, social and economic sense. It makes human sense, because people in prison have been deprived of their freedom, and the punishment is the deprivation of freedom itself, not the prison regime. It makes social and economic sense because someone who has solved – or received substantial help in solving – his/her problematic drug use, will less likely become a burden to society, be less likely to re-offend and more likely to become a functional member of the society. It also makes social and economic sense from a public health perspective, as infections and STDs, which if not prevented have demonstrated to spread easily inside prisons, do not stop at the prison gates but are released into society alongside prisoners. The resources pooled into working with problematic drug users in prisons should therefore be seen as an investment for the whole of society.

It is crucial to work with problematic drug users in prisons, because it makes human, social and economic sense

On the question on how to provide services that make sense, it is important to highlight that, while problematic drug users in prison can be seen as one large target group, this group is composed of many smaller target groups, each one of them with different motivations and needs. The effective response, for the whole of the target group, lies in a *continuum of care*

and treatment. This ranges from harm reduction to abstinence services. Services offered must include everything from needle exchange, to substitution treatment to voluntary counseling and testing; education and information on sexual transmitted infections, to Hepatitis prevention and treatment; condoms, psychotherapy, drug free treatment, and follow-up. It must also include aftercare, inclusive of health and support, and assistance with employment and housing. The pursuit of long-term changes for problematic users needs to be realistic and pragmatic, rooted in the idea that pragmatism is the way forward for the whole of society.

Feedback from Participants

The Conference organizers received 45 filled-in feedback forms. Each form contained two types of data: quantitative and qualitative. The quantitative data provided organisers with a general overview of the conference, while the qualitative data provided tips on individual presenters and presentations as well as on ways to improve future events.

The quantitative part

The quantitative part contains the following items, evaluated on a 5 point scale (1 – lowest mark; 5 – best mark):

- The **conference program** was evaluated at **3,95** with a very little variance (43 responses)
- **Organization of the event** received **4,5** with minimum variance (44 entries)
- **Accommodation** was evaluated at **4,8** with just five marks other than "5" out of 39 answers.
- **Evaluation of each separate workshop.** This part, as we found out, was probably not explained well enough and caused quite a bit confusion, which resulted in relatively smaller number valuable answers:
  - **The "harm reduction" workshop** was attended by the biggest group and received fourteen evaluation marks with an average of 4. Only one person granted a lowest rank (1), and four persons granted the highest possible rank (5).

- **The "Not just heroin" workshop** received ten marks with the average of 3,8 and relatively big variance.
- **The "Young people" workshop** received the highest evaluation of all the workshops. It was evaluated by six people with an average of 4,3 and minimal variance
- **The "Epidemiology" workshop** received just four evaluations with the mean of 4 and a small variance
- **The "Involving families" workshop** was evaluated by six people and received a high mean of 4,20 with a small variance
- **The "Involving NGOs" workshop** received only 2 evaluations. Both people granted the rank of 4.

It is worth mentioning that quite many people preferred to evaluate individual presentations rather than the entire workshops. Several referred to individual presentations even though they were asked to evaluate entire workshops.

The qualitative part

1. Conference Organisation:

General comments

General comments on the conference were very positive, successful and well organized. Several people suggested that the venue was too rich for that type of conference and that choosing a different venue might have resulted in a lower registration fee. The other common suggestion concerned the lack of representatives of prisoners and of service users. A single voice suggested that more detailed participant information would be very useful, specifically if it contained the area of interest, not just country and contact info.

Social events

The evaluation of social events ranged from "good" to "just excellent", especially the boat trip on Friday evening received very positive feedback.

Event organization

The organization of the event was evaluated very well. The only two issues which received delegates' repeating attention were the lack of proper sound-proof interpreting boxes and a very big plenary hall, which was evaluated as too big by several delegates.

2. Conference Programme

Comments on the program

Again, the event received an overall very positive feedback. Several issues pointed out by delegates were:

- probably too strong focus on Eastern Europe
- some countries lacked representation
- not enough time for discussion
- several voices requested more scientific and data-focused approach
- service-users as presenters missing

The most positive aspects noted by delegates were:

- a very informative content
- good plenary debate

A request for Russian-only session focused on some Eastern European / Central Asian issues was noted.

A single voice noted lack of an overall, strategic aim and final conclusions of the workshop.

Comments on Speakers and Workshop Facilitators

In general, speakers and chairs were praised for good management of time, passionate and informative presentations, and good preparation.

Comments on particular presentation

The following presentations received delegates increased attention:

- Final debate – “very interesting”
- Paolo Pertica Fellowship presentation by Elena Grigoryeva was evaluated positively on the informative level.
- Families workshop – “interesting and passionate”

3. Topic suggestions for future conferences

- Crack, cocaine and changing the prison system
- Working with diverse groups in prison
- Presenting real treatment programmes (e.g. CARAT)
- Youth, youth offenders
- “How to” workshops, e.g. how to design and implement needle exchange program in prison
- Efficiency data, including statistics of effectiveness of HR programs
- Evaluation methods and research designs
- Cultural aspects, e.g. immigrant/refugee drug patterns
- Presenting existing national law, guidelines and recommendations on HIV, health issues in prison etc.
- Different drug treatment attitudes in different closed institutions in one country
- Presenting available drug dependency treatment methods in prison settings
- More on HIV and Hepatitis C in prisons
- Treating clients with multiple problems in prison and after release

- Dealing with policy issues and political context
- Important key factors for success
- Drug trafficking and role of media
- Enforcing alternative sentences for drug-related crimes
- Involvement of service users
- Less known approaches to Harm Reduction
- Training for prison officers
- Hepatitis B – vaccinations for prisoners
- Legal obstacles to NGOs work in prisons
- Access to ARV therapy in prisons
- HR programs (in particular NE) in post-soviet countries

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