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Public Health England

Meeting report
International meeting on prisons and health in joint collaboration with Public Health England (PHE) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

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Day 1 (Monday, 11 December 2017)

Dr Carina Ferreira-Borges, Programme Manager for the Prisons and Health Programme (HIPP) at the WHO Regional Office for Europe, welcomed all participants to the conference and thanked the organizers: the WHO Regional Office for Europe, the United Kingdom Collaborating Centre for WHO HIPP (PHE), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Portuguese Ministry of Justice, and the Portuguese Reintegration and Prison Service. Thanks were given to the Finnish Ministry of Social Affairs and Health for providing funding to HIPP. Dr Ferreira-Borges spoke about the prevalence of drug use in the prison population and that effective treatment is essential for ensuring safety in prisons and preventing communicable diseases. Dr Ferreira-Borges noted that the aim of the conference is to share good practice in prison health care and harm reduction. HIPP was established in 1995, and since its inception, the programme has supported strengthening practice and collaboration with Member States. Moreover, in recent years, there has been an emerging interest from international partners beyond the European Region. Work is currently being undertaken on the Health in Prison European Database (HIPED), with 41 participating Member States. In addition, the Worldwide Prison Health Research and Engagement Network (WEPHREN) is an exciting step towards improving the evidence base for prison health.

Next, Dr Éamonn O'Moore, National Lead for Health and Justice at PHE (the United Kingdom Collaborating Centre for WHO HIPP), welcomed all participants to the conference and spoke of gathering evidence to support the understanding of health needs of people in prison and improving the health and well-being of those individuals. Dr O'Moore noted that improving health among prisoners is an important strategy to address health inequalities both within prisons and in the wider society, as prison health care provides an opportunity to address these inequalities. Dr O'Moore also spoke about 'The Community Dividend', which is the societal benefit from public health interventions in prisons and ensuring that no one in prison is left behind from wider improvements in health. Finally, Dr O'Moore noted that HIPP provides global leadership to support this remit.

Following the Collaborating Centre's welcoming remark, Mr Alexis Goosdeel, Director at EMCDDA, welcomed all those who had contributed to organizing this conference, from the Portuguese Ministry of Justice, WHO Regional Office for Europe, PHE, EMCDDA, ECDC, Council of Europe and all other colleagues. Mr Goosdeel spoke about emerging trends in drug use in prison and changing behaviours and risks, and the increasing challenge of addressing these behaviours in prison. Whilst Mr Goosdeel noted that there are many challenges in prison health, the meeting will provide an opportunity to discuss and share learning among all partners, which can contribute to the adoption of best practice in prisons. Finally, thanks were given to Dr Lars Møller for all his work and effort throughout the years managing HIPP.

Dr João Costa Freire, Chief of Cabinet of Secretary of State, Ministry of Justice, Portugal, welcomed the participants to Lisbon and gave thanks to the organizers. Dr Costa Freire noted that substance use in the correctional system is a distraction, making harm reduction a priority. A summary of the Portuguese prison population was given, including drug use patterns and statistics. Dr Costa Freire spoke about the shift in the dominant user profile and choice of substances, particularly towards new psychoactive substances (NPS). Furthermore, Dr Costa Freire informed participants about the new strategy for diagnosis, prevention and treatment of communicable diseases is prisons, which is a new partnership between the Ministry of Justice and the Ministry of Health.

In concluding the welcome speeches, Ms Marianna Zwozdziak-Carbonne, Policy Assistant to the Director, Health and Food Safety at the European Commission, gave an opening address. Ms Zwozdziak-Carbonne spoke about prison health care as a very diverse field, including communicable diseases, drug use and other health care issues. Monitoring and surveillance work from EMCDDA and the European Centre for Disease Control (ECDC) has provided more data on communicable disease in prisons. For example, Ms Zwozdziak-Carbonne mentioned ongoing projects and programmes on HIV/AIDS, tuberculosis, hepatitis C and sexually transmitted infections. The evidence suggests that actively offering screening tests for communicable diseases yields a higher uptake of these tests in prisons. Ms Zwozdziak-Carbonne informed participants about a new Steering Group on Promotion and Prevention, which will support the United Nations Sustainable

Development Goals (SDGs) by selecting interventions from Joint Action projects and explore national implementation using EU funds.

Following the opening speeches, keynote presentations were delivered. First, Mr Paul Griffiths, Scientific Director at EMCDDA, discussed the function of EMCDDA in collecting both quantitative and qualitative data on drug use, drug related problems and drug treatment in prison. Mr Griffiths noted that whilst data in this area is poor, it is still informative. The picture across Europe is mixed in terms of data collection and policy, and major issues with the data are weaknesses in national coverage and country comparability. Caution is therefore necessary when interpreting and commenting on trends over time. The overall picture, however, is still one of unmet needs despite improvements over time. Mr Griffiths also spoke about the high lifetime prevalence of drug use and drug related problems before and during imprisonment and that drug use and risk behaviour can continue or be initiated in prison, meaning that prisons are regarded as a high-risk setting for drug use. However, for some individuals, incarceration presents an opportunity for engagement with health services. Mr Griffiths highlighted the two main international principles that should drive the implementation of responses to drug-related problems in prison in Europe: equivalence and continuity of care between the community and prison. Finally, Mr Griffiths talked about the EU Early Warning System for NPS, which detects new substances and has shown a shift from recreational to problem drug use with new synthetic opioids and cannabinoids emerging that are often highly potent and difficult to detect.

Next, Mr Celso Manata, Director General of the Portuguese Reintegration and Prison Service, summarized the Portuguese criminal justice system, which includes 49 prison establishments, 13 900 inmates, 48 probation teams, and six educational centres in Juvenile Justice with 154 young offenders. All prisoners are entitled to use the National Health Service, with equivalent access to services and standards as in the community. Services provided in prisons include medicine, nursing, psychology, pharmacy, and nutrition, with a specialized prison hospital providing acute and psychiatric care. The rates of HIV, hepatitis B and hepatitis C, and tuberculosis are declining within Portuguese prisons. Mr Manata discussed the drug-free units in prison, which involve a voluntary, abstinence-based, integrated intervention for addiction-related

problems with multidisciplinary teams formed of staff from health care, surveillance/security, education and training that focuses on the development of social and interpersonal skills.

Dr João Castel-Branco Goulão, General-Director at Services for Interventions on Addictive Behaviours and Dependencies (SICAD), discussed how the management of prison health care is the responsibility of the Health Care Management Department (CCGCS) under the Ministry of Justice. There is a new model of care focusing on treatment, prevention and public health, as well as preventing incarceration due to drug use. The National strategy on drugs and drug addiction led to the decriminalization of drug consumption in Portugal in 1999, a policy which is based on the principles of Humanism and Pragmatism. Drug use, possession, and trafficking remain illegal in Portugal, and in prisons, there are abstinence-oriented and pharmacological programmes available. Dr Castel-Branco Goulão spoke about how data trends show a decrease in the number of prisoners in treatment programmes, probably due to an overall decrease in opiate use in Portugal. In regard to screening for drug use, coverage in Portuguese prisons is close to 100% and takes place on reception and then once a year, with the aim of drug services in prisons being to promote the reduction of the use of psychoactive substances, prevention of addictive behaviours and decrease in dependencies in all contexts.

The next session focused on monitoring of drug use and drug-related harm among prisoners in Europe and beyond. First, Professor Stuart Kinner from the Murdoch Children's Research Institute in Australia gave a presentation on health data for the global prison population, including drug use, communicable diseases and risk factors for mortality following release. Professor Kinner noted that there are large gaps in data on the prevalence of HIV and hepatitis C among prisoners across the globe, as well as gaps in data on the number of people who circle through prisons annually. Professor Kinner discussed the Australian correctional system, where the most common drug of concern is methamphetamine. Furthermore, injecting drug use in prison is common, with one in eight prisoners reporting recent injecting drug use in Queensland prisons. Multimorbidity is normative in the prison population, with chronic physical conditions, psychiatric conditions and drug and alcohol use often co-occurring. Recently released prisoners are therefore high-cost users of community health services, as these costs are disproportionately incurred by individuals with dual diagnosis.

Professor Kinner spoke about risk factors for mortality following release from custody, as individuals recently released from prison are at increased risk of dying compared to the general population. The main causes of deaths after release from prison have changed over time from predominately opioid-related deaths to deaths caused by other drugs. Indigenous Australians are more likely to die from non-opioid drug-related deaths and not immediately after release from custody, but in the following months. In Australia, there is no spike in suicides following release from prison, but in the long term, suicides in ex-prisoners occur at the same rate as drug-related deaths following release. Overall, long-term survival following release from custody is poor, and youth detention is a major risk factor for mortality, indicating that alternatives to detention are desirable for reducing mortality.

The next presentation was given by Mrs Linda Montanari, Principal Scientific Analyst at EMCDDA, who discussed the work of EMCDDA in collecting data on drugs in prison from 30 countries; data were gathered from prison surveys, national surveys, prison workbooks on drug epidemiology and interventions and ad hoc requests. These data include health problems among drug users in prison, services for drug users in prison, and adverse effects after release. The European Questionnaire on Drug Use among Prisoners (EQDP) gathers information on substance use inside and outside prison and other health factors. Mrs Montanari explained how EMCDDA uses a checklist to ensure data collection tools are ethically appropriate and accurate. EMCDDA conducted a pilot exercise for the EQDP with a sample of five countries, which explored the lifetime prevalence of drug use before and during imprisonment, as well as injecting drug use before and during incarceration. Overall, it was found that the reduction of drug use in prison was lowest for tobacco and cannabis, and highest for heroin and cocaine. The prevalence of drug use in the prison population was higher than the general population. Heroin, cocaine and amphetamines are the most commonly used drugs. Mrs Montanari concluded that data monitoring is crucial to assess the extent and nature of drug use in prisons and the harmonization of data collection methods across countries is important to allow for comparisons between countries. The EQDP will continue to be applied to more countries, and a second component on drug-related interventions is currently being developed with partner organizations.

The next presentation was delivered by Dr Lars Møller and Dr Lisa Schölin, Consultants at the WHO Regional Office for Europe, who discussed the new database (HIPED), which is now live on the Global Health Observatory web site. The database aims to address the lack of comprehensive, consistent and reliable public health data on prison populations across the WHO European Region and was developed with funding from the Finnish Ministry of Social Affairs and Health. Forty-one countries have contributed to this database, and currently, data are available for 39 countries (two countries require further data validations before publication). Information on different health issues and indicators are separated into seven domains, and there are plans to support the expansion of this database to other WHO regions. In relation to drug use, the database includes indicators for screening for drug use, injecting drug use, harmful alcohol use, availability of harm reduction and treatment, and preventative strategies. Some preliminary trends show that the proportion of prisoners bio-medically tested for drug use varies significantly among countries, and injecting drug use prevalence varies considerably across counties. Screening for harmful alcohol use occurs in all prisons in 44% of Member States. Few countries have needle/syringe exchange programmes, and maintenance and detoxification are the most common treatment programmes available. Half of the countries do not have guidelines for the prevention of post-release drug-related deaths.

Dr Ehab Salah, Advisor at United Nations Office for Drugs and Crime (UNODC), discussed global prison statistics and noted that that since 2000, the global prison population increased by 20%. In 115 countries, prisons are operating at more than 100% of their capacity, and in 22 countries, prisons are operating at over 200% capacity. In four countries, prisons are operating at over 300% capacity. Poor prison conditions, such as overcrowding, contribute to the transmission of communicable diseases. Dr Salah discussed the issue of HIV in prisons on a global scale. For example, the prevalence of HIV is much higher in prisons in east and southern Africa than in other parts of the world, which also reflects the higher prevalence in the community. The female prison population has increased by 50% since 2000, and the prevalence of HIV among women in prison is higher than in men. In regard to prevention, only eight countries provide evidence-based needle and syringe exchange programmes in prison, while 52 countries have opioid substitution treatment (OST) in prisons. Resource issues and the absence of clear

policies are major barriers to health care services in prisons. Dr Salah stated that there are multiple global commitments to reduce HIV, including the SDGs, and there are many UNODC and UNAIDS publications relating to HIV in prisons, including the principles of the Mandela Rules and Bangkok Rules. UNODC has developed a global survey on HIV in prisons and supports countries to develop policies, strategies and action plans for sustainable HIV and tuberculosis responses, as well as to operationalize health strategies in service provision.

The next session focused on drug prevention, treatment and harm reduction in prison. The first presentation illustrated the perspective of people in prison and featured a video with interviews with prisoners from a drug-free prison in Portugal. Two prisoners talked about their experiences using drugs heavily in both the community prior to incarceration as well as during their prison sentence. Both inmates had been selected for the drug-free prison programme and talked about their current experience of living drug-free in custody.

The next presentation was given by Mrs Sunita Stürup-Toft, Health and Justice Public Health Specialist at PHE (the United Kingdom Collaborating Centre for WHO HIPP), who spoke of the importance of raising awareness about the United Nations Mandela Rules. The rules focus on protecting and supporting people in prison, and Mrs Stürup-Toft focused on how these rules are being applied in practice. There are 122 rules, divided into nine thematic areas, with one area being health needs. The Rules clarify that the health care of prisoners is a state responsibility, and services should be of an equal standard to that available in the community and organized in close relationship with the general public health administration. Further to the Mandela Rules, there are United Nations rules on the treatment of women offenders and prisoners (the Bangkok Rules, 2010) and WHO provides guidance for the governance of prison health services.

Dr Lara Tavoschi, Scientific Officer for HIV/AIDS and Blood-Borne Infections at ECDC, gave an overview of a recently published systematic review on active case finding of communicable diseases in prison settings. Dr Tavoschi stated that in 2015, ECDC and EMCDDA published evidence-based guidance on prevention and control of communicable diseases in prison settings, which was developed collaboratively with input from international partner organizations. The guidance was based on the principle of

equivalence of care, as well as the guiding principles of consent, confidentiality, communication, correct test results, connection to care, supportive culture and continuity of care. Dr Tavoschi discussed active case finding, which is the systematic identification of people with a disease in a predetermined target group, using tests, examinations or other procedures that can be applied rapidly. The published systematic review was conducted on active case finding, which produced 90 literature sources including both peer reviewed and grey literature on HIV, tuberculosis, hepatitis B, hepatitis C, and sexually transmitted infections. It was found that for hepatitis B, hepatitis C and HIV, the uptake of testing and positive tests is variable across the region and that the introduction of opt-out testing leads to a further increase in the proportion of testing uptake. However, the evidence is not sufficiently strong to clearly specify the most effective timing and modality of testing for blood-borne viruses' active case finding in prison settings. In conclusion, it was found that the uptake for testing of sexually transmitted infections is generally quite high, and provider-initiated testing seems to be more effective for screening. It was also found that testing uptake for TB is high across countries in comparison to other communicable diseases, which is important considering the public health implications of TB transmission in closed settings. It was further concluded that provider-initiated strategies yield a higher uptake than client-initiated strategies for testing and that provider initiated approaches at entry to prison are consistent with the general principle of disease prevention to not delay testing in order to prevent transmission within the prison setting.

The next session looked at examples of drug prevention, treatment and harm reduction practices in prisons. First, Dr Fadi Meroueh[1], Chef de Service of CHU de Montpellier, presented on the elimination of hepatitis C in French prisons. The elimination of infection is the reduction to zero incidence of the infection caused by a specific agent in a defined geographical area. Hepatitis C is a chronic pathology of the liver and can significantly affect quality of life, with significant mortality rates. There is an overlap of risk factors for both incarceration and hepatitis C. Historically, hepatitis C therapy has not always been offered due to various factors, including homelessness, active injecting drug use, and liver disease. In Dr Meroueh's presentation, it was stated that older treatment

[1] Presentation was delivered by Dr Eammon O'Moore on Dr Merouh's behalf

methods including Interferon, which was long-lasting, required a lot of medication and had significant side effects. There is now a short and well-tolerated treatment for hepatitis C; however there is currently no vaccination. Direct-acting antiviral medications are now used, and almost 100% of patients are experiencing successful treatment, and there is no medical reason why individuals on OST cannot take direct-acting antivirals. The presentation also discussed the Montpellier prison, where testing for blood-borne viruses occurs on reception to the prison and consists of a dried blood spot test, which is a good testing modality especially for individuals who are intravenous drug users. There has been an increase in the uptake of testing over time as well as the number of patients taking up treatment for hepatitis C. Harm reduction interventions are also required to tackle hepatitis C, and these need to consider monitoring for re-infection.

Next, Dr Lisa Kawatsu, Senior Researcher at the Research Institute of Tuberculosis in Tokyo, discussed tuberculosis in prisons in Japan. The Japanese prison system includes 187 prison institutions, including both adults and juvenile prisons, as well as 105 correctional institutions, including juvenile detention homes. All prisons in Japan have a medical facility, which can be a clinic (that provides only primary care), a subhospital, or a prison hospital (general or psychiatric). However, a recognized issue in Japan is the serious shortage of prison medical staff. Dr Kawatsu stated that there is a low proportion of drug use in Japan due to harsh penal regulations and a strong societal intolerance to drug use. Rehabilitation of drug users has therefore been a neglected area with a limited number of specialist institutions and professionals. In Japan, 99% of drug related charges were for stimulants, and there is a 50% recidivism rate amongst those charged with drug possession. Dr Kawatsu discussed support for prisoners with drug addiction, including a rehabilitation training programme that commenced in 2007 and is based on a matrix model, not on a harm reduction approach. Nongovernmental organizations (NGOs) provide support for prisoners and ex-prisoners with drug addictions; however, there are a limited number of public health services offering drug rehabilitation programmes. As the rates of tuberculosis in prisons in Japan are high, there are now guidelines on coordinating care for prisoners.

Dr Jack Stone, Postdoctoral Researcher in Population Health Sciences at University of Bristol, discussed the relationship between

incarceration, drug use and communicable diseases. Globally, it is estimated that 58% of people who have ever injected drugs have been incarcerated at least once, and drug users typically experience higher rates of re-incarceration. Studies have shown that recent incarceration is associated with increased risk of injecting drugs, homelessness, and relapse to injecting drug use. Being incarcerated increases an individual's likelihood of acquiring HIV by 81% and hepatitis C by 62%. It is known that prison-based OST can reduce HIV infections, and the decriminalization of drug use could be another mitigation strategy for preventing the acquisition of communicable diseases.

The final session of the first day of the meeting looked at professional development in drug prevention, treatment and harm reduction in prisons. The first presentation was given by Dr Juma Khudonazarov, Advisor at HelpAge International, who spoke about how substance misuse in central Asia is a growing problem. As a response, training modules have been developed to help tackle substance misuse in countries in central Asia. Dr Khudonazarov discussed the challenges in tackling drug problems in central Asia, including: organized crime, the influx of drugs from across the region, increasing cases of HIV in the Russian Federation (which is an imminent threat due to migration in central Asia), lack of harm reduction programmes, lack of acknowledgment of addiction among women, increasing rates of violence, and production of opium in multiple countries across the region. There has been little investment in substance misuse treatment in central Asia; however, the developed training programmes are now aligned with the EU Drugs Strategy 2020 and aim to contribute to a reduction in the demand for drugs, drug dependence and drug-related health risks, as well as contribute to the disruption of the illicit drug market.

Ms Ann Norman, United Kingdom Professional Lead for Justice and Forensic Nursing and Learning Disabilities at Royal College of Nursing, spoke about how the workforce is the most valuable commodity in prison health care, and there must be investments to improve health service delivery in prisons. Currently, prisons in England are facing a complexity of needs and political challenges, including overcrowding which has led to prisons being less safe for both prisoners and staff, and is contributing to more self-inflicted deaths, self-harm and assaults. Ms Norman discussed the priority areas for prisons, including: the right framework to make improvements; raising standards; empowering governors; reform;

safety and security; developing leaders; and building the right estate. The NHS England Health and Justice Strategic Direction 2016–2020 was discussed, which focuses on care not custody, care in custody, and care after custody. Furthermore, Ms Norman spoke about how the nursing workforce is passionate about their commitment to their patients, but there is currently low morale within the workforce, related to recruitment and retention issues, staffing pressures, development and training opportunities, and a lack of understanding of prison health care among the wider health care community. The opportunities for nursing include enhancing nurse-led models, nurse prescribing and advanced practice, and developing the role of health care support workers. Daily challenges for the nursing workforce include the limited time for handover, limited breaks, high costs of living in hot spot areas, disinvestment in training budgets, lack of pay raises and rising costs of living. There are currently 36 000 nursing vacancies across the NHS in England, and so there is an over-reliance upon agency staff. It is essential to invest in the nursing workforce as they have an essential role in prison health care and a well-equipped and skilled workforce can deliver more effective care interventions.

The final presentation of the day featured a video developed by Professor Sheila Lindner and Mr Carlos Magno Neves and looked at a professional development programme in Brazil. The video raised awareness of professional development training courses in Brazil for graduated health professionals based on the challenges faced by these professionals working in prison health care. The training is delivered as an e-learning course hosted on a university web site with five modules on prison health and a formative assessment system to complete the course.

Day 2 (Tuesday, 12 December 2017)

The first session focused on recent and ongoing projects in the prison field, with updates from organizations. First, Dr Éamonn O'Moore spoke about the role of the WHO United Kingdom Collaborating Centre (PHE). The Collaborating Centre is focused on enabling and leading developments in prison health and building an evidence base that informs policy and practice to enable the delivery of the strategic objectives of HIPP. This requires building capacity across the system, including the prison health workforce. The Collaborating Centre also provides direct support to Member States,

for example, a review was conducted for Belgium to explore transferring the responsibility of prison health care from the Ministry of Justice to the Ministry of Health. Dr O'Moore outlined the key activities of the Collaborating Centre in 2017, including: the redesignation as a WHO Collaborating Centre for another four years; the launch of WEPHREN in July 2017; supporting the minimum public health dataset for prisons to enable the collection and collation of data across Europe, and potentially beyond Europe; global engagement opportunities; collaboration with EMCDDA and ECDC on data for health protection in prisons; the production of a number of publications; data, evidence and intelligence gathering, which is necessary to work towards reducing both health inequalities and reoffending. Dr O'Moore stated that the next step for the Collaborating Centre is to promote prison health in all health policies, so that all public health programmes consider people in prison, as well as working towards gathering more evidence on the effectiveness of health interventions in prisons. Additionally, in a WEPHREN survey, mental health and substance use were voted the top research priorities, while management skills were voted the top professional development priority. It was concluded that in the context of prison health, while the principle of 'equivalence' means providing the same quality and standard of care as in the community, it may in fact be more appropriate to consider the principle of 'equity', meaning that health services should be based on need, and therefore more services may be required in prisons due to a greater need for them in this population.

Next, Ms Annette Verster, Technical Lead for HIV and Global Hepatitis Programme at WHO headquarters, discussed the global issue of HIV and incarceration. There are currently 36.7 million people living with HIV globally, with the majority of cases concentrated in Africa, followed by South-East Asia and the Americas. Key populations, such as people who inject drugs, are important in epidemic settings, and key populations are disproportionately affected by HIV in every region. The most vulnerable populations tend to be over-represented in prisons, and also to a greater extent suffer from communicable diseases and mental health issues. Ms Verster spoke about the cost–effectiveness of harm reduction strategies for drug use, which yield a positive financial gain, as opposed to incarcerating people who use drugs, which is not financially beneficial. In prisons, HIV risk factors include syringe sharing, lack of availability of condoms, sexual

violence, high-risk sexual behaviours, and tattooing and piercing. Prisons therefore concentrate HIV risk. and ex-prisoners may return to the community with an infection. It is important to note that what happens in prisons has an impact on public health in general. Ms Verster discussed evidence-based interventions, and although interventions that work in the community are known to also work in prisons, implementation levels are low. People in prison often face interruptions in treatment programmes due to a lack of continuity of care between the community and prison, and this negatively affects treatment. WHO promotes structural interventions, such as harm minimization strategies, supporting policy, and addressing stigma and discrimination, within a comprehensive public health approach. The challenge for prison health care is to work within a law enforcement system that is focused on punishment and protecting society and is not aligned to the public health approach of promoting the health of individuals and society. However, in order to address the HIV/AIDS epidemic, the prison population must not be forgotten and collaboration with stakeholders in the criminal justice system is essential.

Mr Robert Teltzrow, Principal Project Consultant at Pompidou Group of the Council of Europe, discussed the Pompidou Group's aim of supporting evidence-based drug policies and connecting research with practice and policies. The target group consists of drug users in contact with the criminal justice system, a stigmatised population vulnerable to illness and infections. The Pompidou Group's programme objectives are to improve drug legislation and drug treatment services in prisons, and to reduce prison overcrowding by promoting alternatives to incarceration. Mr Teltzrow provided examples of regional projects. In the Republic of Moldova, work has been undertaken with the goal of strengthening and diversifying drug treatment and rehabilitation services in prisons. To achieve this, prison staff and social workers have been trained on how to run a prison-based Therapeutic Community. In Georgia, the focus has been on developing policy changes on alternatives to imprisonment in line with European standards. A national roadmap for policy changes has been developed, a comparative study undertaken, and based on this work, recommendations on alternatives to punishment have been formulated. Finally, work in Ukraine has focused on improving therapeutic tools in juvenile prisons, which led to the pilot of the

Family Conference methodology that provides support to juvenile prisoners.

In the final organizational update, Ms Alison Hannah, Executive Director of Penal Reform International (PRI), spoke about PRI's work to promote fair and effective justice systems and humane treatment and conditions for prisoners. PRI advocates for drug use to be treated as a health rather than criminal justice issue, through practical programmes to improve health care in prison and advocacy to raise awareness and support for proportionate responses to drug offences and reducing the over-use of imprisonment. Currently, one in five prisoners worldwide is incarcerated for drug-related offences; of those, 83% are for drug possession (low-level offenders). Women are disproportionately imprisoned for minor offences, with serious consequences for their health and their families. Ms Hannah noted that prisons do not prevent drug use, and some prisoners begin injecting drugs whilst in prison. Treatment in prison is often unavailable, rates of communicable disease are far higher than in the community, and there is a large disparity of provision of OST and needle and syringe programmes between the community and prison. PRI advocates for promoting the removal of criminal penalties for minor offences, proportionate sentences, non-custodial sentences (probation and community service orders), better health services in prison, and post-release support to reduce mortality and aid integration. Ms Hannah outlined the Portuguese example, where drug use was decriminalised in 2001 and a Commission was set up to provide treatment and support for users. Following decriminalization, HIV infections reduced from 907 in 2000 to 79 in 2012 and drug overdose deaths are now the second lowest in Europe. Ms Hannah noted that prohibition as a drug policy has failed to reduce the global drug problem and has instead led to mass incarceration, overcrowding, poor health and violence in prisons. In 2016, a United Nations General Assembly Special Session on drugs was held; however, the assembly could not reach an agreement on a global change of policy direction. There was however an increased awareness of alternative ways to treat drug offenders, and the outcome document called for proportionate sentencing practices for drug-related offences and encouraged the use of alternatives to imprisonment.

The final session focused on updates from Member States. First, Dr Lars Håkan Nilsson, Senior Medical Adviser for the Swedish Prison and Probation Service, gave an overview of treatment of substance

use disorders. Dr Nilsson stated that there are 4000 inmates in Sweden, and every third inmate has a sentence for a drug-related crime. Based on self-reports, 20% experience excessive alcohol use, 30% use illicit drugs, 21% report alcohol and drug use, and 29% reported no use of substances. In Sweden, the main responsibility for drug treatment is held by social services in the community. There are 6000 places for OST in Sweden, and there is also a focus on non-pharmacological treatment, which involves institutions with accommodation and cognitive behavioural therapy based programmes. Dr Nilsson explained that there are high rates of hepatitis C, and Sweden has one of the highest rates of overdose deaths in Europe. Opioid maintenance therapy is only possible in prison if it has been started in the general health care system in the community. In two Swedish regions, prisoners are treated in prison for hepatitis C, but only if they have cirrhosis (degree two to four).

Next, Dr Zdeněk Šmerhovský, Senior Officer, Health Services, Prison Service for the Czech Republic, gave a presentation. Dr Šmerhovský outlined the Czech prison system, which includes 35 prisons and a total of 22 500 prisoners. Of the total prison population, 8% is female. Prison security categories in the Czech Republic include minimum, medium, high, and maximum security, as well as juvenile prisons. There are 11 000 prison employees across the system, and most specialists working in prisons, including health care staff, are civilian employees. Dr Šmerhovský stated that in the Czech Republic, 25% of prisoners meet the ICD-10 criteria for addiction, 30% of prisoners are problematic drug users and 50% of prisoners have tested positive for drugs on admission to prison. During imprisonment, the rate of detection is approximately 4–5% for positive drug tests. There is currently a high consumption rate of methamphetamines in the Czech Republic. Treatment for drug use within the prison system includes detoxification (opioid agonists or benzodiazepines for approximately seven days), substitution maintenance treatment (this cannot be initiated in prison but can only be continued from treatment before admission, and there is capacity for only 50–60 patients), counselling (offered in all prisons), drug-free zones and specialized units organized as a therapeutic community (voluntary and court-ordered treatment), and harm reduction measures (including condom distribution).

Ms Merja Mikkola, Development Manager at the National Institute for Health and Welfare in Finland, gave an update on the Finnish prison system. Prior to 2015, the prison health care in Finland was

the responsibility of the Ministry of Justice. However, on 1 January 2016, prison health care was transferred to the Ministry of Social Affairs and Health An inter-ministerial working group was essential for the transfer to ensure that expectations were met regarding roles and responsibilities. The planning took place during 2015 and the law on 'Organizing Prisoners' Health Services' was passed on 31 December 2015. Ms Mikkola stated that to facilitate the transfer, a new management team and board were appointed, consisting of academics, social services staff, and advocacy groups. Both the Ministry of Justice and Ministry of Social Affairs and Health collect information about prisoners in their own databases, so there were discussions on how information could be shared effectively during the transfer. The trilateral cooperation agreement between health care, the prison service and the Health Institute, was finalized in 2016, which set out roles and responsibilities. Ongoing development work following the transfer includes strategic work (to help prisoners in custody prepare to return to the community), ICT information sharing and health records, human resources, budgeting, performance management, continuity of care, quality management, and a new prison concept to build a women's prison.

Dr Tatyana Gaborets, Head of Medical Office at the Ministry of Justice of Ukraine, gave an update from Ukraine, where prison health services are currently in the process of becoming independent from prison services, as the responsibility of health care moves from the Ministry of Justice to the Ministry of Health. Dr Gaborets stated that in Ukraine, the HIV prevalence decreased from 15% in 2009 to 7.6% in 2017. More than 60% of HIV positive prisoners currently receive treatment in prison. Ukraine is open to cooperation with the international community in the field of prison health.

In the final presentation, Dr Éamonn O'Moore provided an update for the United Kingdom for 2017. In England, the implementation of the smoke-free prison programme currently covers 60% of the estate, meaning 48 000 prisoners are now living in a smoke-free environment, and implementation will continue over the following months. In Wales, the smoke-free programme has already been implemented across the entire estate. In Scotland, Northern Ireland and the Republic of Ireland, smoke-free prison estates are currently in the planning stage. In England, a blood-borne virus testing programme has been implemented to improve testing and access to treatment for HIV, hepatitis B and hepatitis C. A partnership event was held to review the implementation of this strategy with NHS

England and Her Majesty's Prison and Probation Service, with full implementation due by April 2018. PHE continues to work with NHS England to improve the quality of data collection; the Health and Justice Indicators of Performance reveal that 80% of new receptions to prisons were offered testing for blood-borne viruses and 25% of these prisoners accepted testing. Dr O'Moore stated that there is a continued need for partnership work across agencies to implement any programme in the prison setting as well as a need to think about sentencing options available for individuals with drug-related crimes in a community setting. Other highlights for PHE in 2017 included the publication of new national drug strategy aimed at reducing demand and restricting supply, an evaluation of a drug recovery prison in England, clinical guidelines for drug dependence in the criminal justice system, and a revised prison health care partnership board in England.

Following the formal session on organization and country updates, a session was organized to discuss a potential meeting statement on drug use and drug-related harm in prisons. There was a general discussion amongst delegates on how the Lisbon Statement could be amended. Suggestions included:

- Dr Salah suggested adding a call to prison policy-makers, health and justice professionals and prison administrators to adopt the United Nations comprehensive package of services to address HIV, tuberculosis, hepatitis B and hepatitis C; to undertake prison reform measures to improve living and working conditions; and to develop, adopt and implement alternatives to prison and punishment and reduce the excessive use of pre-trial detention.
- Dr Ferreira-Borges suggested adding advocacy for supportive legislation, structural changes and policy changes.
- Dr Marc Lehmann, Northern Dimension Partnership in Public Health Expert Group on Prison Health, suggested that the document should not be limited to a list of particular diseases, but should be open to include all health problems.
- Professor Kinner suggested adding that prisons are important settings to address health inequalities, and recognizing that treatment and prevention programmes restricted to prison settings are unlikely to have sustained benefits to people experiencing imprisonment.

- Dr Samuel d'Almeida, Hospital Practitioner Centre Hospitalier Sud Francilien, suggested adding that prisons should be included in all public health policies.

The final session of the meeting was a keynote speech from Dr Cees Goos and Dr Lars Møller – both previous Programme Managers for the Prisons and Health Programme at the WHO Regional Office for Europe. First, Dr Goos reflected on the fact that HIPP has grown since its inception 20 years ago. In 1992, the Health of the Nation – a strategy for health in England was published, which was the first Green Paper on public health or addiction that referred to prisons. Dr Goos noted that prisons are a source for disease epidemics to spread to the community, and HIPP therefore must operate within a broader public health agenda. Those who have the power to influence prison policy are governors and prison administrators, which can be a challenge for prison health care. Additionally, as the responsibility of prison health care has moved to the Ministry of Health in many countries, this can lead to the Ministry of Justice feeling that they no longer have any responsibility or role in the health of prisoners. Dr Goos thanked Dr Møller for continuing and building upon the programme and noted that the programme is in safe hands with Dr Ferreira-Borges's new appointment as Programme Manager. Dr Møller continued the presentation by reflecting on when he became Programme Manager in 2001. The programme was then able to continue with funding from France, the European Commission, the Netherlands, Switzerland, and Finland. The HIPP Steering Group meets once or twice a year and includes international organizations and Member States to share good practice and collaborate on projects, which along with funding, is essential to progress the work. Dr Møller noted that the launch of HIPED at the conference is a milestone for HIPP and creates a chance for expanding the prison health programme to other WHO regions.

Annex 1

Updates from Member States

Irish Prison Service – Drug Treatment Services
Deirdre O'Reilly

The Irish Prison Service seeks to ensure that those in custody receive healthcare services, including substance misuse services, on an equivalent basis to that available to those entitled to general medical services in the community.

Drug Treatment Services

Given the large number of persons requiring drug treatment services, the IPS endeavours to provide a comprehensive range of such services. It is the policy of the Irish Prison Service that where a person committed to prison gives a history of opiate use and tests positive for opioids, they are offered a medically assisted symptomatic detoxification, if clinically indicated. Patients can, as part of the assessment process, discuss with healthcare staff other treatment options, which may include stabilisation on methadone maintenance for persons who wish to continue on maintenance, while in prison and when they return to the community on release. Services available include the Drug Treatment Programme (DTP) as well as Slow Detox and Stabilisation and Relapse Programmes.

Drug rehabilitation programmes involve a significant multidimensional input by a diverse range of general and specialist services, including prison healthcare staff and in-reach services as required, including Addiction specialist (GPs and Consultant Psychiatrists), Addiction Pharmacists, dedicated Addiction nurses and Addiction Counsellors, as well as support provided by visiting statutory and non-statutory organisations.

On a daily basis, approximately 12% of the prison population access methadone treatment programmes.

Drug Strategy/Policy
The Irish Prison Service (IPS) continues to review existing drug treatment programmes, and Clinical Drug Treatment Policies, in line with the National Drugs Strategy –" Reducing Harm, Supporting Recovery" - and continues to seek to construct a range of programmes, support services and through-care options for prisoners demonstrating a commitment to addressing their substance misuse. IPS Drug Treatment policies are also being reviewed in line with national policy.

The IPS is now a co-lead, with the Dept. of Health and HSE, for the development and implementation of dual diagnosis services, to address the co-morbidity presence amongst the prison cohort.

Prevention
Overdose prevention is provided on a regular basis to those in custody, particularly close to date of release. In conjunction with the National Health Service Executive, Naloxone training is provided in some prisons, with the aim of extending this training to other locations in 2018.

NPS
With the recent concerns over the use of NPS, the IPS has developed an information booklet for all staff, outlining the most common substances and the recommended management of same.

Drug seizures/analysis
Data on the seizure of illicit drugs is maintained for the IPS by the Operational Support Group (OSG), which was established to assist in preventing contraband entering prisons.
In April 2016, all illicit drugs seized in all prisons were analysed by the Forensic Science Ireland that provides a scientific service to the Criminal Justice System. Their report outlined that the main drugs seized were heroin, cannabis and "tablets", while the level of NPS drugs seized was very low.

The IPS intends to continue to collaborate with FSI in this area.

Research

A recent Five Year Retrospective Study of Drug Toxicology and Self-inflicted deaths in the IPS reported that of the 69 deaths in custody between 2009 and 2014, 26 deaths (68%) were associated with use of illicit drugs, which are a major contributory factor to deaths of prisoners.

Luxembourg
Romain Stein

- There is a syringe exchange program organized by the nurses and otherwise anonymous.
- Psychiatrists and GPs are not informed about the users in order to make it easy for them to ask.
- That is the reason why we are not informed about the prevalence, there is only a statistics about the number of syringes given.
- We have not had drug related deaths for years, at least for 8.
- Methadone and buprenorphine substitution is available.
- Hepatitis C screening and and treatment is offered, unfortunately, we have a quite high prevalence of reinfections in prison and after release, about 25 percent.
- "Tox Project" is organizing the continuous care after release and cures in Luxembourg and abroad for some patients.
- As we have no real monitoring, we don't collaborate with other organizations.

Sweden
Lars Håkan Nilsson

According to self-reporting questionnaires ¾ of Swedish inmates use either alcohol or illicit substances. Among the users 1/3 use only alcohol, 1/3 only illicit substances and 1/3 both alcohol and illicit substances. The psychiatric comorbidity Is highest among the poly-drug users. The use of substances within the prisons are fairly low due to the security system. Randomized urine samples are taken regularly with very few positive results, most coming from newly arrived persons to open prisons who probably had used the substances before arrival. Quite many persons in the remand prisons are treated for different kind of withdrawal symptoms. Severe withdrawal as delirium tremens are sent to hospital. This year we had on person who died in remand prison and according to forensic toxicology the cause of death was a combination of illegal imported benzodiazepines and buprenorphine.

All prisoners are offered manual based programs against substance use and some prisons also offers 12-step programs. The responsibility for drug treatment is on the communities and if the community agree an inmate can finish his/her sentence at a treatment centre. A governmental investigation suggested that the responsibility for treatment of SUD should be changed to the counties (Health care system) and that is a strong need. In that situation it was also suggested that MMT could be initiated within the Prison system. Today only few treatments with methadone/buprenorphine are initiated in prison.

Naloxone for nasal use is not available in Sweden yet and could only be prescribed for own use for i.v use. The health care system in southern Sweden plan to use nasal naloxone when available and The Prison system wants to be a part of that project. We plan to educate the inmates in cardiopulmonary rescue with focus on overdoses. We send annual report to EMCCDA.

Poland
Mariola Grochulska and Paweł Kaczor

According to the Executive Penal Code healthcare assistance is provided to the convict primarily by healthcare units for imprisoned persons. Non-prison healthcare units cooperate with the health service in prisons in order to provide the convicts with healthcare services, when it is necessary, in particular to provide healthcare assistance immediately due to a threat to life or well-being of the convict or to conduct specialist tests, treatment or rehabilitation of the convict. If the prison doctor suspects a drug addiction, he defines the place of accommodation in prison, method of the monitoring and sends to the psychiatrist. In Polish prisons is also provided substitution treatment for the inmates who are opiate dependant. "Substitution Program for imprisoned persons in Poland" is implemented in a close cooperation with the National Bureau for Drug Prevention, medical centres and other institutions which help drug addicted on the area of the whole Poland. On 30th September 2017 substitution treatment was provided to 144 prisoners.

Drug addicted persons undergo a therapy in prison. In Polish prisons are located 16 therapeutic units for drug addicted sentenced prisoners with 587 places. The therapy is based on the programs approved by the Director General of the Prison Service and conducted by a therapeutic team including a psychologist and a therapist. An order to undergo a therapy can be a part of the sentence given by the court and in this case the therapy is obligatory. It can also be a voluntary decision of the inmate to undergo a therapy and in this case, a deciding body is a Penitentiary Commission.

A regular offer for drug addicted convicted prisoners includes: 6-months stationary therapeutic programs with extended spectrum of objectives, psychotherapy of addiction as well as social rehabilitation based on abstinence.

In 2016 the addiction therapy was provided to 1556 prisoners, an average waiting time for the therapy is about 14 months. Additionally, in all prisons in Poland the convicted inmates who used to use drugs participate in preventive programs. These programs are conducted by personal educators and psychologists.

In 2017 the Prison Service and the National Aids Centre organised two international seminars under the Join Action project entitled „ HIV, infection prevention and harm reduction (HA-REACT)" implemented as a part of the Third Programme in the Area of Health of the European Union (2014–2020). The objective of the seminars were to extend the knowledge of the personnel working in prison about the implementation of effective substitution programmes as well as learning about harm reduction programmes from the perspective of other countries. The participants were the representatives of Poland, Germany, Czech Republic, Luxemburg, Hungary, Lithuania, Latvia, Greece, Italy and Finland, who are responsible for planning and implementation of the treatment programmes and harm reduction in the prisons in their countries.

Czech Republic
Zdenek Smerhovsky

In early 2016, the Government of the Czech Republic approved the Conception of the Prison System to 2025 which consists of 9 areas including illicit drug issues. In the field of illicit drugs, the conception defines two main strategic objectives:

- functioning and properly interconnected standardized system of effective expert assistance to users of addictive substances motivating to abstinence not only during the execution of sentence but also after the release.
- effective protection of the prison environment against intrusion of illicit substances, reduction of the use of narcotic drugs and psychotropic substances by prisoners and systematic prevention of the spread of drug addiction.

The different areas of the Conception are outlined in the Action Plan for 2016-2018, which also includes cooperation under the Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT). The harm reduction in prison system is a priority for the Czech Republic and involves a wide range of activities. One of them is the free-off-charge distribution of condoms, which has been carried out by means of condom dispensing machine at selected departments of the Remand Prison Pankrac in Prague as a pilot project since 2017. In the framework of this project and in accord with the Conception and the Action Plan, a free-off-charge distribution of condoms has been introduced for visits without visual and hearing supervision of prison staff.

The prevalence of drug use in the whole prison population (22 481 inmates in 2016) is estimated based on 3 main sources:

- a survey, which is carried out every 2 years, indicating approx. 30 % of problem drug users,
- risk/needs assessment tool SARPO indicating approx. 25 % of abusers or dependent according ICD-10 criteria,
- routine urine testing on admission, positive for illicit drugs use in approx. 50 % of new inmates.

Primary prevention, treatment of addictions and reduction of possible health and social impacts of drug misuse were implemented in prisons through drug prevention counselling, drug-free zones,

specialized departments with intensive care based on principles of therapeutic community and other programs. Drug prevention counselling teams were in all prisons in 2016. The services of some of them utilized 9 329 inmates in 2016. The drug-free zones are a separate prison departments, either with standard or therapeutic regimen. The drug-free zones with the standard regimen were in all prisons, their accommodation capacity was 1943 inmates. A total of 3 prisons had drug free zones with therapeutic regimen. Accommodation capacity was 92 inmates. It was used by 221 inmates.

The treatment of addictions during imprisonment could be completed in specialized departments, available in 12 prisons, of which 9 are specialized prisons, designated for voluntary treatment and 3 prisons are assigned for the execution of a court-ordered protective treatment. The capacity of specialized departments with voluntary treatment was 335 inmates. The option for voluntary treatment in one of the departments was used in 2016 in total by 578 inmates. There are 9 prisons providing opioid substitution therapy. Substitution treatment programs in prisons recorded 67 persons involved in the substitution program. Methadone was used as the substitution substance in all cases. Detoxification was performed in 6 prisons. The treatment of acute withdrawal syndrome was administered to 194 patients. Users of opioids accounted for 65 % of detoxified patients, users of methamphetamine for additional 35 % of patients.

United Kingdom of Great Britain and Northern Ireland
Éamonn O'Moore and Sunita Stürup-Toft

Drug use in the United Kingdom is among the highest reported in Western Europe. In 2015 to 2016, around 2.7 million (8.4%) 16-59 year olds in England and Wales reported using a drug in the last year. According to the National Drug Treatment Monitoring System (NDTMS), a national database on specialist substance misuse treatment received in the community and in secure settings, 60,254 adults were in contact with drug and alcohol treatment services within secure settings during 2015-16.

The presentation will take into consideration the publication of the recent England and Wales national drug strategy (July 2017), as well as new United Kingdom clinical guidelines on Drugs and Drug Dependence (July 2017) which place a stronger emphasis on recovery and on a holistic approach to the issues and interventions that can support recovery as well as incorporation of a new chapter on clinical guidance on prison-based treatment.

Current actions in the United Kingdom on this agenda include PHE's work with partners on testing and evaluating new approaches to community sentence treatment requirements (CSTR) as well as a Drug Recovery Prison pilot. To coincide with the publication of the first annual report on individuals receiving treatment for drugs and alcohol misuse in prisons and other secure settings, PHE also released three new reports relating to substance misuse in prisons, including a Brief interventions in prison: Review of the Gateways initiative, Thematic analysis of training for prison staff on new psychoactive substances and New Psychoactive Substances (NPS) in prisons: A toolkit for prison staff.

In regards to drug related harms, a United Kingdom annual report called Shooting Up (November 2017) which looks at infections in people who inject drugs, Hepatitis C prevalence remains high and half of those infected are undiagnosed, HIV levels remain low, but risks continue and although Hepatitis B remains rare, vaccine uptake needs to be addressed. England has been working on a BBV opt out programme in prisons for 3 years and recently reviewed progress at an event held by PHE in partnership with NHS England and HMPPS

on November 30th in London. The event promoted the final phase of implementation the blood-borne virus (BBV) opt-out testing programme for consenting eligible adults in prisons in England. Currently, 75% of adult prisons in England are implementing BBV opt-out testing with full implementation by March 2018 agreed between PHE, NHS England and HMPPS. Since the introduction of the programme, there has been a reported seven fold increase in collective (HBV, HCV and HIV) testing uptake observed compared to traditional prison testing baseline before BBV 'opt-out' programme implementation (increase from 4% to 29%).

United Kingdom developments on smoke free prisons with the current England programme being successfully rolled out in partnership with NHS England, Her Majesty's Prison and Probation Service, and Public Health England. Scotland is also developing plans for roll out, Northern Ireland are actively considering action on this and Wales already has a smoke free prison estate.

Copenhagen, 29 January 2018