

Drug situation in European prisons and HIV prevention programmes

EXECUTIVE TRAINING: “Drug Treatment and HIV Prevention”

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The Nelson Mandela Rules:

Rule 24

1. The provision of health care for prisoners is a State responsibility.

Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

The Nelson Mandela Rules:

2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.

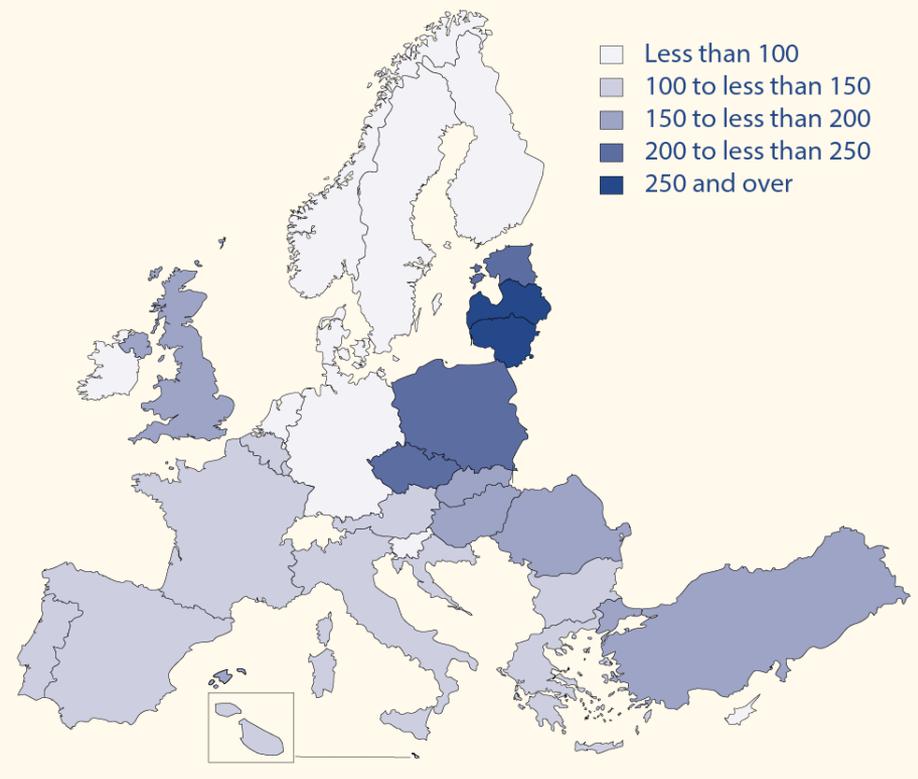
1. Epidemiology



Prison Population in Europe¹

~ 770.000²

- ~2000 prisons in EU-30
- Prison Population Rate: EU: 130
- Russia: 475; US: 698
- 4 % women (~ 32 000)
- 17 countries with overcrowding
- 16 % average foreigners
- 1 / 4 prisoners no final sentence
- DU mainly short sentences
- High recidivism
- Vulnerable and marginalised



¹ Sources: SPACE 2014 – Council of Europe

- Europe: 28 EU countries, Norway and Turkey;
- International Centre for Prison Studies

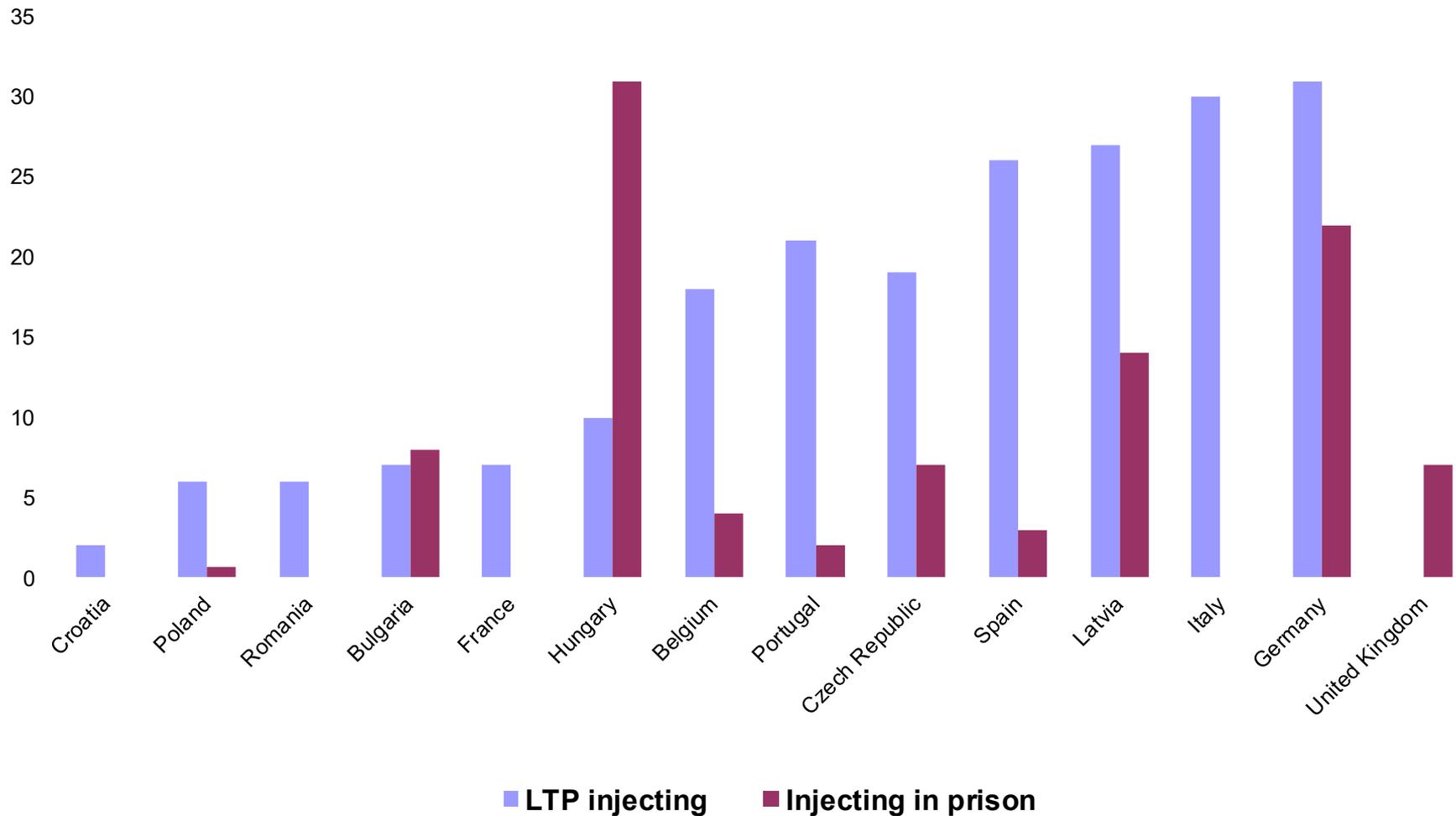
² 1st September 2013 – data collection Linda Montenari et al. EMCDDA

Drug Users in European Prisons¹

- ~ One million prisoners per year in Europe
- 15-25% sentenced for drug related offences²
- US: 25-50% drug dependent on admission³
- Europe: ~ 1 in 6 prisoners problem drug users⁴
- 10–42% report regular drug use in prison
- 1–15% have injected drugs while in prison
- 3–26% first used drugs while incarcerated
- Up to 21% of injectors initiated injecting in prison⁴
- 90% relapse to heroin after release⁵

¹ Stöver & Michels (2010): Drug use and opioid substitution treatment for prisoners. In: Harm Reduction Journal 2010, 7:17; ² Source: Council of Europe-SPACE I, Table 7; ³ Fazel et al. (2006); ⁴ Hedrich et al. (2012); ⁴ Stöver & Kastelic 2014, ⁵Stöver 2016

Drug injecting among prisoners (before and within prisons)



Source: Statistical bulletin 2013

BG: heroin; LV: amphetamines; UK: females

Different years ; data: Lisa Montenari, EMCDDA

People Who Inject Drugs and Infectious Diseases in prisons¹

- Unprotected sex,
- multiple sexual partners,
- low and inconsistent condom use,
- intravenous drug use incorporating the
- sharing of syringes, needles and drug use paraphernalia,
- tattooing and body piercing

are among the principal drivers of the global HIV epidemic⁴.

¹ Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. *Lancet Infectious Diseases*. 2009;9(1):57–66.

People Who Inject Drugs and Infectious Diseases in prisons¹

- HIV, STI, hepatitis B&C and TB prevalence **2 - 15 times higher**
- TB incidence rates **23 times higher**

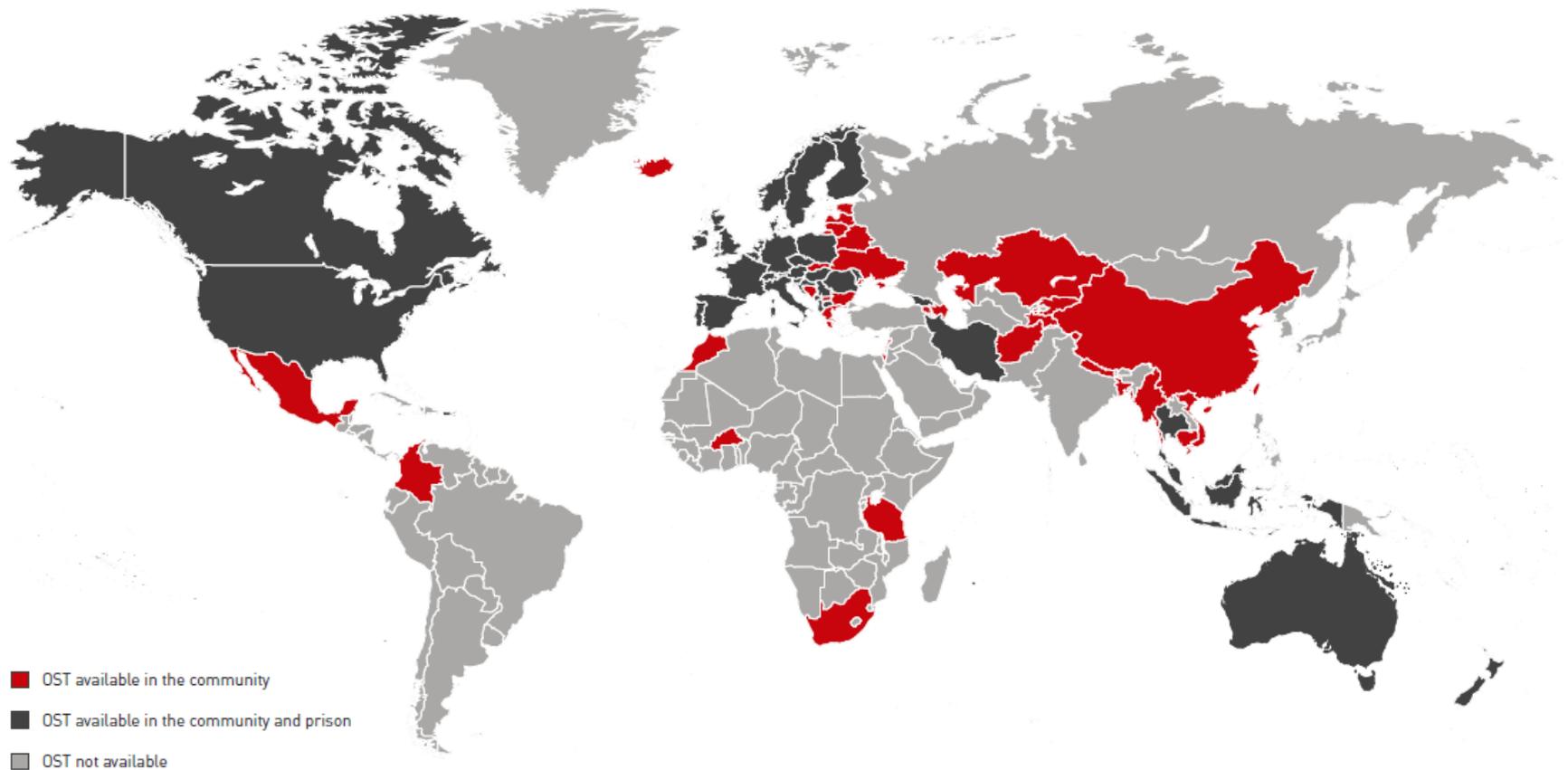


HIV-Prevention – The Comprehensive Package: 15 Key Interventions

(UNODC/ILO/UNDP/WHO/UNAIDS 2012)

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

OST in Community & Prison worldwide¹



1 HRI (2015): The Global State of harm reduction



Systematic OST review of prison¹

- Review of 21 studies (incl. 6 RCTs) shows that OST is effective among the prison population:
 - ++ reduced heroin use, injecting and syringe-sharing in prison, if doses adequate;
 - ++ increases in treatment entry and retention after release;
 - ++ post-release reductions in heroin use;
 - + pre-release OST reduces post-release deaths;
 - +/- evidence regarding crime and re-incarceration equivocal;
 - ? lack of studies addressing effects on incidence HIV/HCV;
- Disruption of continuity of treatment, especially due to brief periods of imprisonment, associated with very significant increases in HCV incidence.**

Andrej Kastelic, Jörg Pont, Heino Stöver

Opioid Substitution Treatment in Custodial Settings A Practical Guide



world health organisation



UNITED NATIONS
Office on Drugs and Crime

ОПИОИДНАЯ ЗАМЕСТИТЕЛЬНАЯ ТЕРАПИЯ В ТЮРЬМАХ

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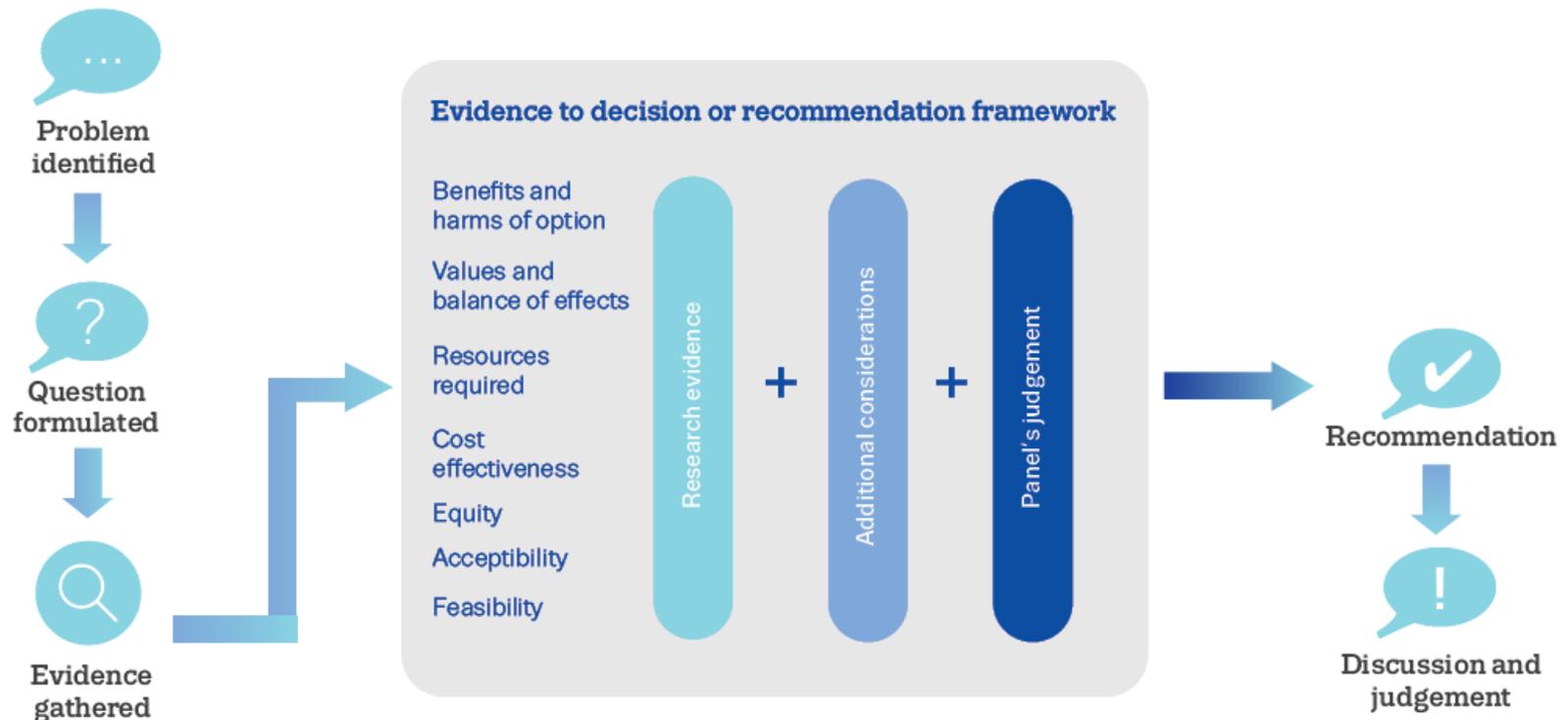
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**Adopted to the national situation
and translated into several
languages**

Implementation

FIGURE 5.1
Using the DECIDE framework for evidence-based decision-making



NB: This graphic is based on an image originally produced by Dr Sarah Rosenbaum, Norwegian Institute of Public Health, Oslo, Norway.

More information on the DECIDE project is available at <http://www.decide-collaboration.eu>.

2. Reduction of post-release mortality

Factors contributing to increased risk of acute death upon release in people with opioid use disorder (OUD)

- Physiological: desensitisation to opiates
 - Fatal OD if pre-incarceration dose is consumed at liberty
- Behavioural:
 - Acute injection (increases drug bioavailability and respiratory effects)
 - Concurrent with alcohol and benzodiazepine (tranquilliser) (exacerbates suppression of respiratory drive)
 - Concurrent with cocaine (induction of cardiovascular arhythmias)

Drug Related Death after Release

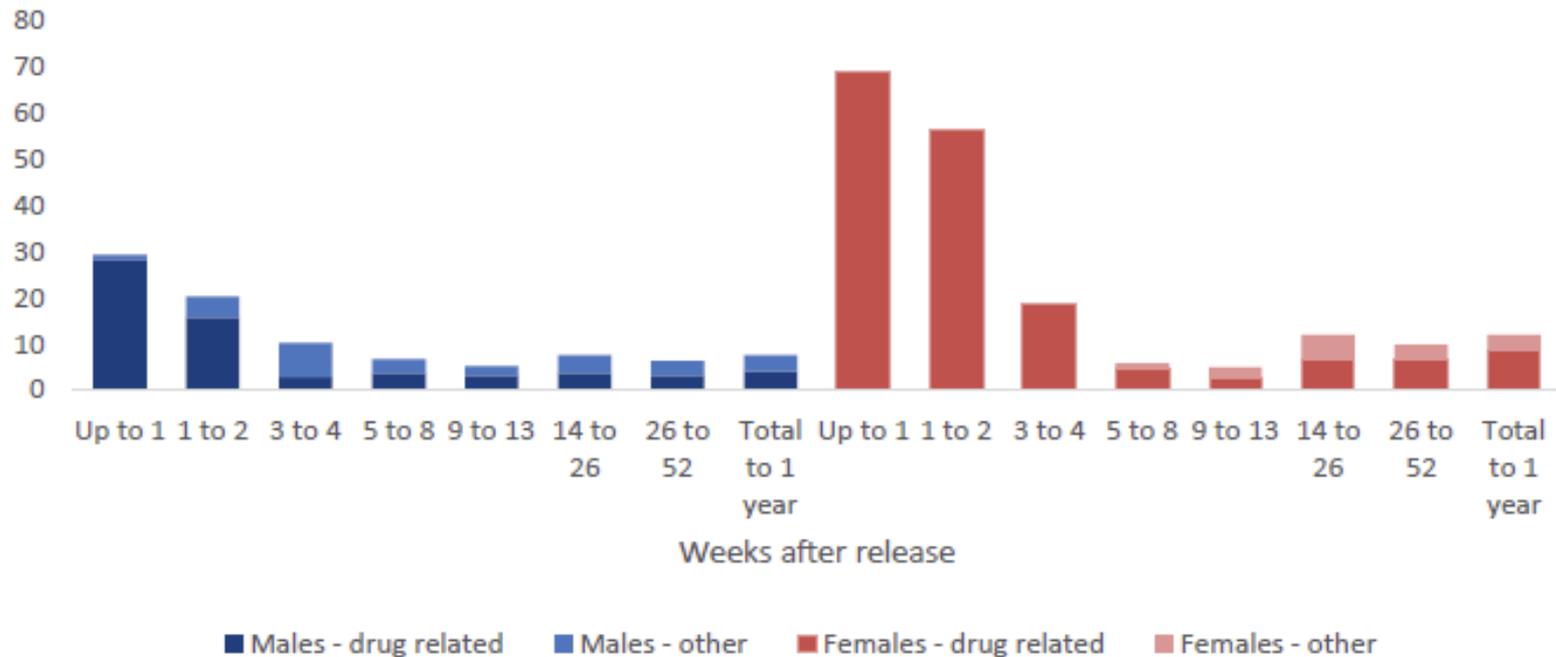
- Mortality risk in the first weeks after release
- European studies on excess mortality risks:
 - England/Wales (first week): X 29 (M) X 69 (F)
 - Denmark (first two weeks): X 62 (M/F).
 - France (first year): X 24 (M 15-34); X 274 (M 35-54)
 - Ireland: comp. Drug Related Deaths prison/no prison:
 - 28% of DRD had left prison since one week
 - 18 % of DRD had left prison since one month

Acute risk of drug-related death among newly released prisoners in England and Wales

Michael Farrell & John Marsden *Addiction*, 103, 251–255

National Addiction Centre, Division of Psychological Medicine and Psychiatry, Institute of Psychiatry, King's College London, UK

Excess mortality rates for released prisoners - drug related deaths & other causes



Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England

John Marsden¹ , Garry Stillwell¹, Hayley Jones², Alisha Cooper³, Brian Eastwood³, Michael Farrell⁴, Tim Lowden³, Nino Maddalena³, Chris Metcalfe², Jenny Shaw⁵ & Matthew Hickman²

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Health & Wellbeing Journal Club - 03/03/2017

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Conclusions

- Prison-based OST (with oral methadone or oral buprenorphine) is a highly effective means of **reducing the risk of death** (75% reduction) among people in the first 4 weeks after release from prison.
- The protective effect observed for OST in this study was independent of behavioural confounders or admission to community treatment.

**3. Take Home Naloxone (THN)
for opioid overdose prevention
in people who use drugs on
release**

THN: Example of Scotland

- Peer trainers/educators are used with success in Scotland to conduct **training on naloxone**
- **Giving out the kit** right in advance of release
- Several pilots worldwide
- Mortality rate reduced¹

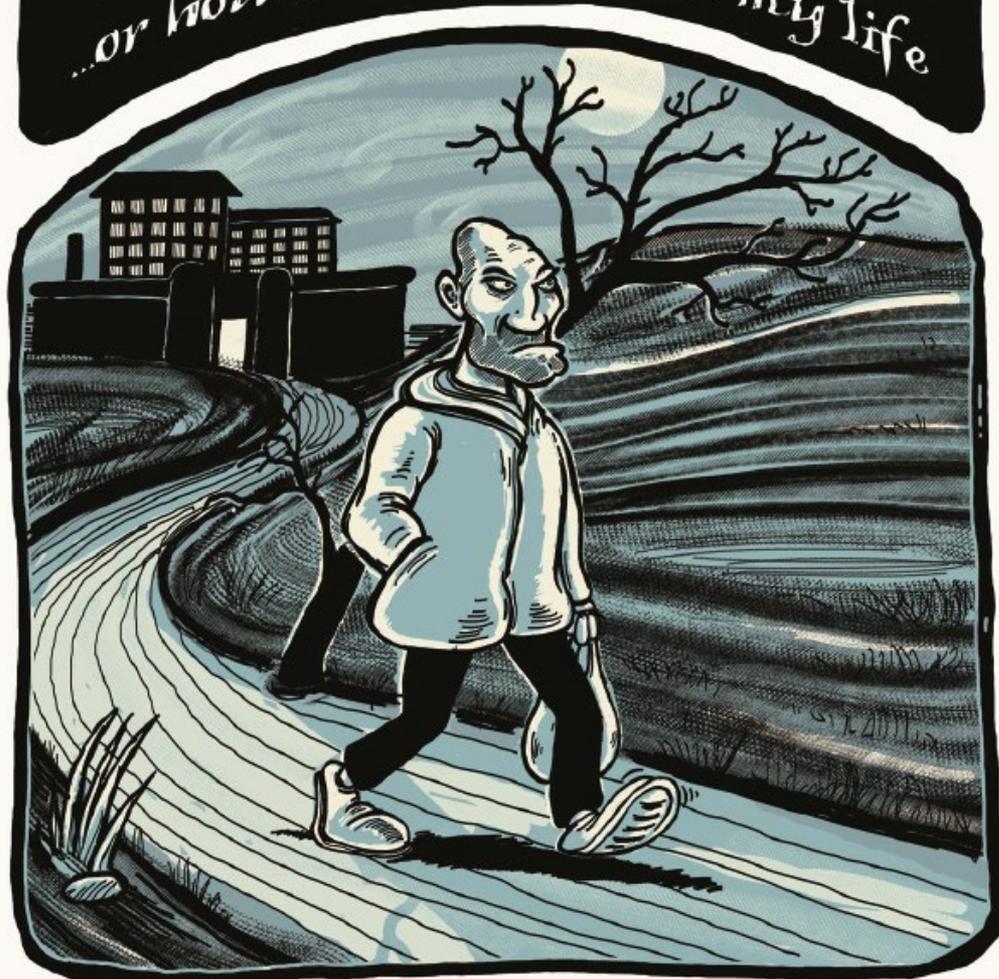
¹Bird, S.; McAuley, A.; Perry, S.; Hunter, C. (2016): Effectiveness of Scotland's National Naloxone Programme for reducing opioid-related deaths: a before (2006–10) versus after (2011–13) comparison. In: *Addiction*, Volume 111, Issue 5 May 2016; pp. 883–891

Naloxone-on-Release

**Guidelines for naloxone provision upon release
from prison and other custodial settings**

My First 48 HOURS OUT

...or how Naloxone saved my life



Naloxone provision upon release from prison and other custodial settings

3. Conclusions



Conclusions: from harm production to harm reduction

- Drug using/dependent prisoners are discriminated in a double sense: (i) incarcerated for coping symptoms of their drug dependence and (ii) not benefitting from the progress in drug treatment/harm reduction, which have been achieved in the community.
- Putting drug users into prisons in high numbers (approx. 30%), means putting them at high risk of relapses, violence, sexual exploitation, debts, risks of infectious diseases.

Future developments

- More attention on the particular situation of drug users in prisons is needed
- Abstinence-oriented treatment can only be one element of a comprehensive drug treatment service – it needs to be supplemented by harm reduction measures (e.g. OST)
- Utilizing international standards for changes in treatment (e.g. **the Nelson Mandela Rules**, CPT)

Conclusions: from harm production to harm reduction

- A shift in the responsibility of healthcare from Justice to the ministry in charge of healthcare generally – like WHO, UNODC and many other international player are recommending – would probably lead to more and efficient healthcare, closely connected to community services.
- Alternatives to imprisonment would be an effective treatment to avoid health risks and health and social inequality.

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www.harmreduction.eu