



Module for Prison Intervention : South Asia

***Preventing Drug Use and HIV among Incarcerated
Substance Users***



2007

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UNODC Regional Office for South Asia

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CONTENTS

List of Abbreviations.....	i
Preface.....	iii
Acknowledgements.....	v
Introducing the Toolkit	vii
Introducing the Module	xi
1. Context	1
Review of Literature	1
Theoretical Framework	9
2. Orientation Phase.....	17
Needs Assessment	17
Regional TOT	22
National Training	23
Site Specific Training	23
3. Intervention Phase.....	29
Management Structure	33
Dynamics of Peer Networking	35
Therapeutic Community	39
Peer-Led intervention	45
Social Re-entry	48
4. Post Release Social Networking Phase.....	53
Glossary	59
References.....	60
Annexures	
1. SAKAPiPP Questionnaire	63
2. Curriculum for Training Programmes	74



LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
AAG	AIDS Awareness Group
AIDS	Acquired Immuno Deficiency Syndrome
BCC	Behaviour Change Communication
DRC	Drug Rehabilitation Centre
GO	Government Organisation
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use
IEC	Information, Education and Communication
IPC	Indian Penal Code
KAP	Knowledge, Attitude and Practice
MSJE	Ministry of Social Justice and Empowerment
NA	Narcotics Anonymous
NACO	National AIDS Control Organisation
NGO	Non-Governmental Organisation
PLA	Participatory Learning and Action
PLI	Peer-Led Intervention
PLWHA	People Living With HIV and AIDS
ROSA	Regional Office for South Asia
SAKAPiPP	South Asia Knowledge Attitude and Practice amongst Prison Populations
SHG	Self-Help Groups
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TC	Therapeutic Community
TOT	Training of Trainers
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WDU	Woman Drug User
WHO	World Health Organisation



PREFACE

HIV/AIDS is a serious health threat for prison populations in many countries and presents significant challenges for prison, public health authorities and national governments.

Worldwide, the levels of HIV infection among prison populations tend to be much higher than in the population outside prisons. This situation is often accompanied and exacerbated by high rates of other infectious diseases, such as hepatitis and tuberculosis. The generally-accepted principle that prisons and prisoners are part of the broader community means that the health threat of HIV within and outside prisons is inextricably linked and, therefore, demands coordinated action.

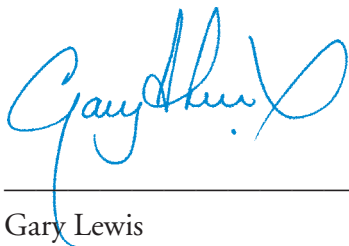
Internationally, the high rates of HIV infection in prisons reflect two main scenarios. The first is in countries where there are high rates of HIV infection among injecting drug users, many of whom spend time in prison, and some of whom continue to inject while incarcerated. In these countries, high rates of HIV (and hepatitis C - HCV) infection are related primarily to the sharing of injecting equipment. The second is in countries where there are high rates of HIV infection in the general population, where infection rates are driven primarily by unsafe heterosexual sex. In these countries, high rates of HIV infection among prisoners are related to high rates of HIV infection in the wider population as a whole. The continued spread of HIV within the prisons in these countries is related especially to sexual contact (primarily men having sex with men) as well as unsafe medical practices or sharing of razors, etc., rather than to injecting drug use.

A third scenario, however, occurs in the South Asian region. Here, many countries have yet to implement comprehensive HIV prevention programmes in prisons, or achieve a standard of prison health care equivalent to the standard outside of the prison, thereby jeopardising the health of prisoners, prison staff and the wider community. Overcrowding, the high percentage of remand prisoners and inadequate resources further compound these problems. There is, however, an understanding that these issues exist despite the limited research on drugs and HIV in prisons.

Among the gaps identified by the UN Office on Drugs and Crime, Regional Office for South Asia, regarding the response to the twin epidemics of substance abuse and HIV/AIDS in prison settings in South Asia is the lack of information and awareness on drugs and HIV issues among prisoners and prison staff.

The complete involvement of prisoners and prison personnel in carrying out any intervention for incarcerated substance users is, therefore, most crucial. In view of the diversities of culture, customs, lifestyle and laws in the different countries of the region, intervention strategies need to be country-specific, locale-specific and site-specific.

This module has been designed with valuable inputs from implementing agencies and local partners, including prison personnel, NGOs and prison inmates, of the region. Its main purpose is to deliver a workable tool for these stakeholders, which is owned by them.



Gary Lewis
Representative
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INTRODUCING THE TOOLKIT

The Prison toolkit (of which this module is a component) is an attempt to respond to gaps in addressing the twin problems of drugs and HIV in prisons of the South Asia region. It details a comprehensive intervention design to address these issues. Different strategies are adopted to address both the issues and prepare the inmates for facing the challenges of drug abuse and HIV after their release from prisons. Engaging the prison inmates and staff is an important first step. As a result, the prison personnel will guide the intervention and adapt the model to local settings. This ensures that the intervention is owned by the prison community and is sustainable beyond the project life. Through guidelines for networking and referral linkages in society, this intervention also attempts to provide vocational and life skills to address the needs of the prisoners after their release. Engaging the prison community also helps in generating awareness on preventing the onset of substance abuse and HIV amongst inmates.

The main objectives of the toolkit are to:

- Sensitise the prison community to drugs and HIV issues
- Create an ‘enabling environment’ in prisons
 - ❖ Advocacy
 - ❖ Delivering ‘key messages’
 - ❖ Networking and linkages
- “Better prepare” prisoners on life-coping skills during crisis and stress
- Increase risk perception and reduction
- Reduce vulnerability to drugs and HIV in prisons through systemic protection
- Create an enabling environment for advocating for a comprehensive package of services¹ for prevention of HIV, through an incremental approach.

There is an attempt to make optimum use of primary stakeholders as “agents of change” – prisoner volunteers, ex-prisoners, community outreach workers/NGO

¹ Prevent the transmission of HIV through injecting drug use, including harm reduction measures - by developing a comprehensive, integrated and effective system of measures that consists of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counseling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy (UNAIDS, 2005).

staff and field-level prison officials. The intervention design was developed with feedback from stakeholders through various stages: needs assessment, regional training of trainers' programme, national training programme and site-specific training.

The intervention uses the therapeutic community, peer-led and social re-entry models to address the issues of substance use, HIV and prisoners' empowerment. The dynamics of prison administrations in the countries of the South Asia region have been taken into account while developing the toolkit so that it fits into the socio-cultural milieu and the rules governing the prisons. The model uses inmates to influence behaviour change/modification amongst their peers. Among others, issues like leading a drug-free life (through the therapeutic community environment), improving self-esteem, dealing with emotions, problem solving, stress management, improving family relationships (through peer-led intervention) and recognition by the community are also addressed through this toolkit.

The toolkit aims to achieve the following:

- Enhance sensitivity of prison officials and prisoners to the twin issues of drugs and HIV
- Provide an understanding of how a prison intervention (to address prevention of drugs and HIV) is rolled out
- Increase knowledge and awareness about drugs and HIV in prison settings
- Enhancement of life skills to enable prisoners to cope with day-to-day challenges in and out of prisons.
 - Inter-personal
 - Decision making
 - Problem solving
 - Conflict resolution
- Increase risk perception and risk reduction through a better understanding of the comprehensive packages of services
- Reduce vulnerability to drugs and HIV through systemic protection
- Increase capacity to diffuse with society—employment, social skills
- Behavioural change through increased or heightened sense of self and social responsibility.

The Prison toolkit comprises the following documents:

1. **Module for Prison Intervention: South Asia**

This document provides a detailed overview of a prison intervention strategy for South Asia. The strategy rolls out in different phases. The first phase, called the *orientation phase*, includes the following elements:

- a) assesses the needs of the prison sector and facilitates a coordinated response amongst managers and service providers,
- b) a regional TOT brings together stakeholders from different prisons/ NGOs/Government officials through a vertical interaction sensitisation cum training programme,
- c) This is followed by national-level training programmes wherein master trainers provide training to field prison staff at the national level,
- d) a site-specific advocacy training, which sensitises the persons involved in actual intervention.

This sets the tone for initiating an intensive training/awareness based intervention amongst prison inmates.

The second phase, called the *intervention phase*, comprises of three elements:

- a) the therapeutic community,
- b) the peer-led intervention and
- c) social re-entry.

During the various stages of intervention, the inmate leaders (senior peer volunteers and peer volunteers) are motivated to volunteer as role models, agents of information and change amongst their peer group.

The third phase, called the *post release social networking phase*, facilitates networking and referrals, and enables prisoners to form support groups.

2. **KAP and Impact Analysis: South Asia Knowledge, Attitude & Practice in Prison Populations (SAKAPiPP):** This is a questionnaire and instruction manual to assess the knowledge, attitude and practice (KAP) relating to drugs, HIV and life skills amongst prison populations. This manual provides clear instructions about how to administer this questionnaire and the interpretation of responses. This is administered for assessing KAP at the beginning and the end of each intervention phase, using a control group design mechanism. This is annexed in the module.
3. **Facilitator’s Manual on Prevention, Care and Support of Drug-related HIV in Prisons:** This is a “how” and “what to” manual, using participatory training methodologies to train prison staff, rehabilitation staff and outreach workers in prisons on knowledge, skills and attitudes with regard to prevention of drugs and HIV. This manual keeps UNODC’s prison framework (UNODC, 2006) as the guiding document (including elements of the comprehensive package) and incorporates issues and recommendations of key stakeholders’ concerns from the South Asia region.
4. **Peer Guide:** This guide uses participatory training methodologies in a more simple, easily understandable manner for peer volunteers (inmates) to enable

them to train their peers in prisons. It focuses on creating awareness, perceiving risks and reducing risk-taking behaviour related to substance use and HIV. Ideas generated by prison inmates during the site-specific trainings (including posters, pamphlets, plays, games, etc.) have been adapted to form a part of this guide. The guide uses graphical and pictorial presentations, minimizing the use of text to enable easy comprehension by prison inmates and field-level prison staff.

In this toolkit, the word ‘prison’ has been used for all places of detention and the words ‘prisoner’ and ‘inmate’ to describe all those held in such places. The context in which these words are used will be clear from the text.



INTRODUCING THE MODULE

This module outlines the roll-out of the intervention strategy for addressing prevention of drugs and HIV in prison settings of South Asia. The strategy is incremental in nature and is being tested in various prison sites across South Asia. The strategy rolls out in different phases, namely, the orientation phase, the intervention phase and the post release social networking phase.

Most of the data on HIV prevention in prisons have been collected in developed countries, and are, strictly speaking, only valid for the countries where they were obtained. However, there is no evidence indicating that interventions implemented in developing countries or in countries with economies in transition would yield different results. Interventions would have to be adapted to the specific cultural circumstances of each country in which they were implemented (WHO, 2004).

HIV/AIDS and prison settings-

Fear of HIV/AIDS often places HIV-positive prisoners at increased risk of social isolation, violence, and human rights abuses from both prisoners and prison staff. This fear is often driven by misinformation about HIV transmission, and the false belief that HIV infection may be spread by casual contact. Since the vast majority of people committed to prison eventually return to the wider community, reducing the transmission of HIV in prisons is an integral part of reducing the spread of infection in the broader society, as any diseases contracted in prison, or any medical conditions made worse by poor conditions of confinement, become issues of public health for the wider society when people are released.

In order to address HIV/AIDS in prisons settings, a comprehensive strategy could be beneficial. An essential first step in developing such a strategy is to create awareness among policy makers on the HIV/AIDS situation in prisons. This module outlines this strategy and clearly explains the methodology (which includes needs assessment, regional, national and site-specific training programmes) that was followed to address drugs and HIV concerns in prisons of South Asia. The deliberations from these initiatives clearly recognised overcrowding, low convict population and resource constraint, among others, as key features of prisons in South Asia. After raising awareness among prison staff, prisoners and other key stakeholders in prison settings, the intervention strategy provides information and education on preventive measures (including counselling, drug dependence treatment etc). The intervention also has an inbuilt mechanism to address rehabilitation opportunities for prisoners through post release social networking.

This module also includes the non-drug-using population as the incarcerated drug users are rarely segregated. Since the bulk of the incarcerated populations in South Asia are non-IDUs, the strategy will be inclusive rather than address only IDUs in prisons. As a result, the approach has to be a judicious blend which enables us to do client matching and at the same time advocate for oral substitution as a pharmacotherapy which may be available especially for IDUs who are opiate users. A menu of options will be addressed in the Facilitator's Manual.

Ultimately, the overall objective here is that every prisoner has access to essential HIV/AIDS prevention and care. This intervention strategy will allow us to develop evidence-informed strategy for prison settings of South Asia which reaches all prisoners. Meaningful rehabilitation activities should be put in place, including post release networking programmes. Training of prison staff could include management of HIV/AIDS in prisons and on the needs of HIV-infected prisoners. Antiretroviral therapy and improved hygiene, sanitation and diets for HIV-infected prisoners should be provided. The role of civil society organisations is encouraged in prisons for addressing the following- to provide knowledge, information, awareness and skills to address HIV prevention, to provide after-care services and to offer drug dependence treatment as an alternative to jail.

Through different intervention strategies (therapeutic community, peer led intervention and social re-entry), among other components, the module addresses and outlines issues relating to drugs and HIV awareness and prevention, peer outreach, empowerment through life skills, livelihood skills, access to services and post release re-integration into society.

The legal and institutional framework for working with incarcerated prisoners in South Asian countries may take a while to change and therefore, this module suggests an incremental approach towards inclusion of all elements of the comprehensive package. The module is trying to advocate the use of existing provisions within the laws and regulations to make a better health impact and smoother implementation of prevention initiatives across the South Asia region. This module for addressing HIV prevention in South Asian prisons attempts to create an enabling environment for emphasizing that all measures against HIV transmission which are carried out in the community outside is available to the prisoners. The WHO guidelines on HIV infection and AIDS in prisons confirm that all prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality. The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community.

The SAKAPiPP questionnaire has been annexed in this module. Additionally, a training curriculum has been annexed in order to facilitate schedule formation for various training programmes.

1. CONTEXT

“...Rape, violence, corruption, overcrowding, and poor prison management all conspire to make the situation appear hopeless. The prospect of controlling HIV/AIDS in this environment is daunting...”

...The presence of drugs and HIV/AIDS in prisons presents two distinct dilemmas: first, drugs in prison represent a failure of security and an affront to the rule of law...

...The second problem turns on drug use among prison populations, and the consequent transmission of HIV/AIDS from prisoner to prisoner, and, after inmates are released, from prisoners to uninfected partners...

...Within the prison population, the disease grows with extraordinary speed and intensity, outpacing anything you see in the general population...”

- Antonio Maria Costa, Executive Director, UNODC
CCO Ministerial Meeting,² Moscow, April 1, 2005

REVIEW OF LITERATURE

A Brief Situational Analysis of Drugs and HIV in Prisons

Prisoners are at an increased risk of HIV infection because they lack access to preventive and care services, making prisons a high-risk environment for HIV transmission. Prison overcrowding, gang violence, lack of protection for younger inmates, corruption and poor prison management significantly increase the vulnerability of inmates to HIV transmission. Drug use in general, and injection drug use in particular, as well as violence and sex between men is widespread in prisons. Drug users are often over-represented in prison populations and may continue using drugs while incarcerated. A significant proportion of drug users have a history of incarceration, often for drug-related crimes. Frequent sharing of contaminated drug injection equipment is the predominant mode of HIV transmission among prisoners (UNODC, 2005). HIV is also transmitted in prisons through unsafe sexual behaviour, sometimes associated with sexual violence. The high turnover rates (worldwide at any given time, there are 10 million) of prison inmates, with an annual turnover of 30 million, also fuel the spread of HIV and other infections. After their release, infected prisoners return to social networks in the general community, thereby facilitating the spread of HIV infection to the non-incarcerated community.

² Committee of Cosponsoring Organizations (CCO) of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

In 2004, Dolan et al³ undertook a review of injecting drug users and HIV infection in prisons in developing and transitional countries. The main findings are discussed ahead.

Several countries have very large prison populations, e.g. China (<1,512,000), Russia (<874,000), India (<281,000), Thailand (<250,000), Brazil (<240,000) and Mexico (<154,000). In only 22 countries, Serbia & Montenegro, Kazakhstan, Lithuania, Russia, Slovakia, Ukraine, India, Iran, Nepal, Pakistan, Singapore, Thailand, Vietnam, China, Hong Kong, Korea (Republic of), Libya, Brazil, Mexico, Cote D'Ivoire, South Africa and Zambia, have positive reports of the existence of IDU in prisons been found, with Russia, China, India, Thailand and Brazil having the maximum. However, little information was found on the prevalence of HIV among IDUs in prison. Research on HIV and IDU in prisons in developing and transitional countries is limited and whatever data does exist tends to be quite varied and unsystematic in nature. Additionally, in many cases, the data is not recent enough to provide an accurate picture of the current situation. More thorough and systematic research is definitely needed in all regions in order to ascertain the true scope of the problem.

Paucity of data

Various difficulties have been experienced with regard to the collection of data. The general paucity of existing work on prisons in developing countries was compounded by difficulties in accessing the data that does exist, due to language barriers or the lack of adequate sources.

Very few developing or transitional countries have systematic surveillance of HIV infection among prisoners, meaning that little or no prevalence data is available. Additionally, in several countries where surveillance has occurred, only the number of HIV positive prisoners is reported rather than the proportion they represent. It is not possible to estimate HIV prevalence from these figures, as the denominator can not be ascertained. In relation to HIV prevalence among IDU prisoners, there were also important variations in the way data was collected, and in the way the figures were reported. Overall, relatively little information on HIV and drug use in prisons is currently available for most developing and transitional countries.

Number of IDUs in prisons

The review of literature by Dolan (2004) revealed that one study in India found no IDUs in one prison while another found about three inmates (1.2 per cent) reporting a history of injecting drug use (n=249). Another Indian study found 4.9 per cent of inmates were IDUs in 1997 and this declined to 0.8 per cent in 2000. A study in five prisons in Eastern Nepal found 28 per cent of the 255 inmates had used drugs and 71 per cent of these had “consumed oral and IV drugs.” This represented

³ Data in this section has been extracted from Dolan et al, 2004.

about 50 per cent of the entire sample. No information was found on Bangladesh, Bhutan, Maldives and Sri Lanka.

In India in 1993, 488 IDUs who had recently been institutionalised for drug use were tested. The largest centre was Manipur Central Jail and of those tested, 80 per cent were HIV-positive.

It is acknowledged that drug use is practised in prisons and this, along with unprotected sex, can lead to HIV transmission. However, there are no needle exchange programmes in prisons in South Asia. Additionally, officials fear that the introduction of a needle exchange programme or condom distribution would be a tacit admission of the scale of the drug and HIV problem in prisons. Clearly, there is a need for a comprehensive public health and human rights approach to HIV in prisons. There is currently no specific strategy and HIV prevention behind bars is still very inadequate, particularly because of the lack of consistency in the penitentiary system. Research shows that drug use and sexual activity take place in prisons. There is, however, no current prison policy in South Asia on condom provision.

At this stage, therefore, what is at least workable in South Asia may be a focus on preventive strategy along with an emphasis on risk reduction. A two-pronged approach on creating awareness about HIV and providing risk reduction information for those who are already practising unsafe behaviours may be 'workable'. The HIV-prevention work in prison settings can involve three stages: the *awareness-raising stage*, the *prevention stage*, and lastly the *risk reduction stage*. It will, therefore, be imperative to include an information package that includes all three.

HIV presents a particular problem in penal establishments due to the nature of the population, the conditions in prison, media attention and misinformation, as also the possibility of transmission within and beyond the prison population. Recent concern about the spread of HIV infection in prisons and anxiety about the contribution of injecting drug use to this has been supported by studies in populations of drug users. Around the world, a high prevalence of injecting and sexual risk behaviour among IDUs within and between custody has been established. Most offenders continue to take drugs while in custody and some not only inject drugs but share equipment too. Some male prisoners compound their risk of HIV infection by engaging in sexual activity with multiple partners. Such prisoners then place their partners in the community at particular risk of HIV infection after their release. Although some drug users are prescribed drugs for their dependency, limited access to appropriate treatment, counselling and health education may compound this situation.

Conditions which facilitate safe behaviour include a non-judgmental and non-moralising attitude by prison staff; the establishment of a climate where prisoners feel confident to seek counselling and the provision of condoms and adequate care. Even though (in some countries), a needle-exchange service has been proposed, it is considered unacceptable at present. Training and health education also need to

include information on tuberculosis and hepatitis B. Further, on discharge, handouts with information on HIV-control and the provision of condoms have been deemed appropriate. The right to have a “buddy” for HIV-infected prisoners has been acknowledged. There is potential for HIV-control and support to prisoners, many of whom are likely to enter into high-risk situations following their discharge.

There is little research evidence on the extent of substance abuse in prisons, in part due to the fact that access to prisons for research on HIV and drug use has been discouraged, and also because of doubts about collecting appropriate information about personal risk behaviour from inmates. The circumstances and conditions in custody, including overcrowding and lack of privacy, may foster high-risk behaviour, such as unprotected anal sex, drug injecting, tattooing, and self-injury with consequent blood-spillage. Prior to incarceration, many people share syringes and have multiple sexual partners. This increases the risk of HIV infection occurring within custodial settings. Levels of risk behaviour outside custody are an indication of the potential crossover from prison to the community, should HIV be transmitted within the custodial context.

Many HIV prevention services available to drug injectors in the community (such as syringe-exchange, condoms, bleach and information about sterilising equipment) are absent in prison. Therefore, imprisonment is often regarded as a serious risk factor in the spread of HIV.

South Asian Scenario

Few select interventions and research studies have been carried out in some prisons in India, Nepal and Sri Lanka.

In *India*, recognising and responding to the sexual health intervention needs of prison inmates in a country where sexual acts in the prison environment are considered unlawful is a challenging issue. Having realised the grave situation in prisons, the Gujarat State AIDS Control Society, a unit of National AIDS Control Organisation, intervened and took up the challenge. The first bold initiative came in the form of a pilot project on behaviour change communication interventions in 1998 in the Surat District Prison. In 2001, after three years of struggle and hard work, the interventions were replicated in nine prisons all over the state. Thus, demonstrating that determined government initiatives can make a sizeable difference in checking the devastating spread of the pandemic (Gandhi, 2002).

Another study (Lingamallu et al, 2002) revealed that homosexual activity, both coercive and consensual, takes place inside prisons. In this regard, Hindustan Latex Limited has established a technical resource unit to manage targeted interventions under agreement with the Andhra Pradesh State AIDS Control Society. Initially, four prisons were selected for the intervention programme,

with their number being up-scaled to eight after a rapid assessment of needs. A proposal and contract for intervention was jointly developed with the prison authorities, wherein committees of prisoners were formed to oversee the implementation. The intervention focused on behaviour change communication sessions, STD care and counselling, peer education, condom distribution and a referral system for partner treatment. Minimum standards for intervention were developed and documented. The recent state-wide rapid assessment survey identified and included 30 new prisons, with 42 prison interventions; this programme is now the largest of its kind in India. The process has highlighted that systematic needs assessment and phased up-scaling is essential; sensitisation and involvement of key stakeholders like prison officials and inmates creates a sense of ownership among them; proper advocacy and sensitisation activities must be conducted with all stakeholders before the project takes off; and that initial media attention should be avoided in order to provide a greater sense of privacy, security and freedom to the concerned project implementers (Lingamallu et al, 2002).

The increase in crime rate, which has worsened due to socio-economic reasons, has led to an increase in the prison population in Indian jails. In January 2000, the Government of Andhra Pradesh started a unique sexual health programme titled “Partnership for Sexual Health” (PSH Prison Project) for prisoners managed by the Andhra Pradesh AIDS Control Society, Hyderabad. It is in operation in 11 (eight central jails and three sub-jails). Three trained staff members (one male project co-ordinator, one male social worker and one female social worker) have been appointed in each of these jails. Under it, basic knowledge on general health, signs and symptoms of sexually transmitted diseases, including HIV/AIDS, their preventive measures, and the importance of the use of condoms is given to all prisoners with the help of pictures, charts, booklets and pamphlets. The programme also includes counselling, referral and medical treatment. Apart from being a source of recreation for prisoners, the impact of the programme reveals a positive change in terms of gain in their knowledge about AIDS and positive sexual behaviour, as has been expressed orally and by the pictures and charts drawn on HIV/AIDS (Mohammed, 2002).

There is an urgent need to modify outdated laws and rules to allow for effective intervention strategies on prevention of HIV. Intervention programmes are being implemented under many constraints, such as the fact that practising homosexuality is a crime under IPC Act 377. Similarly, the distribution of condoms inside a prison is not possible due to the prison rules. Condom distribution is necessary as the prison population is mobile (Pachpinde, 2002).

The lifestyles of many inmates prior to incarceration include unprotected sexual intercourse, drug and alcohol abuse, poverty, homelessness, under-education and unemployment, all of which are associated with the risk of HIV/AIDS. Another study (Rajkumar et al, 2004) was aimed at documenting the social characteristics, HIV/AIDS knowledge and preventive practices of selected male

prisoners in Central Prison, Chennai. It also elicited the impact of educational programmes on knowledge and practice among the inmates. Under it, a control group design was adopted and 200 randomly selected prisoners in the age group of 20 to 40 (Experimental/E Group) were given HIV/AIDS awareness education in the form of street plays, demonstrations and interactive sessions by an NGO. A similar age matched group of 300 prisoners (Control/C Group) who had not attended the programme were used for comparison. The study comprised an interview session using a well-structured questionnaire to seek information about the prisoners' social data, their knowledge about HIV/AIDS, including its transmission and prevention, and their indulgence in HIV/AIDS risky behaviour. An analysis using SPSS (10.0) software revealed that the average scores of knowledge about HIV/AIDS, including its transmission, was 95 per cent for the E Group while it was only 23.5 per cent for the C Group. Similarly, awareness about the use of condoms for casual sexual contacts to prevent HIV/AIDS was 90 per cent for the E Group but only 12 per cent for the C Group. This study demonstrated that information campaigns and other prevention measures appear to have inculcated risk awareness. Well-designed (IEC) programmes on AIDS, with the provision of risk-reduction counselling, are therefore recommended for prisoners to effectively combat the imminent HIV/AIDS epidemic.

The AASRA programmes, or therapeutic communities for rehabilitation of drug addicts, house 800 prisoners (7 per cent of the adult male population in prisons in Delhi). A review of the Delhi Prison Model for Treatment and Rehabilitation of drug users indicates that a majority of the prisoners were illiterate. Of them, 23 per cent were labourers and a similar percentage unemployed. Over 60 per cent were single drug users while 4.7 per cent were IDUs, of whom 2.6 per cent reported sharing needles and syringes. Half of all prisoners sampled had a history of unsafe sex while 30 per cent had multiple sex partners. Although the programme recognised a significant treatment procedure for the above-mentioned population, certain lacunae were found. These included no selection filter for entry into community; no control over duration of resident stay in the programme; need for more trained counsellors; and lack of resources to set up a contact or "follow up" intervention following the prisoners' release. There were some recommendations for future such as continued data collection in prison, setting up detoxification and rehabilitation centres in prisons and extending the treatment option under Section 39 of the Narcotic Drugs & Psychotropic Substances Act to those accused under Section 27 (UNODC-MSJE, 2002).

Similar findings were also seen in the annual report of the AIDS Awareness Group (AAG) by Elizabeth Vatsayayan (Delhi Prisons, 2000).

A pilot study was also conducted in the year 2000 to establish the seroprevalence rate of sexually transmitted and blood-borne infections among inmates of district jails in Northern India (Singh et al, 1999). A questionnaire asking their background characteristics, alleged criminal background, period of confinement,

sexual activity, and sexual partners was administered on 240 males and 9 female inmates, aged 15-50 years. Any history of blood transfusion, injury, injecting drug use and drug addiction were also noted together with their level of AIDS awareness. Serum samples were obtained from these inmates and tested for antibodies against HIV (1+2), hepatitis C virus (HCV), treponema pallidum, and hepatitis B surface antigen (HBsAg). The results indicated a high prevalence of sexually transmitted and blood-borne infections. It showed that 11.6 per cent subjects had active hepatitis, 10.4 per cent active pulmonary tuberculosis, 4.6 per cent syphilitic ulcers on the penis, and four-fifths of the teenagers had moderate to severe scabies. Similarly, 1.3 per cent of the subjects were HIV-1 positive, while 11.1 per cent men and 22.2 per cent women were positive for HbsAg. This indicates that sexually transmitted and blood-borne infections are highly prevalent in jail premises and pose a threat of rapid spread through drug use and homosexuality.

A study (Paul et al, 2002) commissioned in five prisons in *Nepal* to determine the awareness, risk perception and risk taking behaviour of prisoners (who use drugs) and the implementation of effective health education programmes used qualitative data involving key informant interviews, focus group discussions and in-depth interviews. Out of the 724 inmates in these five prisons, in-depth interviews revealed that 28 per cent of the participants were drug users with a median age of 24. The median age for starting of drug use was 21 (range 13-34) while that for the number of years of drug use was 5 (range 1-14 years). Also, 71 per cent of the drug users consumed drugs orally as well as intravenously, and 75 per cent of them always shared needles. Similarly, 38 per cent had casual partners and 30 per cent had frequently visited sex workers. None of them had ever used condoms. Only 14 per cent perceived that they might have HIV. Awareness on HIV/AIDS was, in fact, very limited with many misconceptions. Again, drug use and male-to-male sex is not openly discussed but it “happens”. The study thus showed a rather high rate of risk behaviours and low level of knowledge. This necessitates the availability of HIV testing as well as the implementation of education and risk reduction programmes in prisons (Paul et al, 2002).

Another study (Senanayake, 2005) conducted in a women’s prison in *Sri Lanka* in 2005 revealed the following: the prevalence of drug using and commercial sex workers in urban low-income communities is high. Also, drug use is becoming more acceptable among women in Sri Lanka. Women play leading roles in the drug trade and use multiple drugs. The objective of the study was to assess trends and patterns of drug abuse and study the relationship between drugs and sex work among women.

The descriptive study was conducted on 55 women drug users (prisoners) by means of the snowball sampling method. Data was collected through questionnaires, case studies and observation. Data analysis revealed that 53 per

cent of the subjects were commercial sex workers, with 72 per cent of them being street sex workers. The highest percentage (42 per cent) of women drug users (WDUs) was in the age group of 31-40 years. A high 91 per cent were multiple drug users, 96 per cent were on remand and 95 per cent were repeated drug or sex work related offenders. Of them, 25 per cent were using heroin in the prison and 18 per cent had been introduced to drugs while they were in prison.

The findings indicate that although few in number, low-income urban women are involved in drug use and sex work; drug using women are vulnerable to drug peddling or commercial sex as means to support their habit; and that there is an inherent potential to have a sizeable women drug-using population in the future (Senanayake, 2005).

Snapshots from India

According to prison statistics India 2003, published in 2005, there were 1,140 jails in the country, having a capacity of 233,543 but with the total number of inmates at 326,519. Convicts comprised 28.1 per cent of the total inmates while undertrials comprised of 66.7 per cent. The rate of overcrowding in Delhi (more than 300 per cent) was much higher than the national average.

**Ratio of Prison Staff and Inmates
(some states of India)**

State Prisons	No. of inmates per jail official	No. of inmates per correctional staff	No. of inmates per medical staff
Assam	10	212	125
Karnataka	29	10902	321
Maharashtra	8	4786	235
Orissa	7	75	142
Uttar Pradesh	9	0	414
Chandigarh	6	525	175
Delhi	13	1522	97

Source: Prison Statistics India 2003, Government of India, published 2005

Indian prisons are managed by three categories of personnel, i.e., custody, correctional and medical staff. But it is the actual number of inmates per official that is a real indicator of how well the inmates are looked after. In 2003, the number of inmates per jail official reported was Karnataka (29), Jharkhand (24), Bihar (20), Delhi (13), Assam (10) and Uttar Pradesh (9). The number of inmates per correctional staff was Haryana (12,099), Himachal Pradesh (978),

Karnataka (10,902), Nagaland (568), Chandigarh (525), Maharashtra (4,786) Jharkhand (2,736), Delhi (1,522), Rajasthan (1,411), Kerala (1,293) and Jammu and Kashmir (948). The availability of health services to inmates is based on the strength of the medical staff per inmate: Gujarat (568), Goa (532), Jharkhand (432), Uttar Pradesh (414), Tamil Nadu (360), Madhya Pradesh (344), Karnataka (321) and Jammu and Kashmir (21). These figures indicate that as opposed to medical care and rehabilitation of prisoners, the prison administration puts more emphasis on custody. There is, therefore, a need to augment the resources for facilitating correction and better medical care.

THEORETICAL FRAMEWORK

Interventions based on the therapeutic community model, peer-led intervention and social re-entry rely on several social change theories and concepts. This prison intervention is designed in a manner that each component is based on a theory or a combination of theories and concepts. It also challenges existing concepts with regard to prisons.

Prisons around the world have distinct characteristics and South Asian prisons are no different. These characteristics have been very well enumerated in Erving Goffman's (1961) concept of total institution, which is defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. Here, special sub-cultures are formed with an articulate set of values and informal rules and roles. Some of the central features of total institutions are: the breakdown of barriers between spheres of life (sleep, play and work); all aspects of life are conducted in the same place under the same central authority, and; tightly scheduled activities, where each activity is carried out in the company of a large group. Each member of the group is treated alike and required to do the same thing together. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution.

In total institutions, there is a basic split between a large managed group, conveniently called inmates, and a small supervisory staff. Often, the staff-inmate split leads to a considerable social distance between the two groups. Inmates typically live in the institution and have restricted contact with the world outside. The staff often operates on an eight-hour day schedule and is socially integrated with the outside world. Each grouping tends to conceive of the other in terms of narrow hostile stereotypes. Social mobility between the two strata is grossly restricted; the social distance is typically great and often formally prescribed. Even talking 'across' the boundaries is often seen to be conducted in a special tone.

The 'Inmate World' (Goffman) is characterised by the following. The recruit comes into the establishment with a conception of himself made possible by certain stable

social arrangements in his home world. Upon entering prison, he is immediately stripped of the support provided by these arrangements. In other words, he begins a series of abasements, degradations and humiliations. His self-esteem is systematically, if often unintentionally, mortified. He begins some radical shifts in his moral career, a career composed of the progressive changes that occur in the beliefs that he has concerning himself and partners and friends.

The staff world is characterised by the following. Personnel in prisons are isolated even from the public and remain invisible, behind the walls. Often, prison officials experience ‘burn out’ (Fox, 1983), which is defined as a syndrome of emotional exhaustion and cynicism that frequently occurs amongst individuals who do “people work” and spend considerable time in closed settings with others under chronic stress and tension.

Studies reveal that correctional officers tend to have the highest rate of illness among all government workers in Japan (Toru, 1983).

The prisonisation model, first developed in 1940, holds that the longer inmates are incarcerated, the more “criminalised” and distanced they become from the values and behaviours of society outside the prison walls. A process involving changes within the individual inmate, prisonisation results in the inmate increasingly acquiring the values, standards and behaviour patterns of the other inmates; imprisonment causes prisonisation, which in turn results in the inmate assuming criminal role identities (Zingraff, 1975). It is a process of being socialised into the culture and social life of prison society to the extent that adjusting to the outside society becomes difficult.

The existence and adopting of a distinctive prison culture, what has been referred to as “prisonisation” or “prison code” is widely acknowledged by those who live and work in prisons (Clemmer, 1963). The existence of gangs, other racially-motivated groups, violence, widespread drug use, sexual aggression and other anti-social behaviour represents just some of the widely known aspects of the prison culture. There are others. Displays of machismo are often considered acceptable; showing love, affection, or compassion, can be viewed as signs of weakness and are not acceptable. The prison culture provides fertile ground for the breeding of a mentality that supports the notion of rehabilitation or reform as something very much needed by the prison not the prisoner. The issue of trust, or more precisely the lack of trust, is a central feature of the prison code. For example, a new prisoner learns very quickly that outside a select group of prisoners, inmates should not trust other people. This is especially true when referring to prison staff or others who work in or represent some aspect of the criminal justice system.

The effects of prisonisation, however, can be neutralised/minimised through various strategies to enable the prisoner to re-integrate into society as a productive member (after release).

Is a change possible?

This toolkit, through its comprehensive intervention model attempts to neutralise the impact of prisonisation by including elements of social learning, behaviour modification and role modelling.

This toolkit is designed in a manner that each stage is based on a sociological theory or a combination of the following theories (adapted from Skinner and Bandura).

Social Learning Theory of Bandura:

The social learning theory of Bandura emphasises the importance of observing and modelling the behaviours, attitudes and emotional reactions of others. Bandura (1977: p22) states: “Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behaviour is learned observationally through modelling: from observing others one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action.” This is because it encompasses attention, memory and motivation, social learning theory spans both cognitive and behavioural frameworks.

The social learning theory presents an excellent framework and meaningful model for explaining the phenomenon of social values, roles, norms and social identification, which in turn affect the behavioural outcome of drug abusing inmates. The social learning theory has been advanced by several researchers, including Rotter (1955) and Bandura (1961) amongst others. All of them have taken a systematic position of explaining human behaviour by synthesising cognitive psychology with the principles of behaviour modification. Principles of social learning can be explained under two broad steps, i.e., the acquisition of new responses through observational learning and the imitation process. Bandura (1961) states that learning may take place through observation of the behaviour of others even when observer does not reproduce the models’ responses during its acquisition. Therefore, the learner may not receive any re-enforcement.

Social learning theory has been applied extensively to the understanding of aggression and psychological disorders, particularly in the context of behaviour modification (Bandura and Huston, 1961). It is also the theoretical foundation for the technique of behaviour modelling, which is widely used in the TC model. The highest level of observational learning is achieved by first organising and rehearsing the modelled behaviour symbolically and then enacting it overtly. Coding modelled behaviour into words, labels or images results in better retention than simply observing.

Parsons Social System:

In a social system, parts are arranged in a pattern of relationships that together makes the system. Talcott Parsons argues that each of us is an actor playing a role

within a system of relationships. He analyses the real (concrete) system we are in into a social system, cultural system and our own personality system.

“...a social system consists in a plurality of individual actors interacting with each other in a situation which has at least a physical or environmental aspect, actors who are motivated in terms of a tendency to the “optimisation of gratification” and whose relation to their situations, including each other, is defined and mediated in terms of a system of culturally structured and shared symbols.” (Parsons, 1951: p5)

Similarly, a prison system comprises of a number of sub-systems based on persons coming from varying criminal and socio-cultural backgrounds. A positive change in any sub-system will have an effect on other sub-systems. One cannot change one part of a system without influencing the other parts in some ways. The impact of TC, PLI and social re-entry will have a spillover effect in the entire prison population.

Operant Conditioning Model of B.F. Skinner:

The behaviour change expected from the members of a therapeutic community can be explained with the help of Skinner’s operant conditioning model. The members operate on the environment to generate consequences, and if the consequences are rewarding, the response will be repeated and will grow in strength. This relationship between response and reward is the essence of operant conditioning and also explains the learning new responses like maintaining abstinence in this case.

Gestalt Principles of study of behaviour:

According to the Gestalt school of thought, the whole is more meaningful than the sum of the parts. The treatment principles in the therapeutic community are also based on the philosophy that drug addiction is a problem of the person as a whole and thus looks for solution to those other problems, which made him a drug addict.

Participative management:

The concept of participative management has been visualised as one of the most successful prison intervention strategies. It has been researched that increased involvement and participation by most people had the ability to energise greater performance, produce better solutions to problems and greatly enhanced acceptance of decisions. It was found that such group dynamics worked to overcome resistance to change, increased commitment to the organisation, reduced stress levels and generally made people feel better about themselves and their worlds. According to French and Bell (1996), “Participation is a powerful elixir-it is good for people and it dramatically improves individual and organisational performance...to empower is to give someone power. This is done by giving individuals the authority to participate, to make decisions, to contribute their ideas, to exert influence and to be responsible. That is why participation is such an effective form of empowerment. Participation enhances empowerment and empowerment in turn enhances performances and

individual well-being...OD [organisational development] interventions are deliberately designed to increase involvement and participation by organisation leaders and members.” A study conducted in five prison sites in different states in India revealed that there is a strong bond between the level of participation of the prison staff and effectiveness of the prison (Sharma et al, 2003).

Hungers:

What Berne (1970) terms as ‘hungers’, we would perhaps more conventionally refer to as ‘needs’ or ‘drives’. The intervention also aims to address all forms of hunger described below.

Stimulus hunger: Also referred to as ‘sensation hunger’, this is the need to seek out stimulating situations. As Berne puts it, this is why roller coasters make money and why prisoners will do whatever they can to avoid solitary confinement. Social interaction itself is thus seen as the gratification of stimulus hunger.

Recognition hunger: This is the quest for other kinds of sensations, which can only be supplied by other human beings or, perhaps by animals. We seek personal recognition from other individuals.

Structure hunger: This is the need for us to create order and be a part of social structures. That is why we form groups and why groups tend to grow into organisations.

Hierarchy of Effects Models focus on individual behaviour change in a linear fashion, which begins with exposure to information and assumes that knowledge, attitudes, trial and adoption of the desired behaviour will necessarily follow.

Diffusion of Innovation focuses on the communication process through which new ideas or products become known and are used in a target population.

Peer Support

The fact that people belonging to the same peer group (defined by age, class, gender or any social construct) communicate best with each other is simple common sense. That people who share a similar economic, social, cultural background or lifestyle should be able to understand each other is quite natural.

The United Nations Office on Drugs and Crime Regional Office for South Asia offers this definition of peer education:

The use of same age or same background educators to convey educational messages to the target group... Peer educators work by endorsing “healthy” norms, beliefs and behaviours within their own peer group or community and challenging those who are “unhealthy” (UNODC, 2003).

Research has shown that whether individual drug users attempt or achieve behaviour changes often depends on whether these changes are endorsed or encouraged by their

peer group. Research also suggests that an individual's attempts at, say, condom use, are considerably easier when there exists a peer norm which is supportive or accepting of such use. If "safety norms" exist, they make it easier for individuals to initiate behaviour change. Therefore, a norm of healthy drug use and sexual behaviour is needed.

Education through Peers

Peer education has been used extensively in different settings for the reduction of risk-taking behaviour related to drug abuse and HIV/AIDS. The basic premise in using peers as peer educators revolves on the belief that young people learn about drug use and sex from their peers. The corollary that these peers can influence social norms in their respective peer group is also tested in this intervention model. As compared to outreach workers, peers have been found to be more effective in recruiting drug users for HIV/AIDS interventions (Stocker, 1999).

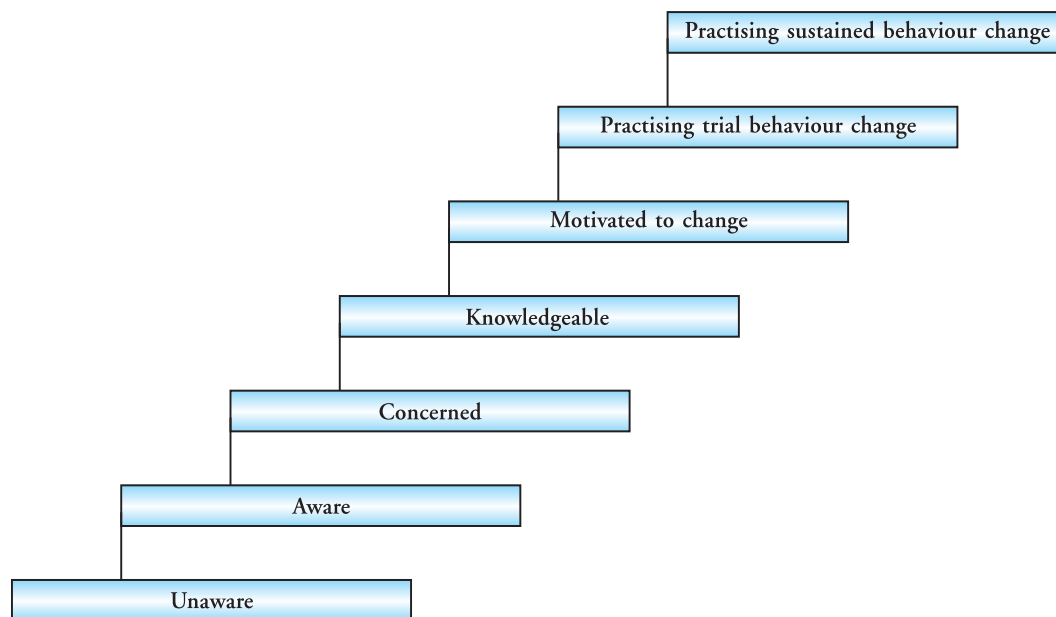
Peer education typically involves training and supporting members of a given group to effect change amongst themselves. Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviours at the individual level. However, peer education may also create change at the group or societal level by modifying norms and stimulating collective action that contributes to changes in policies and programmes. Worldwide, peer education is one of the most widely-used strategies to address the HIV/AIDS pandemic.

Guided group interaction and positive peer culture-peer led intervention mechanisms to prevent HIV amongst incarcerated substance users

There are studies to prove that the most widely used means to rehabilitate institutionalised delinquents is group counselling. Forms of group counselling may vary from informal and unstructured meetings between prison staff and inmates to sophisticated treatment modalities led by trained or professional staff (Bartollas, 1985).

This comprehensive strategy of guided group interaction programmes attempts to substitute a whole new structure of beliefs and behaviours for old structures. Since prison staff members can lead guided group interaction, more staff members can be involved in the intervention processes without any additional burden on the prison.

The positive peer culture approach is extended to all aspects of daily living. The basic goal is to "turn around" a negative peer group toward a productive direction, placing great significance on positive behaviours. The responsibilities of successfully using a guided group interaction model with the positive peer culture model rests with the prison community. These two models are threaded through the entire phase of the intervention.



Behaviour change approaches

This intervention adopts a range of approaches to achieve change in risk-behaviour:

- Behaviour change communication (BCC)
- Participatory learning and action (PLA)
- Information advocacy

BCC is an interactive process with communities (as integrated with an overall programme) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours, promote and sustain individual, community and societal behaviour, and maintain appropriate behaviours. The basic framework in diagnosing a community, group or individual and bringing about a change in behaviour is based on the following hierarchy (where applicable):

It is used in this project to:

- Increase perception of risk behaviour
- Develop the skills and capabilities of inmates to promote and manage their own health and development
- Foster positive change in behaviour as well as in knowledge and attitudes
- Work in partnership with prison staff, families of inmates, NGOs, health services and communities to influence the social norms and policy environment within which inmates function

BCC strategies at the community level use participatory community and social change techniques to involve communities at the local level.

PLA approaches are used to gain community acceptance at project entry and as formative research to obtain qualitative data. PLA fosters community decision-

making, which helps ensure that change is facilitated and grows from within, rather than dictated by outside sources. The PLA approach is used to achieve the formation of partnerships of key stakeholders.

Information advocacy is used to introduce effective and evidence-based interventions for risk-reduction related to drug abuse and HIV. Results of research and intervention studies implemented by the project will be used to advocate policy change and mobilise the support necessary for scaling up.

Many inmates who consider themselves to be heterosexual assert their masculinity not by suffering through the frustrations of abstinence, but by engaging in homosexual activities. In some institutions for male offenders, sub-cultural norms exist allowing “real men” to have homosexual relations without having their heterosexual identity challenged, as long as they always take the penetrative role. Receptive males, many of whom are unwilling participants in the sexual activity, are stigmatised and may be subject to prostitution and rape within the institution (Donaldson, 1990). The combination of sexual frustration and the need to maintain one’s masculine image while facing a long period of incarceration with only members of the same sex leads many male inmates to acquire sexual gratification from other men through persuasion, bribery, coercion or force (Sykes, 1966).

Studies reveal that homosexual relationships among female long-term inmates emphasise the satisfaction of emotional needs in addition to the desire for sexual release. Deprivation of heterosexual relationships has a profound impact on both male and female inmates. Homosexual relations are the only means for participatory sex in prison and many female inmates in particular, undergo changes in identity and self-perception. Some male prisoners are spared this change and are allowed to maintain their heterosexual “real man” status, but often this requires the victimisation and abuse of other prisoners (Sykes, 1966).

During various stages of interaction with stakeholders in the orientation phase, it emerged that sexual activities inside prisons take place in the following forms: comfort sex, sex for power, initiation sex and sex for punishment.

This toolkit, to a large extent, takes into consideration key sensitivities and cultural realities of South Asia. However, it is important to note that there may be slight variations within countries.

This South Asia Module is developed from key recommendations and strategies proposed by stakeholders from the prison community across five countries of South Asia (Bangladesh, India, Maldives, Nepal and Sri Lanka). The project strategy included a participatory step-by-step approach to address concerns of the prison community of South Asia. Through select pilot interventions in prison settings across the five countries, this project validates the methodology/intervention design by the stakeholders to address HIV prevention amongst substance using populations from a ‘South Asian’ standpoint.

2. ORIENTATION AND CAPACITY - BUILDING PHASE

Phase I: Creating an enabling environment

Activities in Phase I deal with the creation of an enabling environment for the intervention and flows into the remaining phases. It mobilises and sensitises stakeholders to own up to the problem of drug abuse and related risks in prisons and attempts to address it through advocacy and networking by mobilising key influencers to lay the ground for sustaining the intervention after project life.

Objectives

- Establish a network of key stakeholders in the prison community for addressing issues relevant to the intervention.
- Sensitisation of prison officials to the twin problems of drugs and HIV.

Activities

- Identify stakeholders in the prison setting for training and sensitisation programmes on drugs and HIV.
- Conclude with the initiation of the actual intervention

NEEDS ASSESSMENT

Having realised the dearth of literature and research on prisons in South Asia, and in order to plan the strategy for carrying out an appropriate intervention to address HIV prevention amongst incarcerated substance users for South Asia, a quick needs assessment was carried out.

This assessment was conducted by the project's prison expert through visits to prison intervention sites in five countries across the region (Bangladesh, India, Maldives, Nepal and Sri Lanka) at three levels:

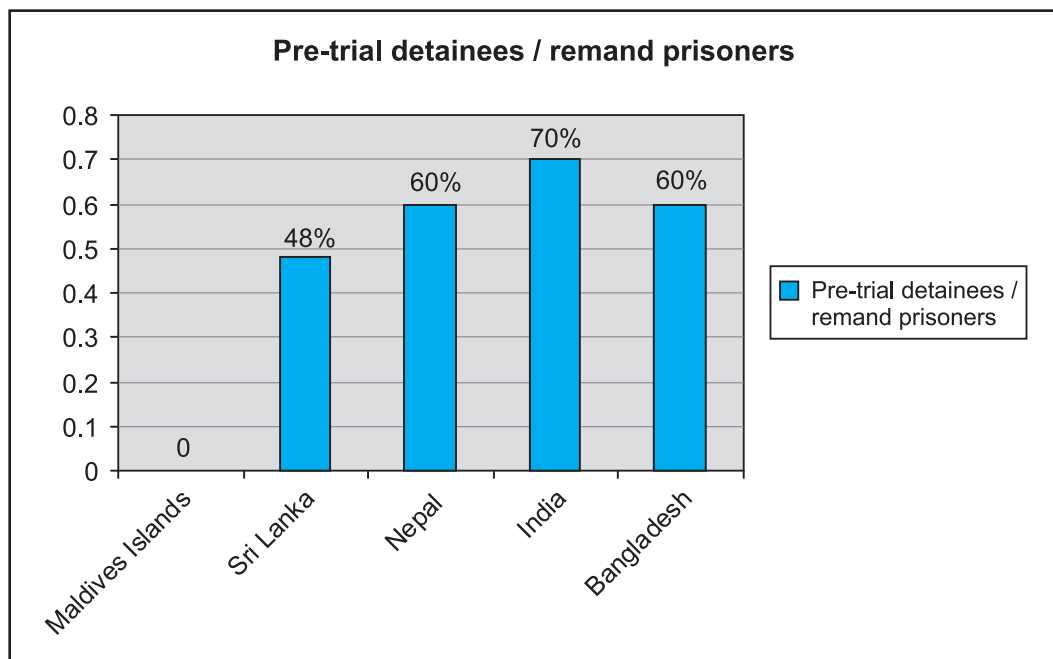
- Prison inmates
- Field-level prison officials
- NGOs

Questionnaires (on demographic profile of inmates, drugs and HIV) were given to prison officials and NGO partners for randomly administering them to a minimum of 25 inmates in the proposed sites.

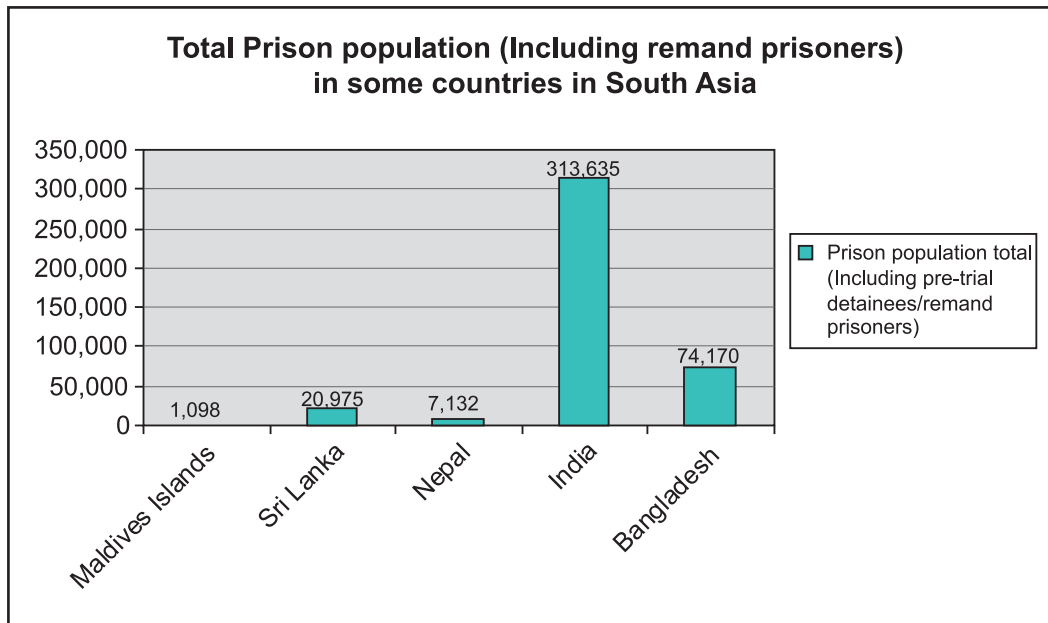
This needs assessment was crucial in providing a roadmap to the intervention since it yielded information on existing ground realities in member states. The capacity-building programme was designed in line with the needs expressed by the countries. Any intervention in closed settings like prisons needs to be country/locale-specific and should be contrived, authored and owned by the decision-making and executing authorities/agencies themselves.

Key findings across prison intervention sites in some South Asian countries

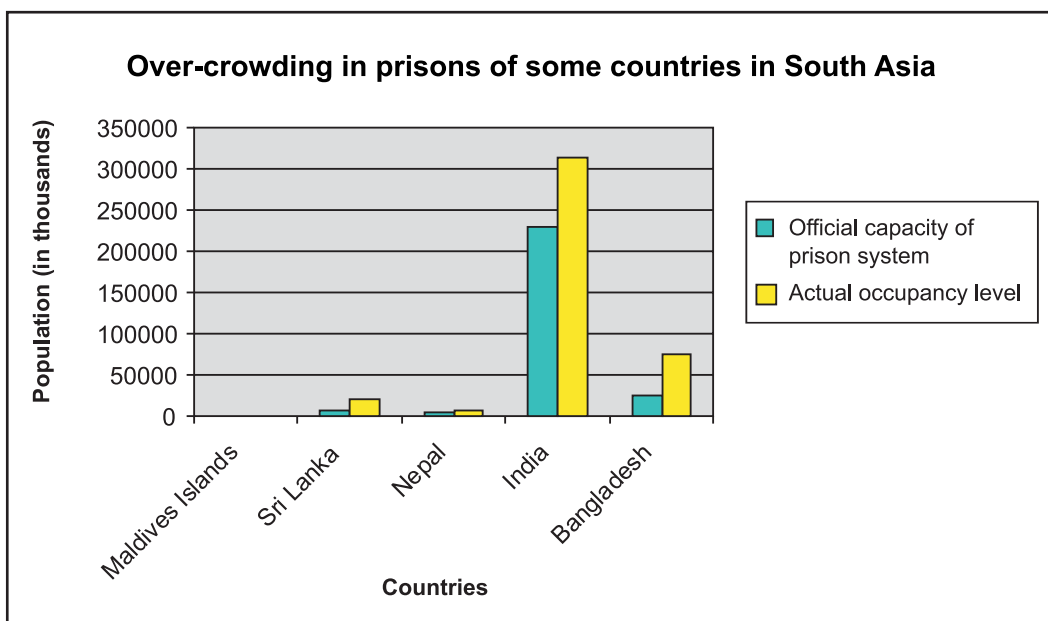
- Overcrowding
- Constraint of resources
- Convicted prisoners are a minority population
- Low awareness about HIV and drug related issues
- Non-existent community participation and involvement
- Urgent need for greater coordination between and training of custodial and rehabilitation agencies
- The proposed module must take into account locale-specific culture, lifestyles and laws
- The intervention must take into consideration the values attached to family ties and in-group associations prevalent in South Asia
- Local laws and practices allow the participation of the prisoners in welfare and administrative activities of the prisons, thus facilitating involvement of primary stakeholders
- Components of Project RAS/H71 are being perceived as a pioneering effort in heading off drug-driven HIV in prison settings



Source: International Centre for Prison Studies, London, 2005



Source: International Centre for Prison Studies, London, 2005



Source: International Centre for Prison Studies, London, 2005

Drugs and HIV in Prisons: Findings from the Needs Assessment Questionnaire

This quick needs assessment was conducted by randomly administering questionnaires (on demographic profile of inmates, drugs and HIV) to inmates in proposed sites of the intervention.

The findings for Sri Lanka, India and the Maldives were analysed by the project team while for Nepal, the NGO partner completed the analysis for 100 inmates. The response from Bangladesh was not received. Based on the limitations above, the following situation emerged:

The Situation

- High percentage of first-time offenders - which puts them at a high risk of sexual exploitation within the prison.
- High percentage of unskilled labour - need to include vocational training as a key component of empowerment in intervention strategies.
- High percentage feel that a 'change' would require the involvement of self, state/prison, NGOs and governments agencies in drug supply reduction and counselling, a reflection of the participatory model component in the toolkit.
- High percentage expressed the need for more efficacy in spreading awareness to combat the HIV problem rather than 'policing' and curbs.
- High percentage felt the prevalence of sexual aggression without adequate protection in the prison.
- Prevalence of unprotected sexual interaction.
- Low percentage of IDUs but sharing of needles in small cliques prevalent.
- High prevalence of the use of sexual favours to procure drugs.

Comparison of findings on parameters across prison sites

- Higher rural population in Amritsar whereas urban population in most other sites - vocational training or rehabilitation strategies to be site-specific.
- High percentage of respondents married - therefore, risk of spouse infection.
- Smaller families in India while large families in Nepal and Kandy - this helps to provide estimate or baseline of level of expected family support.
- Awareness about drug abuse and its consequences higher in Kandy while low in other sites.
- All sites reported similar opinions about the cause of spread of HIV in prisons.
- Highest access to drugs in India - more risk of sexual exploitation.
- Money and sexual favours or exploitation a common means for procuring drugs across all sites.
- Prevalence of sexual aggression and unprotected anal sex across sites.
- High percentage feels prison only provides partial or negligible protection against sexual exploitation and drug use.
- Apart from Nepal, most respondents feel that prisons are equipped or can 'handle' the situation.

REGIONAL TOT

The next step is the regional training of trainers programme. The training was based primarily on the principles of adult learning and experiential sharing. A 'vertical interaction' training programme with an apt mix of theoretical and practical inputs was adopted.

Objectives

- To create a cadre of master trainers to facilitate national training
- Sensitisation of prison officials to the problem of drugs and HIV
- Through a participatory process:
 - ❖ Develop and design appropriate country/locale-specific prison interventions
 - ❖ Develop country-specific guidelines for national and site-specific training
 - ❖ Create a platform for networking and advocacy (between UNODC and different sectors, i.e., prisons, drug control, HIV and civil society from member states)

Methodology

The programme was designed in order to provide an apt mix of theoretical inputs, experiential learning through participatory methodologies (fair field, role plays, group discussions, etc.) and a field visit to a prison. The curriculum comprised of 20 per cent theoretical inputs, 30 per cent role modelling (sharing of experiences by managers/experts as resource persons in the field of drugs and HIV in prison settings) and 50 per cent of sharing by participants from member states.

The resource persons were carefully chosen, based on their experience of managing and working (NGOs and researchers) in prison settings. Their sharing generated immense enthusiasm amongst participants and also motivated participants to carry back best practices to their respective countries. The curriculum for the regional TOT attempted to address knowledge, attitude and skills on prevention of drugs and HIV in prison settings.

Key recommendations

- All prison staff were trained and sensitised on issues related to drugs and HIV.
- Prison inmates and their families should be involved in the development of IEC information package.
- Methodologies like drama, poetry, poster-making, etc., must be explored and used by the prisoners.
- Prison inmates are provided with information on reducing risks associated with drugs and HIV.
- Intervention is based on the existing rules and practices within prison settings of each country.

- The country/locale-specific interventions take into cognisance the cultural and ethical considerations of each country.
- Separate intervention strategies address each of the issues - drugs, HIV and empowerment.

This training provided an opportunity for each country to share their experiences and strategies for handling prison-related problems/constraints.

NATIONAL TRAINING

In order to deliberate on the outcome of the regional TOT and to further develop country and site-specific modules, seven national training programmes were envisaged: two each in India and Sri Lanka, and one each in Nepal, Bangladesh and Maldives. The outcomes and recommendations from the national training programmes significantly contributed to the development of this toolkit.

Seven national training programmes envisaged:

- 2 in India
- 2 in Sri Lanka
- 1 in Nepal
- 1 in Bangladesh and
- 1 in the Maldives

- More of ground-level, site-specific information and issues.
- Participants: Senior/middle level officers, medical officers and welfare officers.

While the methodology and syllabus used in the national training programme was very similar to the regional TOT, it had additional inputs providing detailed information about drugs and HIV. The resource persons mostly comprised of master trainers from the regional TOT.

This training proved crucial in sensitising prison officials, officers responsible for rehabilitation of drug users and NGOs working in HIV/AIDS prevention to the problems of substance use and HIV/AIDS in prison settings.

SITE-SPECIFIC TRAINING

This training took place at the site of the prison intervention. It was a day-long training aimed at capacity building of approximately 250 participants, including peer patrons, peer volunteers, NGOs and other correction/welfare field-level personnel.

It aimed to sensitise field-level functionaries to ensure an enabling environment for initiating the actual intervention.

To facilitate this training programme, locally (site-specific) available prison officials/NGOs/welfare officers/medical officers trained at the regional/national level were



present to provide inputs as resource persons. Also, this methodology was adopted to ensure a guided group interaction amongst prison inmates and field-level prison personnel.

The training was fully participatory, wherein the inmates were involved in skits, role-plays, poetry reading, painting, group discussions, dancing and other creative activities to disseminate key messages on drugs and HIV. This set the tone for the intervention, where the ownership will be transferred to the actual beneficiaries of the intervention.

A baseline assessment instrument has been designed to document knowledge, attitudes and practices of substance using prison populations. This instrument is translated into the local language, and then translated back into English by a person not familiar with the original instrument; this translation when compared to the original instrument will test the correctness of the first translation.

Objectives

- Create an enabling environment for initiating the intervention
- Orient and sensitise peer patrons, peer volunteers and other prison personnel
- Identify the most suitable enclosure/ward for carrying out the intervention
- Generate appropriate IEC materials/key messages
- Deliberate upon role allocation (who does what)
- Developing a site-specific monitoring kit
 - ❖ Record keeping/register
 - ❖ Administering the baseline and end line KAP questionnaire

The diagram on the following page illustrates the overall capacity building strategy proposed for preventing the spread of HIV amongst incarcerated substance users in South Asia.

This strategy was adopted to arrive at the South Asia Module. At the outset, it is believed that no intervention in prison settings is possible without the involvement and sensitisation of prison personnel. The first step is, therefore, to sensitise and train prison officials/NGO staff working with prisons on drug-related HIV concerns.

As depicted in the diagram, the first row of persons are prison officials (senior and mid level), NGOs working in prison settings and government representatives from drugs and HIV sectors across South Asia who were trained in the regional TOT programme. Thereafter, select master trainers trained/sensitised in the regional TOT train a similar category of persons at the national level in their respective countries. The persons trained at the national level also include medical and rehabilitation officers working in prisons. This cadre is prepared to then train prison staff and key inmates at the site-specific levels. At the site-specific training programme, the actual



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Capacity building

28 Master Trainers

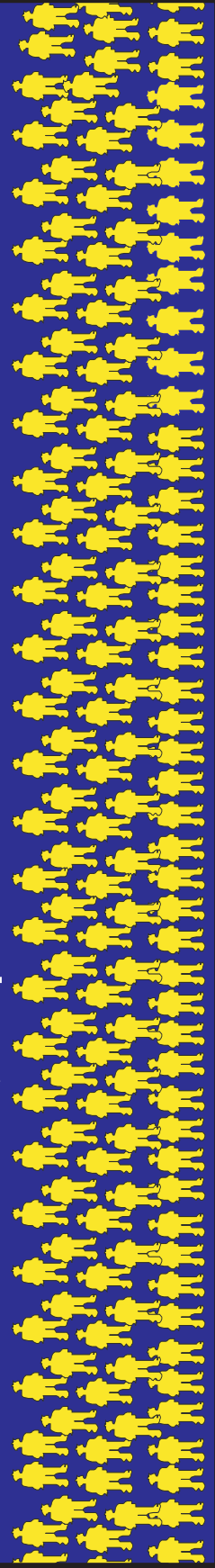
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175 National Trainers

2000 prison inmates capacitated

10,000 prison inmate beneficiaries



intervention will roll out-by using peer-to-peer networking, positive peer culture and guided group interaction.

Key messages on safe behaviours, risk reduction will be provided to inmates through short training/awareness sessions, which in turn will be disseminated to other inmates using peer-led methodology. In the training sessions, peer volunteers (inmates) will develop their own creative mechanisms to spread messages of safe behaviours and prevention, etc. Such mechanisms will include painting, plays, puppetry, etc. Through a process of rewards and recognition, inmates will be encouraged to promote safe behaviours amongst themselves and their peers.

The 'trickle down' of knowledge and skills from the 'top to bottom' is crucial in driving home the point that drugs and HIV are important issues to reckon with. Unless the problem of drugs and HIV is accepted and addressed by the prison staff at the senior levels, and unless they provide the lead in disseminating the knowledge and skills to the inmates, a change in attitude and behaviour will be difficult. Additionally, the training will build capacities of prison personnel to better address drug-driven HIV concerns in prisons across South Asia.

3. INTERVENTION PHASE

Phase II: Risk reduction and life-skills training

The intervention phase encompasses the ‘actual intervention’ and the rollout includes three elements:

1. Post detoxification: creation of a therapeutic community (TC) - six months
2. Peer-led intervention: creating awareness and providing intensive risk reduction and life-skills training to inmates (to enhance their coping skills) and ultimately to empowerment - three months
3. Re-entry phase: preparing for post-release rehabilitation - three months

The criteria for entry into the therapeutic community is as follows:

- Only a drug user who has undergone detoxification
- Anyone who reports dependence on drugs (including alcohol) even once in the last one month prior to arrest.
- Those users who don’t report a debilitating physical or mental illness or a major communication handicap.
- Those users who don’t show acute withdrawal symptoms.

The minimum period of stay in the TC is six months. However, a person requiring further help could continue up to a maximum of 2 years.

After ‘phasing-out’ from the TC at the end of six months, the inmates would either move to the PLI for a period of three months or stay as a peer / peer volunteer in the TC depending upon his/her suitability or preparedness to move on to the next phase.

The criteria for entry into the peer-led intervention phase is as follows:

- Anyone who graduates from TC.
- Anyone who is not a substance user but needs to be provided with appropriate knowledge and skills on drugs and HIV. This identification will be done by the peer assembly and through peer monitoring (described ahead).
- Anyone who is likely to stay in the prison for a longer period.

The minimum period of stay in PLI is three months. However, there is no upper limit.

The criteria for entry into the social re-entry phase is as follows:

- Anyone who graduates from PLI.



- Anyone whose release is impending. This may include even those who haven't passed through the TC and PLI phases. This is more appropriate for inmates undergoing short-term imprisonment. This could be a 'stand alone' phase for those inmates who enter the prison for a very short term.

The minimum period of stay in the social re-entry phase is for three months. However, inmates can stay longer, till they are released.

Even though the minimum period for stay of inmates is provided for each intervention phase, discharge from the prison is in the hands of the courts. It is therefore crucial that the intervention managers take utmost care while selecting of peers for each intervention phase.

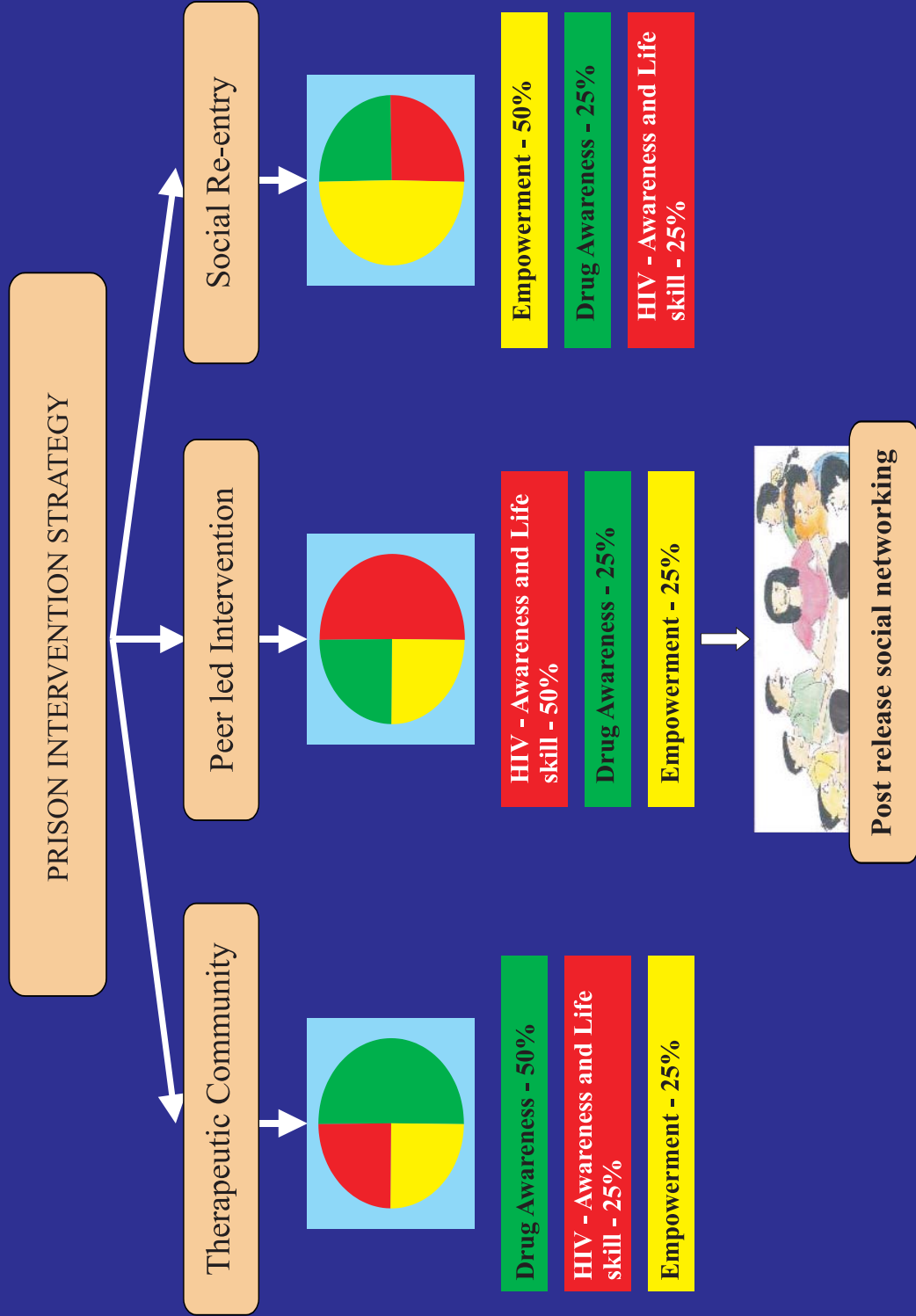
The intervention will follow a guided group interaction model for all the three phases. This guided group interaction would include members from prison staff, welfare officials and NGOs working in prison settings.

Systemic Protection : The intervention strategies are aimed at better physical and mental health and well-being. In the entire intervention rollout, the chain of command in carrying out the intervention would be maintained. South Asian prisons are riddled with problems of overcrowding, low convict population and large turnover of prisoners for a short period of stay. This is compounded further by constraint of resources and low staff-inmate ratio. All these issues contribute to high risk behaviours, exploitation, fights, drug abuse etc. In most of the cases, particularly during the night lock up hours, one custodial staff takes charge of a large number of inmates locked up in their barracks/ cells/ enclosures. Round the clock shifts of two persons in each barrack preferably on rotation from amongst different peer groups would facilitate surveillance, monitoring and detection of inappropriate behaviour. Through effective peer network (suggested in this module) involving prison inmates and prison staff, systemic protection can be ensured to vulnerable inmates to a large extent.

In all the three phases, the SAKAPiPP (South Asia Knowledge Attitude and Practice in Prison Populations) **baseline** will be administered to the inmates upon entry and an **endline** at the time of exit of each phase.

In a prison setting, the release of prisoners cannot be predicted in most of the cases. In such circumstances a **midline** is proposed in those cases where the inmates are released from any of the intervention phases without completing the mandatory minimum period of time.

In each prison site, a group of persons would constitute the **experimental group** (where the intervention is rolled out) and a **control group** where the intervention is not rolled out. For the **control group**, it is advisable to identify prison inmates who are likely to be in the prison for a very short duration or those who are likely to be



shifted from one prison facility to another, or even those who may not wish to be part of the intervention.

The modality and human resource management structure is highlighted ahead:

MANAGEMENT STRUCTURE

Who's Who

Peer: a prison inmate

Peer volunteer: an inmate who is responsible for training/delivering messages to his/her peers. He is also a 'protector' and 'guardian' of fellow peers. May be addressed as 'elder brother/sister' by other peers. It may be advisable to have a peer group comprising of 5-25 persons under a peer volunteer depending upon population and space in a particular setting.

Senior peer volunteer: An inmate who is chosen by and from among the group of peer volunteers to be the leader. May be addressed as 'father or mother' by others in the group. Each enclosure/barrack/ward may have one senior peer volunteer and a number of peer volunteers under him/her.

Peer patron: the peer patron is a field-level prison official (head warder/senior warder) who forms an important link between the jail authorities, community and prison inmates. He is like a 'father figure' for the peer groups. He also takes regular feedback from the senior peer volunteers / peer volunteers and is a 'damage controller'.

Coordinator peer patron: A middle-level prison functionary (i.e., assistant superintendent/jailor) responsible for supervising a number of enclosures/wards. Debriefing regarding functioning of the intervention will be at his level on a day-to-day basis.

Deputy Chief peer patron: The second-in-command in prison administration (Deputy Superintendent/ Chief Jailer) who is responsible for day-to-day internal administration and monitors the intervention. Should any level of networking fail, it is his task to put it in place.

Chief peer patron: The superintendent/governor of the prison who is in-charge of overall superintendence and control of the prison. He is the facilitator and a nodal point for networking and advocacy with community, government and policy-making levels.

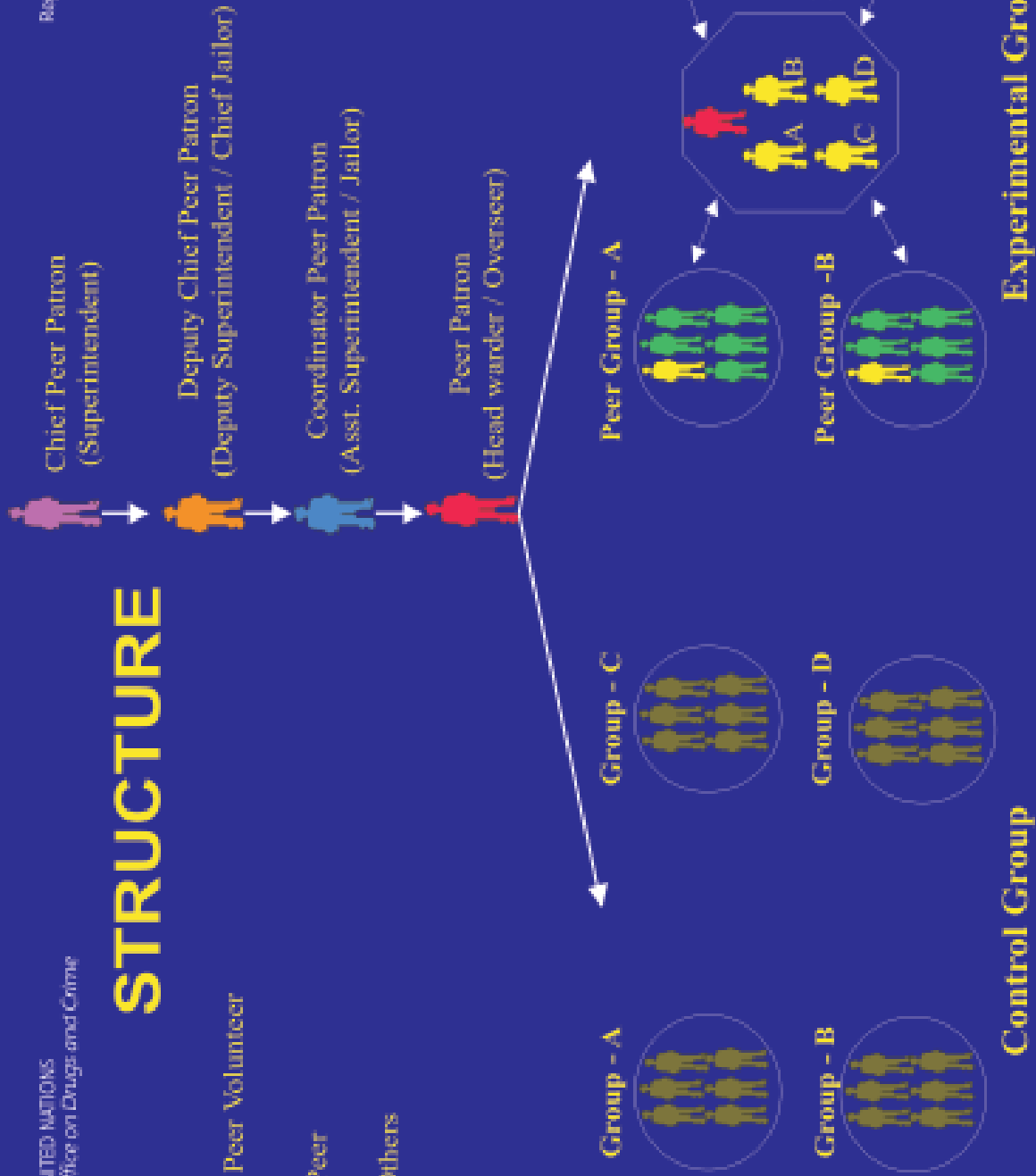
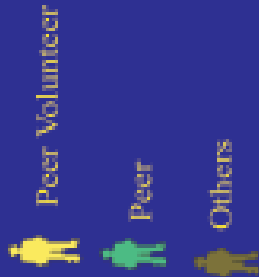
This is essentially a "supervised" or guided peer-driven intervention. The reason behind this is that the inmates are a 'floating' population moving in and out of the prison. Most of the prisons in South Asia have a majority of undertrials/remand prisoners with short and unspecified lengths of stay in prisons. In conditions like this, the role of the field-level supervisory prison official is that of a key facilitator and guardian. He/she is responsible for supervising and maintaining the group



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STRUCTURE



dynamics of peer networks. The involvement of the prison officials and other professionals in the peer network will bring about continuity, transparency adaptability and sustainability.

The NGOs and social welfare officials, including medical, vocational trainers and rehabilitation officers associated with the prisons, will be facilitators for training peer volunteers.

According to Dr. Kiran Bedi (1998), “all these developments substantially reinforce the concept of good health—both of the mind and body—among the prisoners. The voluntary organisations not only provided a healing touch to the addicted inmates, but also propelled them towards adopting a new, salubrious lifestyle.”

Supervision: Prison staff/rehabilitation/welfare professionals/NGOs (where applicable) will provide the necessary supervision, guidance and training to peer volunteers on an ongoing basis. They are also the principal trainers of peer volunteers.

DYNAMICS OF PEER NETWORKING

In a particular prison setting, some enclosures will be part of the therapeutic community, peer led intervention and social re-entry phases of the interventions whereas other enclosures may not be covered under the intervention.

The **peer training** will roll out in the following manner: the peer patrons train the senior peer volunteers/peer volunteers with the help of rehabilitation professionals and NGOs (wherever applicable) in risk reduction information, safer practices and life skills through participatory training methodologies. These volunteers, in turn, will train their peers. The peer training will be organised on a daily basis. Each peer volunteer is expected to train all the peers of his/her peer group (5-25 persons).

Before starting the peer training, all the peer volunteers and senior peer volunteers will narrate a report of the incidents in their group (of the past 24 hours) for the entire gathering to deliberate upon it. This can be documented in the incidence register.







The **peer assembly** is a ‘clearing house’ of suggestions and grievances for inmates in the peer groups. It will be an advisory body for taking important decisions about peer network and its members. The peer assembly will be attended by senior peer volunteers, peer volunteers and the peer patron, and will be supervised by the coordinator peer patron with the support of welfare officers (like medical, vocational and rehabilitation officers) and NGOs. There will be half-day sessions every week.

Peer monitoring: The chief peer patron and deputy chief peer patron will monitor the intervention every month. Coordinator peer patron, welfare officers, NGO, peer patron and senior peer volunteers and peer volunteers will attend the peer monitoring. Remedial action, if any, will be taken on the basis of feedback and suggestions. The line of communication will be maintained with the set chain of

DYNAMICS

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-  NGO
-  Coordinator Peer Patron (A. S. / Jailer)
-  Welfare Officer
-  Peer Patron (Head warden / Overseer)
-  Peer Volunteer
-  Peer



command to facilitate speedy intervention in emergency situations (including medical and law and order problems). Deliberations in the peer assembly and the feedback received in peer trainings will be taken into consideration and a gap analysis would be conducted leading to necessary modifications, if any.

The proceedings of the peer training, peer assembly and peer monitoring will be documented and recorded. Every event and main activity, such as who enters/exits, commitments made by new residents, to negative behaviour/incidents and action taken of the community will be recorded and monitored. In all the three phases of the intervention, there will be in-built mechanisms to monitor progress and impact.

Creation of a self-contained community within the prison set-up has got an effective beneficial value and a special advantage for the prisoners. So, attempting to lead a drug-free life while in the prison community is in itself a positive step towards the process of reintegration.

The programme establishes “cardinal rules” (for example, no sex, violence, substance use, etc.), which, if violated may result in adverse consequences and in extreme cases may lead to the termination from the peer group.

Demonstrated pro-social behaviour ensures positive reinforcement of privilege and promotion in the status level system. Similarly, infractions of programme rules lead to loss of privilege and programme status. A balance of negative and positive rewards is a very effective behaviour modification technique.

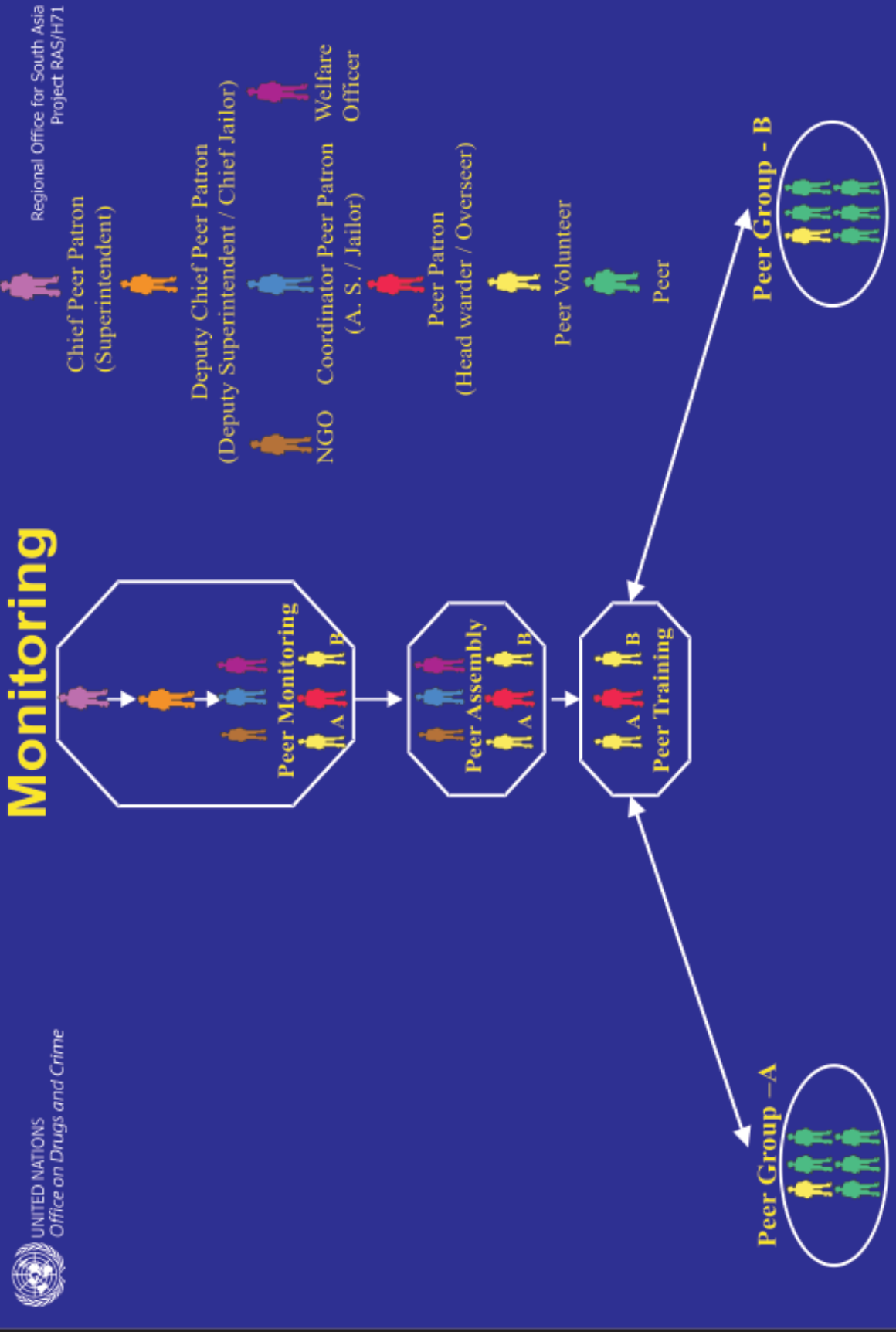
Senior residents managing the house (as peer volunteers/ senior peer volunteers) also act as positive role models for the junior residents; Participants are aware of each other's goals and objectives, and help each other to achieve such goals. The key to the intervention process (including TC, PLI and social re-entry) is self-help, which includes direct, honest and immediate feedback system.

Peer pressure acts as a catalyst in producing insight into the behaviour change and learning. Daily, participant-led interactions enhance right and independent living skills. Health education training, including both prevention of HIV/AIDS, drug abuse and STIs, is provided.

The peer models in all the intervention phases provide its participants a surrogate family and a chance for sharing one another's joys and sorrows. The community has a pyramid like structure. Participants/residents may be divided into different groups like “families”. All the members of these peer groups are accountable to each other for their own action and the action of the group as a whole.

There is a clearly defined hierarchy so far as the duties and responsibilities are concerned. Increased responsibility follows higher status. Responsibilities of senior

Monitoring



members are more as compared to the junior residents, like running house meetings, orientation of new members and other house management functions. Inter-personal relationships inside the peer groups are based on 'brother-sister' model. Locus of programme control is shared between the staff and the residents, although the ultimate authority lies in the staff. Encounter groups exist, who are involved in identifying faulty attitudes of fellow residents.

During the SAKAPiPP midline administration, if it is noticed that there is need for modification of the methodology or content- this will be addressed through peer monitoring and peer assembly.

The management structure (who's who) and the dynamics and monitoring will be applicable in all the three intervention phases.

THERAPEUTIC COMMUNITY

Residential treatment provides opportunities for intensive interventions and support that may not be present in outpatient settings. In the area of substance abuse treatment, the therapeutic community (TC) has become synonymous with residential treatment. A growing body of prison TC outcome research has led to a gradual acceptance of prison TCs as a major innovation in correctional institutions around the world. One living example is the modified therapeutic community model run by an NGO (AASRA) in Tihar jail, New Delhi, India. AASRA takes care of the counseling and rehabilitation needs of incarcerated substance users. A type of recovery and rehabilitation for drug users that caters to the post medical treatment of the addicts provides de-addiction and re-integration facilities to the prisoners (Bedi, 1998). While some used to believe that “nothing works” in prison rehabilitation, research by psychologists and others has shown that treating prisoners’ substance abuse problems while in prison, and after they are released leads to major reductions in recidivism.³

TC is the term used to describe the formal and informal curriculum directed towards teaching the point of view on self-help recovery and the view of right living. These messages and lessons are given repeatedly in the various groups and meetings throughout the institution. The TC correctional environment becomes the natural setting for the challenge of structure, re-socialisation and support, thus becoming the agent of change.

The therapeutic community model of prison substance abuse treatment and aftercare is believed to significantly reduce recidivism rates. The TC is also a conducive environment for dissemination of key messages on safe behaviour related to drug-related HIV. It is hoped that these programmes make a significant positive difference in the lives of inmates following their release from prison.

³ Prison Substance Abuse Treatment With Aftercare Reduces Recidivism, *Psychology Matters*. accessed at http://www.psychologymatters.org/prison_drugabuse.html



Therapeutic community is a place where people with psychological, social and behaviour problems are helped through a highly structured and supervised recovery programme.

The objective is that the cultural pressure of the TC is directed towards the drug users acceptance of a more useful social role, which may then appear desirable because of his growing identification with the group. TC principles are often applied to the therapeutic care of a wide range of people and sectors such as prison, social care, health sector, etc. This method works with all age groups, adults, children and adolescents, and with problems like substance abuse, mental illness, learning difficulties, severe emotional and behavioural difficulties, etc.

Prevention of drug dependence inside the prison and achievement of this goal of drug demand reduction involves two steps:

1) Getting off drugs

Getting off drugs is very important in the process of drug demand reduction. The stage of getting off drugs involves a medically supervised detoxification process, which is not actually designed to address the psychological, social and behavioural problems associated with addiction, and thus does not produce lasting behavioural changes. Additionally, provisions could be made to enroll drug-dependent prisoners in drug treatment programmes (like drug substitution therapy) while in prison, with adequate protection of their confidentiality. Such programmes should include information on the treatment of drug dependency and on the risks associated with different methods of drug use. Prisoners on substitution therapy prior to imprisonment could be able to continue this treatment while in prison.

2) Staying off drugs

Staying off drugs is equally important or rather more important in the attainment of this goal. It is a difficult task and it takes into account other factors which contribute to drug dependence. In places like prisons, it is best achieved in a “therapeutic community”, which is a residential treatment programme. There are also other residential programmes like cognitive behaviour therapy in the treatment of the problem of drug dependence.

How it Works?

Because of the high turnover rate, the culture of each community is established by dividing it into peer groups / families of about 5-25 individuals, each with a senior prisoner, called big 'brother / sister' (also prisoners). The admission is, however, spread evenly amongst the peer groups / families to soften the disruption caused by frequent change of population. In any barrack or enclosure, there can be more than one such community. Each barrack has a head called a 'father/ mother'.

After the detoxification process, rapport is built with the substance users and their needs are assessed by the service providers (GO/NGO officials, wherever applicable). They are then motivated for induction into the TC, which provides them with counselling and instruction to help them stay off drugs and succeed outside prison (e.g., teaching decision-making skills, self-discipline and respect for authority). These services are provided four hours per day during weekdays.

The peer will be recruited in the TC environment for a minimum period of six months (which can extend up to two years). It is here that he undergoes behaviour modification and empowerment (through life skills) to enable himself to stay off drugs and is given awareness and information about HIV and associated risks, risk reduction practices/safer practices. After the process of assimilation and induction in the TC environment is complete, the peer is ready for phasing out and has the option of participating in a peer-led intervention, wherein he learns better life skills and safer practices, and is ready for re-socialisation and re-integration into society (explained in detail later). After 'phasing-out' from the TC at the end of six months, the inmates would either move to the PLI for a period of three months or stay as a peer/ peer volunteer in the TC depending upon his/her suitability or preparedness to move on to the next phase.

Mechanisms for addressing Confrontation and Behaviour Modification in TC:

- **Pull ups:** It is used to reprimand objectionable behaviour; Commendation for pro-social /desirable behaviour
- **Structured learning experience:** This form of contact is used for repeated objectionable behaviour
- **Behaviour chart:** A five colour code used to rate each person's daily behaviour
- **Incident register/reception register:** Events and main activities are recorded, such as who enters /exits, commitments made by new residents, negative behaviour/incidents and action by the community.
- **Monitoring system:** Round-the-clock shifts of two persons from each barrack, preferably on rotation from amongst different peer groups
- **Indicators of change:** Increased self-esteem; discipline, higher sense of responsibility and respect for authority and others; better coping with feelings of anger; better detection and control of supply as well longer abstinence; better impulse control; increased power of the community as well as sense of accountability in residents; greater honesty.

Stages of TC Process

Therapeutic programme includes three distinct phases with goals, activities and member expectations clearly defined.

A) Assimilation/Orientation Phase

New members are inducted into the community and oriented towards the programme. A proper need assessment as well as personality analysis is done during this phase.

B) Healing/Treatment Phase

Emphasis is laid on abstinence and then psychological growth through value-based behaviour modification.

C) Community Reintegration Phase

This includes preparation of residents for actual re-entry into the wider community. It takes care of intensive interaction with family. Job placements, social security, treatment continuation plans, etc., are also important aspects of the reintegration process.

Salient Features of TC Model in Treating Drug Dependence

1. It upholds the Gestalt Approach, which states that the “whole is more meaningful than sum of the parts”. According to the view of TC philosophy, addiction is a disorder of the person as a whole. Therefore, treatment of actual addiction lies in the treatment of the problems of a person as a whole.
2. It is a psychosocial model that postulates that substance abuse is a symptom of a disorder. Or in other words, it is a manifestation of the underlying psychosocial problems of the person.
3. Humanistic approach to treatment: Physical punishment is an absolute no-no in this model. Positive reinforcement and negative reinforcement are the guiding principles of behaviour modification.
4. Existential approach: As the term ‘existential’ implies, the action of the residents of the community decides their future. It requires truthfulness by word and deed, and the focus is on here and now.
5. Community-as-healer versus individual focus: The primary therapeutic agent in a TC model is the entire community and not the individual alone.
6. Highly structured and supervised programme: This model operates within firm boundaries and expectations. Violations of established cardinal rules lead to adverse consequences.
7. Based on experiential learning: As the term implies, learning takes place on basis of the resident’s own experience, sometimes direct from their own actions and sometimes from the action of others. It involves the confrontation of an individual’s perception, values, behaviour and attitudes.
8. 3-R approach: Reformation, Rehabilitation and Reintegration are the three goals of the TC model. An ideal TC model does not stop after the process of detoxification.

9. Psychological healing: The basic behaviour modification technique is based on psychological principles, like the use of positive and negative reinforcement, etc.

Living Example of TC Inside a Prison

A treatment strategy of drug addiction inside Tihar Prison, New Delhi, provides a case study of the practice of TC model in solving the problems of substance abuse. In fact, the entire reformation package of Tihar Prison is based on the **New Delhi Correction Model** (Sarangi, 1995), which is based on the following elements:

- Bringing Community into Prison
- Participative Management
- Creating Self-Sustained Community Inside the Prison

Keeping these factors in consideration, the TC model is adopted to deal with drug-abuse prisoners. The drug addicts are kept in a separate enclosure. The community is called 'New Delhi Model Parivaar'. Parivaar in English means family. This programme is run by AASRA, an NGO situated in Tihar Jail, New Delhi, India.

The entire community works on the principle of "I am my brother's keeper" and aims at value-based shaping behaviour. Started in 1993, it has today evolved as a successful model. The indicators of change include: increased abstinence, increased self-esteem, responsibility, discipline, voluntary participation, skill to cope with anger, better impulse control, decreased false blaming, transgressions were owned more easily, etc.

Therapeutic Community In Prison: Some Impediments

The following are some of the impediments faced frequently in the way of the success of therapeutic community in the prison.

- Lack of control over the period of stay of remand prisoners
- Lack of resources: human and material resources
- Lack of orientation of the staff who are in close contact with the community
- Lack of after release continued treatment programmes
- Requires skilled professionals

Advantages of Therapeutic Community model in South Asia

Despite these constraints, the advantages of a TC model inside the prison outnumber its disadvantages.

- This model is cost effective, as most of the activities are shared between the staff and the residents of the community.
- Healing process is faster.
- It produces long lasting behaviour change.

- Reintegration into the mainstream becomes easier.
- It is most suitable model for people of the South Asian region where values of family are of paramount importance.
- In South Asia, where resource constraint is a reality, NGOs can be involved to make this process work inside the prisons.
- Staff can be sensitised towards the existing problem and oriented towards handling it, and thus can be an additional strength to the manpower resource.

PEER LED INTERVENTION

This component emphasises using peer-to-peer contacts to disseminate knowledge and skills. The idea is to enhance life skills, communication skills and knowledge, and skills on safer practices. During this stage, the peer volunteer is amongst other peers who may not necessarily be ex-substance users. Since this component will prepare him for reintegration into society after release, it is essential to test his social and coping skills with other peers in prison. PLI is an ongoing process, having a multiplier effect in the dissemination of information. Since prison settings are vulnerable to HIV, this peer-to-peer networking is crucial for preventing the spread of HIV to new inmates. It is crucial for all inmates to possess basic knowledge and awareness about the risks of drugs and HIV. Since the turnover in prisons is very high, even basic information and awareness to all inmates will be beneficial to the community at large. This peer-to-peer networking aims to foster group security among inmates and protect the vulnerable ones from the “bullies”.

PLI entails training on reducing risk-taking behaviour and includes interactive knowledge and skill-building sessions, using behaviour change communication, participatory training and learning action tools. It is for prisoners who have either graduated from TC or belong to the general category. Training of peers in the PLI shall provide:

Knowledge on drugs and HIV:

- Problems faced by drug users, with a focus on health hazards
- Drugs, HIV and STIs-basics/myths
- HIV transmission and prevention
- Introduction to risk behaviour and risk perception.
- Services available in the community for status of current users in relation to HIV/hepatitis B/C, tuberculosis, STI
- Accessing services
- Forming support groups
- Introduction to changing behaviour and practices



- Role-modelling
- Relapse, recognising relapse and relapse prevention

Skills:

- Life skills
 - Refusal/negotiation skills
 - Communication skills
 - Decision-making skills
 - Problem solving/conflict resolution
 - Dealing with emotions and stressful situations
- Motivating and training others
- Training on how to minimise danger to self
 - Demonstration and rehearsal/practice sessions in condom use (and using bleach to clean syringes/needles for injecting drug users) through visuals

Attitudes:

- Sensitivity to the problems faced by family and other users/PLWHAs
- Commitment to train others in the peer group and role model risk-reduction behaviour.

Risk

The WHO defines risk in relation to HIV as the probability of contracting HIV. It deals with the person's own perception of probability of getting HIV.

Risk behaviour

Risk behaviour is defined as “specific form of behaviour, which is proven to be associated with increased susceptibility to a specific disease or ill-health,” in this case STIs/HIVs.

Risk behaviour in relation to drug abuse and HIV/AIDS in prisons:

Following is an abbreviated list of risk behaviours in relation to drug abuse and HIV/AIDS in prison settings:

- Drug abuse (any kind)
- Injection drug abuse, particularly sharing of unclean injection paraphernalia; direct and indirect sharing
- Having multiple sexual partners
- Unprotected sex (forced sex/comfort sex through oral/anal sex)
- Tattooing
- Lacerations
- Bites

- Prison fights
- Sharing of shaving blades, toothbrushes
- Accidental transference of body fluids

Activities

1. Identify five inmates (peers) for disseminating knowledge and skills (for addressing HIV prevention)
2. Identify peers who are motivated to learn about risk-reduction;
3. Motivate the inmates for recruitment into the intervention;
4. Enrol inmates demonstrating leadership skills as peer volunteers;
5. Train peer volunteers into knowledge on drugs, HIV and life skills;
6. The peer volunteers will further train a batch of five peers each. This will be an ongoing exercise.
7. Organise peer assembly meetings to recognise successful completion of this component; recognising successful participants in the understanding of risk-reduction.

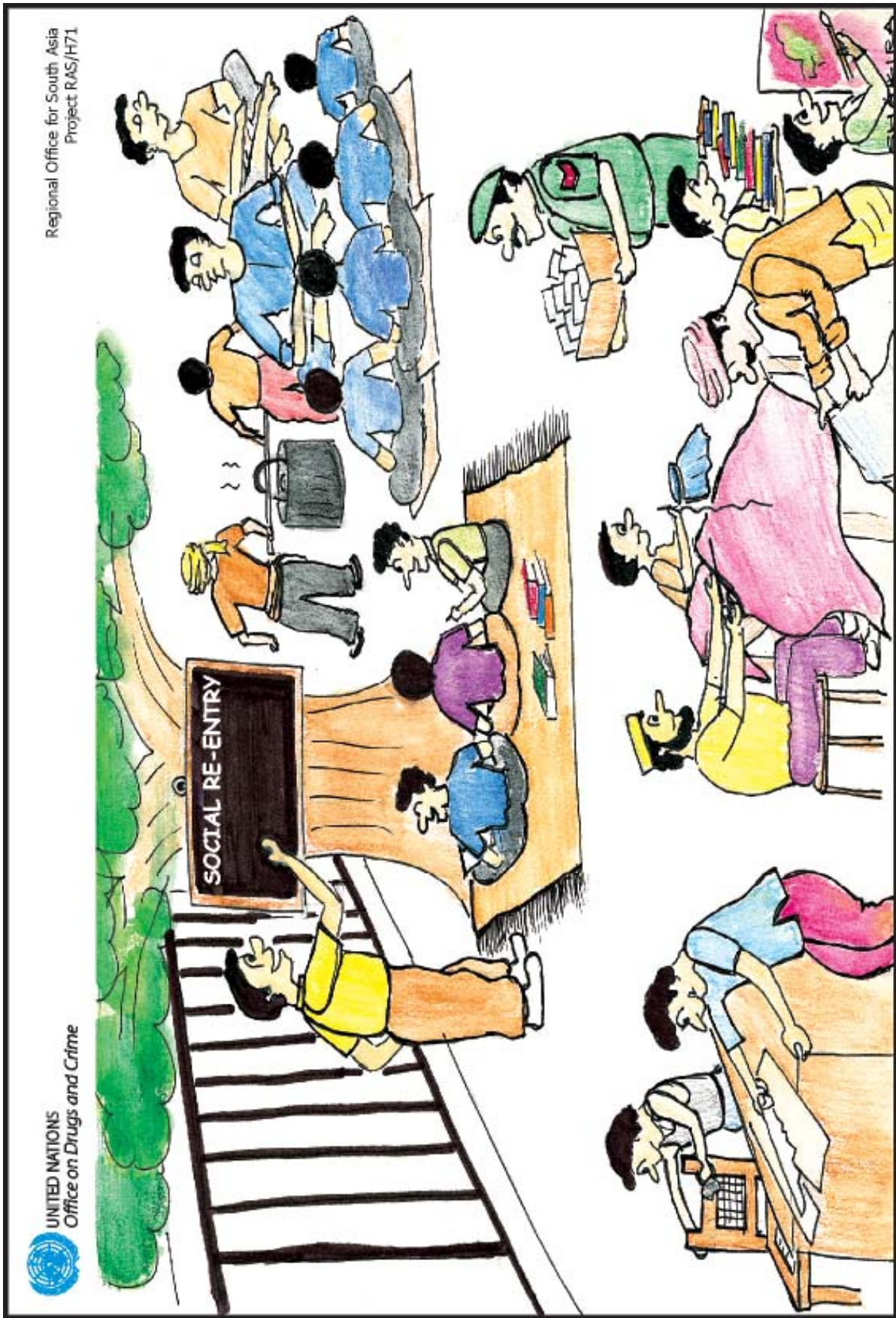
Networking Peer Volunteers and forming the nidus for support groups

Networking peer volunteers helps in building a support system for maintaining the newly-formed health-seeking behaviour. This sets the stage for formation of support/self-help groups in the next phase.

SOCIAL RE-ENTRY

Following release from prison, inmates move directly from a very controlled environment to a low level of supervision or complete freedom. They may immediately be exposed to high-risk places, persons and situations, and few develop relapse prevention skills during their incarceration to deal with these risks. Prisoners facing release often report anxiety about re-establishing family ties, finding employment and managing finances once they return to their communities. In order to minimise these effects, the social re-entry phase has been designed.

“Very early in the process for reformation, we realised the fundamental fact that the prisoners were keen on changes-drastic ones at that-in the system. However, we had no ready-made magic formula for instant reform. Given the remote possibility of our discovery and instant blueprint for action, even if we did find one, the actual process would require the willing acceptance of the entire population of prisoners. Their participation would have to be voluntary and not coercive, in order to not defeat the very purpose of the reforms” (Bedi, 1998).



The greatest resource within a prison is its human resource. “In fact, the jail itself housed the greatest strength-human resource. The human beings confined within the four walls had all the time, energy and professional skills, which constitute the foundation of any vibrant society. What was required was an identification and recognition of this talent with direction and guidance, as and when required. Here was a mass of human potential waiting to be entrusted with responsibility.” (Bedi, 1998).

Social re-entry prepares the peers for re-integration into society. The aim of social re-entry is to form a replication of an ideal society as it exists outside prison. This has been experimented with in Delhi and is part of the “New Delhi Correction Model” of prison reform (Sarangi, 1995). The three important elements of this model are:

1. Bringing the community into the prison
2. Formation of a self-contained community in the prison
3. Participative management

Objectives

- Establish mechanisms for sustenance of project activities beyond project life
- Involve family members to impart support to inmates
- Facilitate networking and referrals-providing linkages to drug and HIV services.
- Establish linkages with social and governmental structures outside the prisons.

Activities

- Providing assistance to prison inmates in formation of support groups and referral linkages
- Assistance in accessing services-review the set-up of the referral system and a directory for each site, a valuable resource for the prison community and the ‘to-be-released’ prisoner.
- The intention of these activities is to create a facilitative environment for
 - Knowledge and skills on drugs and HIV
 - Counselling
 - Life skills
 - Recreation
 - Economic empowerment
 - Spiritual empowerment

The social re-entry phase is ideally for a minimum duration of three months. This phase will address empowerment, HIV/AIDS information and skill-building. Out of the three months, the components will be delivered in the following manner: 50 per

cent of the total focus to be on empowerment (education, vocational and recreational training, etc.), 25 per cent on life skills and prevention of HIV/AIDS, and 25 per cent on drug awareness and prevention.

The residents in this phase will comprise of all the inmates who are likely to be released in the near future (including those graduating from TC and PLI) along with inmates from the general category (i.e., even those who are not part of the TC or PLI). The peer networking and dynamics will be identical to those in TC and PLI.

The formation of a self-contained community within the prison facilitates learning of social skills for adapting to society after release. In the entire process, participation of the prison staff, community/NGOs and inmates plays a very crucial role. In this direction, educational and vocational activities have a very important role. To supplement formal education, knowledge and skills pertaining to drugs, HIV and life skills should form an important component. In view of resource constraints in prisons, it is advocated by many that involvement of community in the form of NGOs or individuals supplements resources apart from bringing about the much-desired transparency in the prison system.

“The...approach of the community towards crime control should be involvement of the programmes for the treatment and rehabilitation of offenders. There are a number of ways in which individuals or groups can offer support to governmental action in these fields...such participation again should not just be limited to supplementing on an ad hoc basis governmental efforts in handling some of the less important processes of correctional work but should be an integral part of the departmental programmes in which certain functions likely to be better handled by private individuals or groups should be assigned to them on a voluntary basis under statutory authorisation” (Government of India, 1984). The process of involvement of the community in prisons brings about a possibility of gradual social re-integration when the prisoner is inside the prison itself. This allows for building linkages for post-release of the prisoner.

“Control and order, including security, are high priority, and coupled with the lack of funds have managed to make psychological ‘needs’ of prisoners a low priority area. Encouraging the involvement of government and non-governmental agencies in prison activities seems a feasible answer, even though this approach is unacceptable to many sections of prison management who regard it as a complete deviation from the old methods of dealing with prisoners/criminals” (Sarangi, 2000).

This phase will facilitate gradual social re-integration to enable the prisoners to play an active role in society after their release. This process is aimed at providing knowledge on drugs and HIV, social skills, including life skills along with skills for recreation, economic and spiritual empowerment.

Knowledge and skills on drugs and HIV

- Drugs and HIV-basics/myths
- HIV transmission and prevention

- Information on risk behaviour and risk perception.
- Services available in the community for status of current user in relation to HIV/ hepatitis B/C, tuberculosis, STI
- Accessing services
- Forming support groups with the help of family members

Counselling

Group, individual and family counselling

Life skills

- Life skills
 - Refusal/negotiation skills
 - Communication skills
 - Decision-making skills
 - Problem solving
 - Dealing with emotions and stressful situations
- Motivating and Training others
- Training on how to minimise danger to self

Recreation

Games, sports, yoga, music, painting and other forms of creative therapy, observance of social functions and festivals to enable inmates to feel connected to family and society outside the prison setting.

Economic empowerment

Vocational training

Education

Providing job-work

Spiritual empowerment

Meditation

Spiritual counselling

This phase can be viewed as an opportunity to improve inmates' skills and prepare them generally for life on the outside. As discussed earlier, many prisoners may have histories of substance abuse, mental and physical health problems, and low levels of job skills and education. There is some evidence that in-prison programmes are cost-effective and beneficial in preparing inmates for life outside prison. In addition to individual rehabilitative benefits, programming may also be beneficial to the internal management of correctional institutions.

4. POST-RELEASE SOCIAL NETWORKING

Phase III: Re-integrating with family and community

Following release from prison, inmates move directly from an extremely controlled environment to one with low level of supervision or complete freedom. They may immediately be exposed to high-risk places, persons, and situations. Prisoners approaching release often report anxiety about re-establishing family ties, finding employment, and managing finances on return to their communities. This condition has been referred to as “gate-fever” (Travis et al, 2001).

The limited research that has been conducted reveals that while very few prisoners ultimately find the experience of release debilitating, the heightened stress levels documented at the time of release reflect very real anxieties about successfully managing the return to the outside world. The heightened stress levels among inmates associated with the moment of release stem from anxieties about everyday problems-whether related to interpersonal relationships or financial pressures-that did not exist for them while in prison.

Furthermore, some studies have demonstrated, released offenders show ineffective or destructive ways of coping with everyday problems. In fact, research attempted to measure the coping process shows that some offenders are unable to successfully recognise and deal with problem situations, leading to increased stress levels and, often criminal, reactions. Little systematic attention has been given by correction agencies on ways to reduce the risks associated with the moment of release. Prevalent practices may, in fact, heighten the anxiety prisoners have about successfully returning to the outside world or increase the risk of failure. Many prisoners are released without adequate documentation; for example, some former prisoners may experience delays in entering drug treatment because they do not know of any medical centres. Thus, the “moment of release” presents opportunities for policy innovation and attention-to develop strategies that build a short-term bridge during this immediate transition period. The social networking phase attempts to address some of these issues.

Empowerment of the prisoner in order to better ‘prepare’ him for release was addressed earlier in the intervention phase wherein life skills, vocational training, information, etc., were imparted. The post-release networking phase specifically aims at equipping the prisoner with the requisite knowledge and skills to ‘face the world’ upon release from prison, provide resources to help them secure employment, access substance-abuse treatment, access HIV services and re-establish family and community ties. The combination of these pre-release preparations coupled with

follow-up on the outside (via NGOs, faith institutions, family, or friends) might reduce the risk of recidivism or drug relapse and improve the odds of successful reintegration after release.

Objectives

- Providing access to services
 - NGOs
 - Government organisations
- Formation of support groups/SHGs
- Involvement of family members to provide support to released inmates- family support groups
- Facilitate networking and referrals- providing linkages to substance use and HIV services.
- Identify existing social/governmental structures to provide support
- Establishing support groups amongst ex-prisoners (like NA, AA)

Activities

- Providing assistance to released prisoners (including drug users and HIV+ persons) in forming support groups and referral linkages.
- Assistance in accessing services: Review the set-up of the referral system and create a directory for each site, a valuable resource for the prison community and the released prisoner.
- Formation of an appropriate agency with the collaboration of NGOs/ex-prisoners and government bodies to ensure a 'help-line' for ex-prisoners in distress.

Therefore, the post-release social networking phase specifically aims at equipping the prisoners with the requisite knowledge and skills to 'face the world' upon release from prison, re-establish family and community ties, provide resources to help them secure employment and access substance-abuse/HIV treatment and services. The combination of these pre-release preparations coupled with follow-up on the outside (via NGOs, faith institutions, family, or friends) might reduce the risk of recidivism or drug relapse and improve the odds of successful reintegration after release.

Linking intervention phases to existing basket of services

The intervention agency will assist in linking this intervention to the nearest governmental and non-governmental agencies in the field of drug demand reduction and HIV/AIDS prevention to provide a basket of services available to substance users.

Assistance in accessing services

Since access to services such as medical, drug rehabilitation and support maintenance groups, HIV care and prevention/testing may be difficult; a referral directory (which is updated regularly) for each site needs to be provided by NGOs.

Community meeting

The relief to family members from the recovery of the substance user and their family's acceptance of the substance user reinforces the reduction in stigma and discrimination. Common features of this recovery process, e.g., increase in self-esteem of the recovering user, reduction in violence and petty crime, and safety of the non-using young people in the community are reinforced. The peer volunteers are then recognised and seen as positive agents for social change in the community.

Support groups

Maintaining abstinence is an important component of drug demand reduction strategy for communities. After discharge from drug rehabilitation centres (DRCs), it has been observed that there is virtually no follow-up or support for recovering drug users. Left to themselves, they do not reintegrate back into their community or society. They are looked upon with suspicion regarding the genuineness of their abstinence by their spouse or other family members. The non-using peers do not want to associate with them, and they are stigmatised as outcasts. They have no assistance to deal with their shame and guilt for having lived a life of drug dependence. Very often, even support from their religious leaders is not forthcoming.

Suggested agenda in support groups

1. "Awareness of change" - Recovering users reporting self-awareness of change acts as a motivating positive reinforcer for sustaining change when appreciated by fellow group members as well as for others in the group to change; also for continuing abstinence, self revelation in front of a group helps in "breaking the secret" which is a factor for continuing drug use;
2. Following the 12-step programme of Alcohol Anonymous/Narcotics Anonymous brings about spiritual healing, and has been found to be self-supporting.

Activities and Problems faced in setting-up support groups or self-help groups

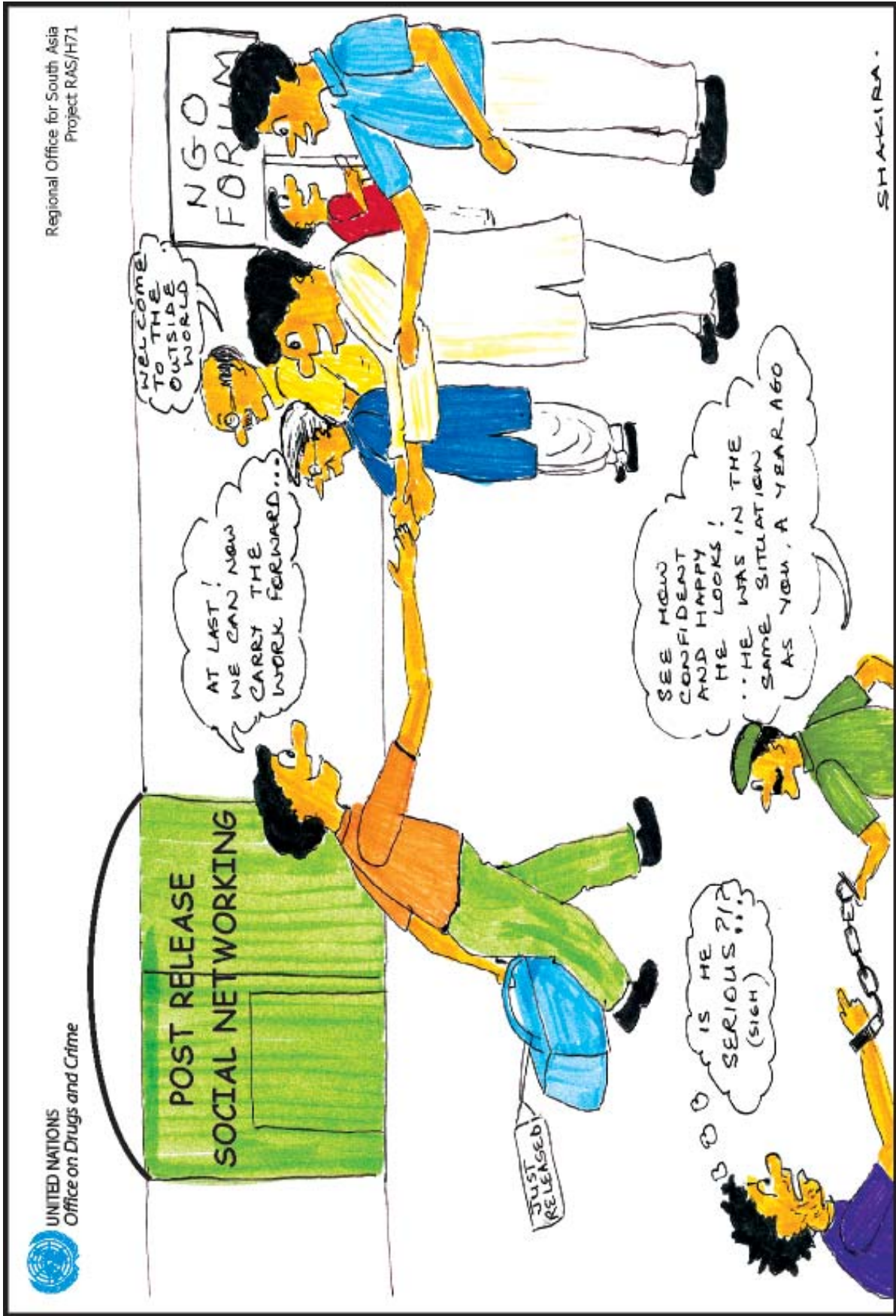
Finding a safe place for a meeting

Often, law enforcement officers may subject released prisoners to harassment. Therefore, finding a safe and appropriate place for meeting then becomes a challenge. Acceptance of a meeting of support or self groups as an activity towards sobriety by community leaders, youth organisations, police, church and other religious institutions, educational institutions, etc., helps prevent such stigma and harassment. Convinced about the need for such groups, community halls, NGOs youth and religious centres and in educational institutions can become available for holding support/self help group meetings. In this regard, the networking process facilitates post-release.

Create/strengthen the existing referral system in the community

On release, the prisoner may have various needs at various times. A wide range of support services such as health and social welfare agencies, therefore, need to be tapped and inter-linked.

Health agencies include services for tuberculosis, STI clinics, voluntary counselling and testing centres, and detoxification and rehabilitation services. An effort must be made to contact key individuals in these centres in the government and non-government sectors, and reach an understanding to create a workable “two-way referral” system ... social welfare agencies, micro-credit facilities and vocational training centres in existence are similarly networked as referral centres.



GLOSSARY

AIDS: Acquired Immune Deficiency Syndrome - An epidemic disease caused by an infection by human immunodeficiency virus (HIV), a virus that causes immune system failure and debilitation and is often accompanied by infections such as tuberculosis.

Drug abuse: Use of a drug for a reason other than which it was intended or in a manner or in quantities other than directed. Drug dependence is a compulsion to take a drug to produce a desired effect or prevent unpleasant effects when the drug is withheld.

HIV: A type of retrovirus (human immunodeficiency virus) that is responsible for the fatal illness, acquired immunodeficiency syndrome (AIDS).

Peer: A person who has equal standing with another or others, as in rank, class, or age.

Prison: used for all places of detention

Prisoner/inmate: used to describe all who are held in places of detention. .

Risk: The probability that an event will occur. It encompasses a variety of measures of the probability of a generally unfavourable outcome.

Risk behaviour: Specific form of behaviour, which is proven to be associated with increased susceptibility to a specific disease or ill health.

Self-help groups: Organisations/groups which provide an environment encouraging social interactions through group activities or individual relationships especially for the purpose of rehabilitating or supporting patients, individuals with common health problems, or the elderly.

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Annexure: 1

South Asia Knowledge, Attitude & Practice in Prison Populations (SAKAPiPP)

Questionnaire

Hello, I am (name) and I am working with (agency). We are trying to find out how we can help drug using prison inmates avoid getting the sickness called HIV/AIDS. We need to ask you some very personal questions. Everything you tell me will be kept strictly confidential. Because we sincerely want to help all the people of [x country] avoid AIDS, if you agree to give the interview, it is important that you are willing to be very truthful. Is it all right to begin?

Site ID Number	:	XXX /__
Date of Interview	:	__/__/____
Respondent ID Number	:	_/__

A. Demographic parameters

1. Sex	<table border="1"><tr><td>0=Male</td><td>1=Female</td></tr></table>	0=Male	1=Female				
0=Male	1=Female						
2. Age (in years)	<table border="1"><tr><td>_____ Years</td></tr></table>	_____ Years					
_____ Years							
3. Are you a	<table border="1"><tr><td>1.</td><td>Convict</td></tr><tr><td>2.</td><td>Pre-trial remandee</td></tr><tr><td>3.</td><td>Detenue</td></tr></table>	1.	Convict	2.	Pre-trial remandee	3.	Detenue
1.	Convict						
2.	Pre-trial remandee						
3.	Detenue						

4. Marital status (most recent status just before imprisonment)

1.	Married
2.	Never married
3.	Staying together
4.	Divorced
5.	Separated
6.	Widow or widower
7.	Separated or divorced due to drug use
8.	Not Known

5. Education

1.	Illiterate
2.	Primary (up to 5 years formal education)
3.	High school (up to 10 years formal education)
4.	Higher secondary (up to 12 years formal education)
5.	Graduate (up to 13 years formal education)
6.	Post graduate (up to 15 years formal education)
7.	Professional education
8.	Not Known

6. Employment status (most recent status before imprisonment)

1.	Was employed (full-time)
2.	Was employed (part-time)
3.	Was unemployed
4.	Not Known

7. Occupation: What kind of work did you do before imprisonment?

1.	Professional
2.	Administrator
3.	Clerical work
4.	Business/self-employed
5.	Transport worker
6.	Skilled worker

7.	Unskilled worker
8.	Farmer
9.	Housewife
10.	Student
11.	CSW (commercial Sex worker)
12.	Unclassifiable
13.	Not Known

8. Place of origin/ residence

1.	Rural
2.	Urban
3.	Semi-urban
4.	Any other, pl. specify.....

B. Crime Record

9. How many times have you been arrested before this crime?

1 = Never	2 = Once	3 = Twice or more
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10. Have you ever been convicted of any crime in the past
i.e. before the current imprisonment?

0 = Yes	1 = No.	2 = Cannot say
---------	---------	----------------

11. Are you a victim of any of the following?

	1. Human trafficking
	2. Organized crime
	3. Terrorism
	4. Any other crime pl. specify.....

12. Have you ever been apprehended for a drug related offence?

0=Yes	1=No
-------	------

13. How long have you been in prison in the current imprisonment?

1.	< One month
2.	Between 1 to 12 months
3.	12 months or more

C. Drug use: Any drug except exclusive tobacco use

14. Do you take drugs?
If the answer is No. skip the section

0=Yes	1=No
-------	------

15. Have you taken drugs in the last one month?

0=Yes	1=No
-------	------

16. Age at first use _____

17. Type of drugs taken

<i>Drug</i>	<i>Last 1 month (prior to imprisonment)</i>		<i>Last 1 month (during imprisonment)</i>	
	0=Yes	1=No	0=Yes	1=No
1. Bhang / Ganja/ Charas / Hashish	0=Yes	1=No	0=Yes	1=No
2. Opium	0=Yes	1=No	0=Yes	1=No
3. Smack / heroin / brown sugar	0=Yes	1=No	0=Yes	1=No
4. Tranquilizer such as diazepam, nitrazepam, avil, alprax etc.	0=Yes	1=No	0=Yes	1=No
5. Alcohol	0=Yes	1=No	0=Yes	1=No
6. Any other (specify)				
7. Not applicable				

18. If yes, how long you have been taking drugs for?

1.	< One year
2.	> One year
3.	> Five years
4.	> Ten years

Questions only for the IDUs

19. Have you ever injected drugs?

0=Yes	1=No
-------	------

20. Are you continuing with taking drugs at present, i.e. while in the prison?

0=Yes	1=No.	2=Cannot say
-------	-------	--------------

21. Have you injected drugs during imprisonment

0=Yes	1=No
-------	------

22. If yes, what were the reasons?

1.	Peer pressure
2.	Better liking for injecting mode
3.	Non availability of non-injection drugs
4.	Not applicable
5.	Any other (pls. Specify)

23. If no, then please mention the reason, which is best applicable behind it.

1.	Drugs are not available here
2.	Drugs are available but not affordable
3.	Want to stop drugs
4.	Any other (pls. Specify).....

24. Do you think injecting drug use can lead to HIV?

0=Yes	1=No	9=No response
-------	------	---------------

25. Have you ever shared any injecting equipment while injecting drugs?

0=Yes	1=No	9=No response
-------	------	---------------

26. The last time you injected and shared with others, how did you clean the needle/ syringe?

1.	Cleaned with water
2.	Cleaned with bleach
3.	Any other mode (pls. Specify).....
4.	Did not clean
5.	Not applicable

27. Have you sought help / treatment for drug problem before current imprisonment?

0=Yes	1=No	9=No response
-------	------	---------------

28. What in your opinion are the problems faced by drug users in the prison?

1.	Sexual harassment
2.	Lack of facilities for treatment of drug abuse
3.	Lack of facilities for treatment of general health problems
4.	Extortion / blackmail
5.	Physical abuse
6.	Any other (pls. Specify).....

29. How do you manage to get drugs in the prison? (Tick all applicable)

1.	Through relatives during visits
2.	Through co-inmates
3.	Through prison staffs
4.	Through any other (pls. Specify).....
5.	Do not wish to respond

30. Do you want to lead a drug free life?

0=Yes	1=No.	2=Cannot say
-------	-------	--------------

31. Do you know where to get help for drug abuse after release from prison?

0=Yes	1=No.	2=Cannot say
-------	-------	--------------

32. If yes, where will you seek help from

1.	
2.	

33. Do you think you can lead a drug free life after release from prison?

0=Yes	1=No.	2=Cannot say
-------	-------	--------------

D. HIV / AIDS awareness/attitude and practice

Now, I would like to ask you about your sex life and knowledge on HIV /AIDS

34. Have you ever had sex?

0=Yes	1=No
-------	------

If the response to question 34 is NO, jump to question number 39

35. How old were you when you first had sex

1.	Less than 15 years
2.	Between 15 to 18 years
3.	Between 18 to 25 Years
4.	More than 25 years
5.	Not applicable/ Never had sex

36. Sexual exposure in the last six months / one year.

1.	Single
2.	Multiple with casual partners
3.	Multiple with commercial sex workers
4.	No response

37. First sexual partner?

1.	Non – commercial, non – regular partners
2.	Commercial sex partners
3.	Regular partners
4.	Spouse

38. Have you ever had anal sex with a partner

0=Yes	1=No
-------	------

39. Have you ever heard of HIV/AIDS ?

0=Yes	1=No
-------	------

40. Do you think that a healthy-looking person can be infected with HIV/AIDS?

0=Yes	1=No
-------	------

41. Can HIV /AIDS be transmitted by contaminated needles/syringes?

0=Yes	1=No
-------	------

42. Can HIV/AIDS be transmitted sexually?

0=Yes	1=No
-------	------

43. Can HIV/AIDS be transmitted by blood transfusion from an infected person?

0=Yes	1=No
-------	------

44. Can a pregnant mother, infected with HIV transmit it to her unborn child?

0=Yes	1=No
-------	------

45. Can HIV/AIDS be transmitted through breast-feeding?

0=Yes	1=No
-------	------

46. Can people protect themselves from HIV to some extent by using a condom correctly and every time they have sex?

0=Yes	1=No
-------	------

47. How in your opinion HIV could spread in the prison? (Tick all applicable)

1.	Sharing of injectible needles
2.	Injury during fights
3.	Sexual interaction
4.	Accidental transfer of body fluids
5.	Any other (pls. Specify).....

48. How do you think the spread of HIV can be prevented in the prison?

1.	Providing awareness to the prisoners
2.	Avoiding the common use of syringe
3.	Controlling the sexual interaction among the prisoners
4.	Segregating the HIV infected prisoners
5.	Any other (pls. Specify).....

49. In prison, do you think inmates have sex with each other?

0=Yes	1=No.	2=Cannot say
-------	-------	--------------

50. Have you ever had sex in the prison?

1.	Never
2.	Once or twice
3.	Several times

51. Are condoms available in the prison?

0=Yes	1=No.	2=Cannot say
-------	-------	--------------

52. Did you use condoms while having sex inside the prison?

1.	Always
2.	Occasionally
3.	Never
4.	Cannot say
5.	Not applicable

53. In the prison usually you consume drugs just before / after having sex with some one?

0=Yes	1=No.	2=Cannot say	9=Not applicable
-------	-------	--------------	------------------

54. Have you ever had any piercing, tattooing?

0=Yes	1=No
-------	------

E. Sexually Transmitted Infections

55. Have you had a thick yellowish/greenish discharge with foul smell from your penis/vagina in the past 12 months?

0=Yes	1=No
-------	------

56. Have you had an ulcer or sore in your genital area in the past 12 months?

0=Yes	1=No
-------	------

57. Did you have pain/burning while passing urine in the past 12 months?

0=Yes	1=No
-------	------

58. If any of the above three responses are yes, did you seek medical help?

0=Yes	1=No
-------	------

59. If yes, did you partner/ spouse seek medical help also?

0=Yes	1=No
-------	------

F. HIV testing

60. Have you ever been tested for HIV?

0=Yes	1=No
-------	------

61. Do you know, where you could get tested?

0=Yes	1=No
-------	------

** note: current = within the last one month

G. Life skills

62. If any inmate/ official pressurizes you to have sex (unprotected), you would:
- a. Assertively say 'No' _____
 - b. Negotiate to convince him/ her otherwise _____
 - c. Give-in to the pressure _____
 - d. Avoid the situation _____
 - e. Complain to higher authorities _____
 - f. Any other response _____
63. When inmates are pressurized to have sex by other inmates, they, most often:
- a. Assertively say 'No' _____
 - b. Negotiate to convince him/ her otherwise _____
 - c. Give-in to the pressure _____
 - d. Avoid the situation _____
 - e. Complain to higher authorities _____
 - f. Any other response _____
64. If any inmate offers you drugs, you would:
- a. Assertively say 'No' _____
 - b. Negotiate to convince him/ her otherwise _____
 - c. Give-in to the pressure _____
 - d. Avoid the situation _____
 - e. Complain to higher authorities _____
 - f. Any other response _____
65. If you see any inmate(s) taking drugs inside the prison, you would:
- a. complain to higher authorities _____
 - b. ignore the situation _____
 - c. Educate them about the effects of drugs/ clean needles _____
 - d. request him/ her/ them not to do so _____
 - e. Go and join them _____
 - f. Any other response _____

66. How do you feel about yourself ?:
- a. Confident enough to face life after release _____
 - b. Not so confident to face life after release _____
 - c. Very scared to face life after release _____
 - d. Do not want to get released _____
 - e. Any other _____
67. Whenever someone approaches you to have sex:
- a. You are able to negotiate the use of condoms _____
 - b. You are not able to negotiate the use of condoms _____
 - c. Any other barriers/ reasons _____
68. When you feel tensed/ stressed, you often:
- a. Take a walk _____
 - b. Meditate _____
 - c. Take drugs _____
 - d. Have sex _____
 - e. Share your feelings with others _____
 - f. Quarrel with others _____
 - g. Beat someone up/ get into a fight _____
 - h. Any other response _____

Annexure: 2

CURRICULUM FOR TRAINING PROGRAMMES

- Introduction of participants
 - Ice breakers,
 - Purpose and objective of the training programme
 - Programme outline and ground rules
- Scenario of drugs and HIV in prison settings
- Detection of substance abuse in the prison, early warning signs of addiction.
- Basics of drugs, causes and consequences of substance abuse: Myths and Reality.
- Drug Abuse- basic prevention strategies
- Epidemiology of HIV/AIDS and other infectious diseases in the prisons
- Legal aspects of drug abuse in prisons
- Basic information about HIV/AIDS (and related infections), modes of transmission and prevention.
- Drugs, HIV and associated risks
- Minimizing risk behaviours related to drugs and HIV
- HIV/AIDS in the prisons and related concerns especially vulnerabilities
- General principles for HIV/AIDS prevention and care in prison settings
- Comprehensive package of services for HIV prevention
- Key issues for prison management to prevent HIV/AIDS, Working with prisoners- prevention of risk behaviour
- Basic communication techniques: individuals and family
- Life skills including coping skills, interpersonal skills, decision making skills and negotiation skills.
- Principles of Therapeutic community for rehabilitation and HIV prevention amongst drug dependents in prison

- Basic counseling skills- pre and post test counseling and confidentiality, role of Voluntary Counseling and Testing Centres (VCTCs)
- Motivation of drug users for treatment
- Discussion on feasibility of setting up prison programmes for drug abuse and HIV prevention
- Developing peer led interventions for reducing risk behaviour related to HIV amongst drug using prisoners.
- Training and education of prison staff for addressing drugs and HIV prevention- using the Facilitator's Manual
- Rehabilitation and HIV prevention amongst drug dependants in prisons.
- Living in a world with HIV/AIDS- addressing stigma and discrimination
- HIV prevention education information and counseling.
- Institutional care for adolescent and women drug dependents in custody
- Human rights of prison community
- Developing support groups for drug users in the community after discharge from prisons
- Prevention of HIV amongst incarcerated substance users- a UNODC perspective
- Sharing global best practices in addressing prevention of HIV amongst incarcerated substance users
- Designing a drug abuse and HIV prevention programme for prisons
- Participatory training methodologies
- Interacting with health, welfare, police and law enforcement agencies; setting up an enabling environment to address HIV prevention amongst incarcerated substance users.
- International instruments and guidelines relevant to effective prison management and prevention of drugs and HIV in prison settings
- Half day visit to Prison intervention site(s).
- Film show on HIV
- Evaluation of Training programme

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