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Follow-up to the implementation at the national, regional and international levels of all commitments, as reflected in the Ministerial Declaration of 2019, to address and counter the world drug problem

Treatment of Drug Use Disorders and Associated Mental Health Disorders in Prison Settings and Forensic Hospitals**

This conference room paper was prepared by UNODC following various requests from Member States for technical assistance on treatment of drug use disorders and associated mental health disorders in prison settings. This effort is related to the United Nations Standards Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), requesting that the "medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment". Moreover, the United Nations General Assembly Special Session (UNGASS) 2016 Outcome Document suggests to "promote and strengthen (…) cooperation in developing and implementing treatment-related initiatives (…) as appropriate and in accordance with national legislation, (…) including access to such services in prisons and after imprisonment, giving special attention to the specific needs of women, children and youth in this regard". Commission on Narcotic Drugs (CND) resolution 61/7 on "addressing the specific needs of vulnerable members of society in response to the world drug problem" is of further relevance for the work on this topic.

In August 2021, UNODC reached out to Member States through Note Verbale CU_2021_319 to obtain information on national responses to address drug use disorders and associated mental health disorders in prison settings. UNODC specifically requested Member States to provide information on existing national level programmes, protocols and good practices addressing mental health and drug use disorders among people in prison settings and in forensic hospitals.

The information received through the Note Verbale process has first been shared at an informal online consultation in (29 November–1 December 2021) with an international group of experts.

This conference room paper summarizes information received from Member States through the responses to Note Verbale CU_2021_319.

* E/CN.7/2022/1.
** This document has not been edited.

The conference room paper is made available to the Commission for its information at its sixty-fifth session.

UNODC
United Nations Office on Drugs and Crime

Discussion Paper

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March 2022

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Contents

List of abbreviations

APA	American Psychiatric Association
CDC	Centers for Disease Control
CND	Commission on Narcotic Drugs
CSAPA	Centre de Soins, d'Accompagnement et de Prévention en Addictologie
DUD	Drug Use Disorder(s)
ECDC	European Centre for Disease
EDRR	Enhanced Drug Rehabilitation Regimen
EMCDDA	European Monitoring Centre for Drugs and Drugs Addiction
FPCS	Federal Penal Correction Service
INPRFM	National Institute of Psychiatry Ramón de la Fuente Muñoz
LGBTTIQ+	Lesbian, Gay, Bisexual, Transgender, Transsexual, Intersexual and Queer+
MassJCOIN	Massachusetts Justice Community Opioid Innovation Network
NCMW	National Council of Behavioural Research
NGO	Non-governmental Organization
NSAP	National Substance Abuse Program
NV	Note Verbale
OFDT	Observatoire Français des Drogues et des Tendances Addictives
PORTO	Prevention of Drug Relapse by Training and Empowerment
PRISM	Programme for Reducing Substance Abuse
PTRS	Prevention, Treatment and Rehabilitation Section
SAMHSA	Substance Abuse and Mental Health Services Administration
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAFEI	United Nations Asia and Far East Institute for the Prevention of Crime and the Treatment of Offenders
UNGASS	United Nations General Assembly Special Session
UNISMA	United Nations Multidimensional Integrated Stabilization Mission in Mali
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1. Background and methods

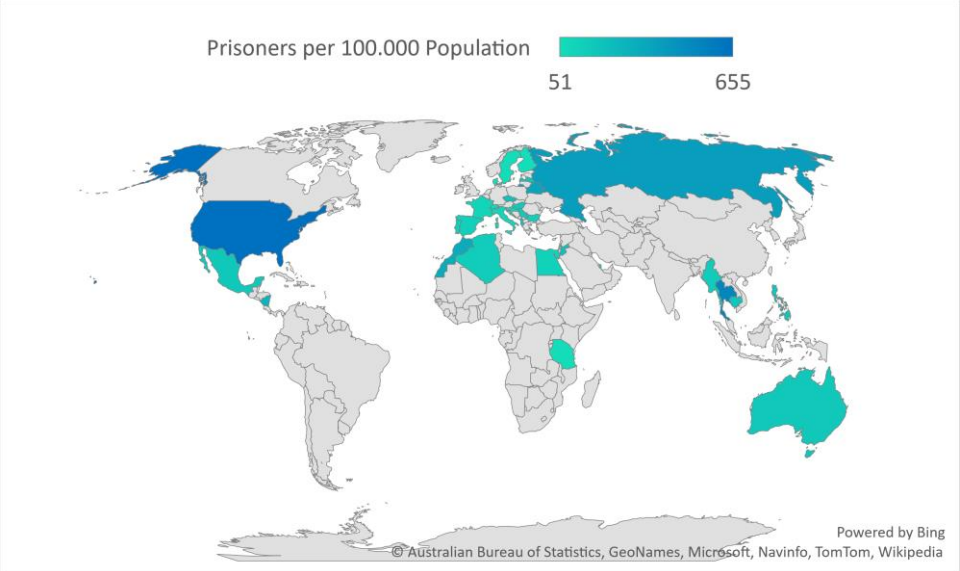
In line with CND resolution 61/7 on "addressing the specific needs of vulnerable members of society in response to the world drug problem", UNODC aims to provide guidance on mental health and drug disorder treatment in prison settings. A literature review conducted by UNODC in 2021, identified a gap in terms of the diversity of evidence available for effective interventions. This led UNODC to reach out to Member States to collect information on drug use disorder and associated mental health disorder treatment in prison settings across countries and regions, as well as current good practices and evaluations available. Through 'Note Verbale' (NV) request in during August 2021, Member States were asked:

- to share information on existing national level programmes, protocols and good practices addressing mental health including the treatment of disorders/drug use disorders for people in prison settings and in forensic hospitals; and

- to provide relevant evaluation of research data on the effectiveness of such treatment for mental health disorders and substance/drug use disorders in prison settings or in forensic hospitals.

A total of 35 countries submitted information in response to the NV. Responding countries are distributed over five continents with more than half of all responding countries being in Europe. These 35 countries house a total of 4.29 million prisoners, which represents 40% of the world's total prisoner population of 10.7 million[i]. However, there are large differences in imprisonment rates between countries, with prison population rates ranging from 51 to 655 per 100,000 general population (see Figure 1 below and Annex I).

Figure 1. Prisoners per 100,000 population in 35 countries responding to the NV



Disclaimer: The boundaries, names shown, and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Substance use disorders are common among people in prison, but estimates vary widely between 10% and 50% of the prison population. As indicated in the responses received, estimates in the ***United States*** indicate that half of all prisoners meet the criteria for drug dependence and according to the National

Institute of Health about 40% of inmates grapple with co-occurring substance use and mental health disorders – although with significant variation in their severity, symptoms and causes. The prevalence of drug use varies between age groups and rates among younger age groups can be high: in a juvenile detention unit in ***Egypt***, a survey among 15–19-year-old inmates revealed that 68% had committed their crime under the influence of drugs. Among all people in prison on a given day in ***Nicaragua***, more than 13% (2500 of 18600) were identified as having a substance use disorder. Slovenia pointed out that in 2019, on a given day, less than a quarter of all prisoners had problems with illicit drugs. Data provided by the ***Russian Federation*** indicate that more than 10% of 480,984 inmates registered on 1 July 2021 (51000/10.6%) were diagnosed with substance use disorders – among them 34000 (7.1%) with drug dependence and 17000 (3.5%) with alcohol dependence.

Results of the analysis of the NV replies regarding the general approach to mental health and/or drug use disorder treatment as reflected in national programmes and protocols are presented in Chapter 2. Section 2.1 describes standards and governance; section 2.2 gives an overview of current treatment practices for people with mental health problems including drug use disorders in prison settings and section 2.3 summarizes the reported studies and evaluation results. Chapter 3 provides recommendations.

The information in this report was extracted from the replies provided by 35 countries and a benchmarking exercise was conducted against recommendations regarding the treatment of mental health problems in prison from the WHO handbook on *Prisons and Health*[ii]. Country examples as reported in the NV responses are highlighted throughout the text.

2. Findings

2.1 General approach (national programmes and protocols)

2.1.1 Standards and governance

Ensuring the equivalence of care between prison settings and the community is a global principle which countries strive to achieve and which some have enshrined in laws and regulations, like for example ***Albania*** in its new law nº 81/2020 which guarantees equivalence of care. In this context, many countries highlight that national treatment guidelines and general standards for mental illness and drug dependence are equally applied in prisons as in the community.

In some countries the responsibility for prison health has been moved from the prison system to the national health services/ministry of health. Among responding countries, this is the case in ***Finland, France, Italy, Portugal and Slovenia*** and planned in ***Cambodia***. Making health ministries accountable for prison healthcare services promotes inmates' access to the services provided by the national health system and facilitates the continuity of care. The ensuing close cooperation between the ministry responsible for the prison system and the ministry of health can trigger powerful joint policies and actions, with effects on wider prison conditions and beyond. For example in ***France***, where prison health was transferred in 1994 to the health ministry, becoming the responsibility of the general public hospital sector, the Ministry of Solidarity and Health and the Ministry of Justice adopted a roadmap for the period 2019-2021, agreeing on specific actions to improve health research and monitoring, to scale up testing for infectious diseases and for identifying addictive behaviour among people in prison as well as to ensure continuity of care after release and promote linkage to addiction care in the community.

Even where responsibility for prison health remains with the Ministries of Interior or Justice, inter-ministerial collaboration between prison services and the Ministry of Health can be close. Examples were presented from ***Nicaragua,*** where prison services collaborate closely with the Ministry of Health as well as with different other state institutions in a model of shared responsibility and inter-institutional collaboration, taking a comprehensive approach to prevention, care, rehabilitation and reintegration; from ***Thailand***, where under the Mental Health Act (2008) the mental health and/or drug use disorder treatment of people in prisons is conducted by the department of corrections in coordination with the Ministry of Public Health; and from ***Croatia***, where county services for mental health and addiction prevention closely cooperate in the treatment of people with drug use disorders taking place in prisons.

Furthermore, national bodies from the health field can play an important role in supporting prison services with their expertise. Examples include: ***Switzerland***, where the Centre of Competence for the Prison Service, based at the Federal Ministry of Health supports cantonal police and justice directors in strategic planning and development of the correctional system (the Centre will publish a handbook on psychiatric services in custody in April 2022); and the ***United States***, where the Center for Disease Control (CDC) supports several efforts focused on improving access to medications for opioid use disorder treatment in correctional settings and upon release, and where Substance Abuse and Mental Health Services Administration's (SAMHSA) funding portfolio includes criminal justice drug court and re-entry programme grants that focus primarily on diverting individuals with substance use disorders from prison and preparing potential clients with substance use disorders for return to the community. In ***Australia***, drug-and alcohol treatment programmes for people involved with the criminal justice system are directly funded by the Commonwealth Government, reflecting a model of governance that considers the health and well-being of people in prison as a whole-of-government responsibility.

2.1.2 Comprehensive and multi-disciplinary approach

The needs-based, psychosocial nature of mental health care in prisons is one of the key-points stressed in the WHO handbook *Prisons and Health*[iii]. An assessment of all needs of the prisoners, including their social needs, is acknowledged by a number of countries as part of a comprehensive approach to the treatment of mental health problems. Multidisciplinary teams, including social workers are involved and close collaboration may take place with different external social institutions, in particular when preparing release. For example, in ***Sweden***, the 'treatment of substance use disorders is a joint responsibility of the public health care and social services' (dual system). In ***Algeria***, a two-stage nationally unified programme involving multidisciplinary teams (made up of a general practitioner, psychologist, psychiatrist affiliated with neighbourhood health services, the head of the integration department, an assistant) follow up on prisoners with substance use disorders with a total of 61 multidisciplinary teams operational in the country; and in ***Belarus*** in June 2021, a Comprehensive Medical and Social Rehabilitation programme for inmates with substance dependence has been introduced in two prisons. In ***Bulgaria***, representatives of the prison service gave input to the national mental health strategy 2020-30, developed under the lead of the Ministry of Health and ***Andorra's*** forthcoming Mental Health and Addictions Comprehensive Plan is based on input from medical, psychological and social societies.

2.1.3 Diversion[1]

Some countries have developed diversion schemes which allow for the early detection of mental disorder including drug use disorders, e.g. at the time of arrest or at appearance in court. This will then allow for either the person to be diverted to the health system without the involvement of the criminal justice system or for the court to take the individual's mental health needs into account when dealing with the case. Diversion of people who have committed minor drug-related offences to qualified health services has been identified as a cost-effective measure that helps to decrease the incidence of re-offending and re-arrest, and to reduce prison overcrowding[iv]. Effective coordination of the different agencies involved is key to the success of these services.

Several countries reported about diversion measures for people with mental health and/or drug use disorders (Table 1). In ***Australia***, state and territory governments support a range of programmes to divert people from the criminal justice system into drug and alcohol treatment when deemed appropriate by the court system. In the ***Philippines***, those with mental health problems who commit minor offenses are diverted to mental health services, to avoid imprisonment. Similarly, in **Singapore**, people who use drugs who have not committed any other crimes will be channelled to a rehab pathway and not prison. In the ***United States***, projects that divert individuals with substance use disorders from prison and prepare potential clients with substance use disorders for their return to the community are funded by SAMHSA.

Among the available alternatives to conviction or punishment in ***Czechia***, some are designed specifically for people with mental health disorder in contact with the criminal justice system and - among other outcomes - allow for the diversion of offenders into drug use disorder treatment. In ***Italy,*** following a judgement by the Constitutional Court in 2019, increased options of home detention for mentally ill offenders are available. Also from ***Jordan,*** alternatives for people with drug use disorders are reported, including free-of-charge treatment at their place of residence or alternative penalties at the pre-trial stage, with the postponement of the execution of the sentence according to the health situation, or the replacement of the sentence with a fine (under supervision) at the trial-stage. In ***Myanmar***, a policy paper about alternatives to imprisonment was developed in September 2020 in collaboration with UNAIDS and UNODC which shows opportunities to reduce drug-related prison overcrowding and promotes public health responses to drug use.

2.2 Mental health/ drug use disorder treatment in prison

2.2.1 Assessment at intake

In its handbook *Prisons and Health*, WHO recommends that all prisoners should be screened on entry to prison for a range of mental health and related problems[v] A majority of countries (Table 1) mention this type of assessment in their replies and several follow similar procedures, adhering to strict timelines and making use of standardized assessment methods: In ***Portugal***, within 24 hours of arrival a first health check is carried out by a nurse. Within 72 hours a full medical consultation follows, checking for the presence of mental disorders, risk factors for suicide and abstinence syndrome. Since 2013, the admission procedure in prisons in ***Denmark*** has been updated in order to intensify the detection of mentally ill prisoners as well as signs of the need for psychiatric assistance. For those with drug-related mental health issues, healthcare professionals ensure that they receive the necessary treatment. The

[1] While 'diversion' was not an explicit topic of the NV request, some countries provided information on this topic.

"entry check" in ***Finland*** also takes place within 24 to 72 hours of arriving and is usually carried out by a nurse. This general health examination includes a substance use assessment, using internationally accepted indicators for the assessment of withdrawal symptoms and mental well-being. The use of accredited standards for mental health screenings in correctional settings is also highlighted by the ***United States***, pointing to those developed by the American Psychiatric Association (APA) and the National Commission on Correctional Health Care's guidelines.

In ***France***, the obligation to conduct a routine health assessment at prison entry incl. the assessment of substance use and related problems is laid down in the 2017 health strategy for prisoners. In ***Serbia***, the reception department makes the first assessment of individual needs and abilities regarding treatment and rehabilitation and in ***Croatia,*** a comprehensive assessment informs individualized treatment plans, based on individual need and focusing on criminal behaviours. In ***Myanmar***, the medical screening on prison entry includes assessment for mental illness. If specialist services are needed, the prison doctor makes the referral, and the treatment is then provided by external psychiatrists. In ***Sweden***, nurses are on duty during working hours and weekends, providing a health check to newly arriving prisoners. In ***Andorra***, the prison doctor assesses the health of each incoming inmate and in ***Slovenia***, all newly arriving prisoners are examined at the prison clinic. While in ***Albania*** and ***Algeria***, incoming prisoners have to self-identify as people who use drugs in order to be provided with treatment, toxicological testing is carried out to identify people with drug use disorders on prison entry in ***Guatemala***. In ***Thailand***, drug problems are addressed during the intake procedure on the first day and subsequently in 6-month intervals, using a questionnaire. Those identified as having a drug use disorder are referred to treatment conducted by the Ministry of Public Health.

2.2.2 Dealing with co-morbidity

Among people in prison, mental health disorders such as psychosis, personality disorders, anxiety and depression are more common than in the general population[vi]. A large majority (25) among the 35 responding countries acknowledged in the NV enquiry that a close link exists between mental health and drug use disorders among people in prison (Table 1). Many countries pointed to the need to apply evidence-based treatment guidelines and standards and to involve treatment specialists, such as psychiatrists, addictologists or clinical psychologists. Depending on the prison system, these specialists may be based at the prison or in the community, working on a consultative basis.

The involvement of forensic hospitals, which are secure mental health facilities for mentally ill patients who have been in contact with the criminal justice system, was only mentioned by a small number of countries. In ***Slovenia***, the Unit for Forensic Psychiatry of the University Medical Centre Maribor treats all prisoners with mental disorders who require inpatient care. In ***Bulgaria***, addiction treatment of prisoners, including detoxification, is conducted externally at the psychiatric department of the specialized hospital for active treatment of imprisoned persons in the city of Lovech. In other countries (e.g. ***Albania***, ***Philippines***) prisoners with acute mental health problems are treated at the secure units of external psychiatric hospitals.

Table 1 Information reported by 35 countries in response to the NV request

Country	Awareness of mental health/DUD co-morbidity	Screening for MH problems on intake	Methadone or buprenorphine maintenance	Involvement NGO service providers	Arrangements for continuity of care	Diversion / Alternatives mentioned
Albania	1	self-declaration	1 (NGO liaison)	1	for OST patients	
Algeria	1	self-declaration			1	
Andorra		1				
Australia	1	1		1	1	1
Belarus	1					
Bulgaria	1		1 (external provider)			
Cambodia						
Croatia	1		1	1	1	
Czechia	1		1	1	1	1
Denmark	1	1				
Egypt	1					
Finland	1	1	1		1	
France	1	1	1	1	1 (via CSAPAs)	1
Guatemala	1	toxicological testing				
Hungary						1
Italy	1	1	1			1
Jordan	1					1
Latvia			1		1	
Mexico						
Morocco		1	1			
Myanmar	1				medication continuity	1
Nicaragua	1	1		1		
Philippines					1	1
Portugal	1	1	1		1	1
Qatar	1	1			1	
Russian Federation			inadmissible		1	
Serbia	1	1	1			
Singapore					1	1
Slovenia	1	1	1		1	
Spain	1	1	1	1	1	
Sweden	1	1	1			
Switzerland		1	1			
Tanzania	1					
Thailand	1	questionnaire			1	1
USA	1	1	1		1	1

Note: Empty cells indicate that no information on the topic was provided in the NV response.
The absence of an entry in the table does not imply that the service is not available in the country.

2.2.3 Availability and range of treatments

Some form of treatment of drug use disorders and other mental health problems is reported to be available to people in prisons in all countries except ***Cambodia***, ***Jordan*** and ***Tanzania***; however, in several countries its availability is limited to some prison establishments (Table 1).

The treatment of drug use disorders may consist of psychosocial/behavioural and pharmacological interventions. Psychosocial treatment is mostly based on cognitive-behavioural principles and includes the use of techniques such as brief interventions and motivational interviewing as well as relapse prevention interventions. It can be provided in the form of day-programmes (outpatient) or residential (therapeutic community) programmes with variable duration (examples given ranged from four to 34 weeks). Some countries, including ***Czechia*** and ***Croatia***, have defined specific standards for the psychosocial treatment of drug use disorders inside the prison system.

In the ***Russian Federation***, medical care for inmates is provided by Federal Ministry of Internal Affairs and by Federal Penal Correction Service (FPCS) on the same legal basis as treatment in the state health care system. Penal institutions operate psychiatric and addiction treatment units, providing outpatient psychiatric and addiction treatment services by licensed doctors. Treatment of drug use disorders is provided on the basis of the prisoner rehabilitation potential and consent, is based on full abstinence and lasts between two and six months. It consists of medical (psychopharmacological) interventions as well as labour, psychological and psychotherapeutic, educational, sports, and production services of the penitentiary system. In the Russian Federation, it is not permitted to use narcotic drugs and psychotropic substances in Schedules I and II of the Single Convention for the treatment of drug use disorders.

The main pharmacological treatment reported is treatment for opioid use disorder, using one or more among a range of medications (methadone, levomethadone, buprenorphine, naltrexone), supported by psychosocial interventions. Opioid agonist maintenance treatment was reported to be available in slightly more than half of all countries: ***Albania, Bulgaria, Croatia, Czechia, Finland, France, Italy, Latvia, Morocco, Portugal, Serbia, Slovenia, Spain, Sweden, Switzerland and the United States*** (Table 1). A number of limitations to the provision of this treatment were identified: the treatment may only be accessible in some prisons and not across the whole prison estate (e.g. ***Czechia***, ***United States***); or daily dispensing of the medication is not done by prison health workers but by an external provider (***Albania***, ***Bulgaria***). It was underlined by several countries that medications should only be prescribed by qualified medical staff consistent with community standards. Beyond improving health and well-being of prisoners dependent on opioids, the aims of medically assisted treatment programmes include the reduction of the risk of overdose deaths (a current focus in the ***United States***) and of recidivism, as well as the building of a continuum of care upon the return of inmates to their communities.

While the daily supervised consumption of oral methadone is the most common form of opioid agonist medications, other application forms are also used. The use of injectable prolonged-release buprenorphine was reported from ***Finland***. This treatment is started with a weekly injection which can later be switched to once a month.

The Centres for Disease Control (CDC) and the National Council of Behavioural Research (NCMW) in the ***United States*** developed a toolkit with real-world guidance, lessons learned, and concrete "how to" steps for implementing medication-assisted treatment in criminal justice settings. NCMW collaborated with Vital Strategies and Johns Hopkins University, members of the Bloomberg Opioid Initiative, to help develop a comprehensive implementation guide.[vii]

Tailored treatment programmes

A number of countries reported about programmes tailored to the needs of the specific population and be ethnically, culturally, and gender appropriate. For example, the ***Australian*** Government provides drug and alcohol treatment to support a range of target groups and settings. Examples include: residential rehabilitation programmes for women and mothers involved in the criminal justice system; for Aboriginal men who are in or are likely to be in the criminal justice system due alcohol or drug related activities; counselling programmes for women; a structured 12-week cognitive behavioural therapy based day-programme for people exiting the justice system (addressing alcohol or drug addictions, including holistic and integrated case management, pre and post admission support). From ***Mexico***, where a team of researchers at the National Institute of Psychiatry Ramón de la Fuente Muñoz (INPRFM) have intensively studied the psychological, social and drug use characteristics of female offenders, interest in the assessment of existing treatment programmes for male, female, LGBTTIQ+ and juvenile offenders, their evaluation and the development of new gender-sensitive and trauma-informed programmes was expressed.

Various other services targeting people with drug use disorders in prison settings were mentioned by countries. These include:

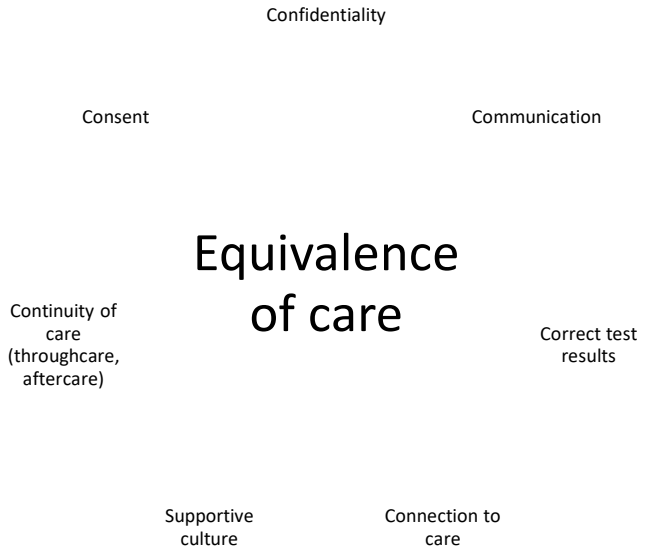
- information and education about drug use and drug use disorders;
- counselling on harmful consequences of drug use, including the prevention of infections;
- overdose prevention programmes (including naloxone distribution);
- needle and syringe programmes;
- medically assisted detoxification;
- abstinence controls (e.g. through urine tests);
- self-help groups (Alcoholics Anonymous/Narcotics Anonymous);
- drug-free zones (without drug use disorder treatment);

work and occupational activities, organized leisure and sports/training programmes;

2.2.4 Continuity of care

The transition between the community and prison can be associated with particular health risks for people with drug use disorders, including withdrawal on admission; disruptions in maintenance treatment or antiretroviral therapy; and death after release. Continuity of care is a particularly relevant principle for the prison context as it focuses on maintaining the provision of healthcare for people in prison as they move in and out of custody. It has been endorsed in recent European guidance as one of the seven principles that define equivalence of care in the prison context[viii] (Figure 2).

Figure 2 The 7 C's Principles



Source: European Centre for Disease Prevention and Control (ECDC), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Public health guidance on prevention and control of blood-borne viruses in prison settings [Internet]. Stockholm & Lisbon: ECDC & EMCDDA; 2018. Page 34.

Arrangements to guarantee continuity of care are mentioned in a majority of countries (Table 1). In countries where the ministry of health leads on prison health, close collaboration with the external public health system exists during the period of incarceration providing a good basis for continuity of care after release. For example, in ***France***, community-based drug use disorder treatment centres work in 162 prisons, taking care of the integration of prisoners. In ***Croatia***, the county services for mental health and addiction prevention and civil society organizations work with prisoners with drug use disorders already during their sentence and continue treatment after release. Through this approach it is also possible to include a family member or other person in the treatment process to support the recovery process. ***Australia*** and the ***United States*** highlighted several programmes focusing on through-care and aftercare for people involved in the criminal justice system.

2.3 Studies and evaluation results

Only a small number of countries provided information on evaluation results regarding prison-based treatment of drug use disorders.

In order to assess the question as to whether the use of psychotropic medications is associated with a lower risk of reoffending for violent crime among released prisoners, researchers in ***Sweden*** [ix] investigated the main psychotropic medication classes prescribed to prisoners using longitudinal Swedish population registers and examined the association between prescription of psychotropic medication and risk of violent reoffending. For comparison, the associations of prison-based psychological treatments with reoffending were secondarily investigated. In a cohort study of 22,275 released prisoners, three classes of psychotropic medications (antipsychotics, psychostimulants, and medications used for addictive disorders) were associated with statistically significant hazard ratios

(0.58, 0.62, and 0.48, respectively) of violent reoffending. The adjusted hazard ratio associated with dispensed drugs for addictive disorders was 0.61 (95% CI, 0.41-0.90), equating to a risk difference of 27.5 (95% CI, 7.0-41.6) fewer violent reoffences per 1000 person-years. The authors highlight two main findings. First, three classes of psychotropic medications (antipsychotics, psychostimulants, and medications used in addictive disorders) were associated with substantial reductions in violent reoffending. Second, the magnitudes of these associations were as strong as and possibly stronger than those for widely disseminated psychological programmes in prison. The authors also note that randomized clinical trials of pharmacological treatments (e.g. methadone for opioid dependence) have mostly demonstrated relapse reduction and symptomatic improvement. The current study suggests that such benefits may extend to lower rates of violent reoffending if validated in trials. Owing to the high prevalence of substance use disorders among prisoners and the strong links with premature mortality, pharmacological treatments for substance use disorders could have a substantial public health benefit.[x]

Some smaller evaluation studies were described by ***Croatia, Egypt, France, Mexico, Singapore and Sweden:***

In Croatia, a preliminary evaluation was conducted among a sample of 20 prisoners involved in the pilot implementation of a structured programme of psychosocial treatment called PORTOs (Prevention of Drug Relapse by Training and Empowerment), designed in cooperation between the Central Office of the Prison System Administration and the Department of Criminology of the Faculty of Education and Rehabilitation Sciences. The treatment based on a cognitive-behavioural approach and targets criminogenic risks and needs and the prevention of relapse. It consists of five distinct phases and involves the implementation of one 90-minute workshop per week among small, closed groups of six to ten prisoners for 34 weeks (short version: 17 weeks)[xi]. The results of the pilot, evaluated by means of a questionnaire, according to the NV information provided, showed positive changes in almost all examined aspects, and a "statistically significant difference regarding offenders' criticism of the crime and their attitude towards security measures/involvement in treatment, cognitive distortions, perseverance, self-esteem, and thoughts and desires regarding drugs".

Treatment at a juvenile prison in ***Egypt,*** the Al-Marj Institution, consists of regular information sessions on the nature and causes of addiction and of cognitive-behavioural interventions, aiming at increasing awareness, refuting misconceptions about drugs, modifying deviant behaviours and improving anger management and problem solving. The treatment also aims at the development of ethical and spiritual aspects. Indicators used to evaluate the outcomes are regular attendance of treatment sessions; improvement of the inmate's relationships with his colleagues and staff; and increased coping skills. Periodical drug testing documents that the institution is completely drug-free since 2017, which is considered a result of the programme.

An assessment of the implementation of the first therapeutic community in a prison environment in ***France***, established in 2017 and located in the Neuvic Detention Centre's drug user rehabilitation unit, was conducted by the French Monitoring Centre for Drugs and Drug Addiction (OFDT). The unit is adapted from models of drug-free units in England and Spain, which also have equivalents in the United States and Canada. It provides a community-based therapeutic framework based on a three-phase peer-helper system over a six-month period. The programme is open to inmates who sign up to quit using drugs. The evaluation showed promising results: the scheme makes it possible to ease relations between inmates and prison officers, changing their practices so they are more in line with the "social" element of their tasks. The majority of beneficiaries also see positive effects on their ability to resist being offered substances and, more generally, on their social relations and where they will stand in

such instances in the future. However, the assessment also raised some questions, notably about the selective aspect of the programme (relatively unavailable to people who want to work while in custody and to sex offenders), the objectives it aims for (abstinence or reduced use) and about the confidentiality of the personal information provided. The overall positive results led to the continuation of the experimental scheme. Further medical and economic data are required in order to determine whether to implement the scheme in other establishments in the country.

Mexico referred to descriptive research among 213 women in prisons in two Mexican cities (2006), which had shown high prevalence of co-morbidity, trauma, and intimate partner violence. A new study in 2015 among this population confirmed again high levels of trauma, victimization/sexual violence.

Against the background of the country's three-pillar strategy of preventive education; tough legislation and rigorous enforcement; and evidence-informed rehabilitation and aftercare, ***Singapore's*** prison service implements Psychology-based Correctional Programmes to help people who use drugs re-examine their lives and goals and allow them to learn new skills and attitudes in abstaining from drugs. Since 2014, 'Enhanced Drug Rehabilitation Regimen' (EDRR) programmes based on international and local research are implemented. In 2020, the effectiveness of the EDRR in reducing recidivism rates amongst people who use drugs was examined among those admitted to Drug Rehabilitation Centres between August 2015 and August 2017 who had reached the two-year milestone after their release into the community. The study carried out by the Singapore prison service compared recidivism rates of EDRR participants with a matched pre-EDRR group and found a reduction of 8%. The effect was higher among high-risk prisoners and not significant among those with a low risk of reoffending. EDRR participants also showed a statistically significant decrease in substance abuse attitude scores over time between pre- and post- intervention.

The ***Swedish*** Prison and Probation Service offers two cognitive behavioural programmes for offenders with substance use disorder: the National Substance Abuse Program (NSAP) developed by the Correctional Service of Canada, and the Programme for Reducing Substance Abuse (PRISM, developed by Philip Priestley and Margareth McMurran from England). NSAP and PRISM were evaluated within the Swedish Prison and Probation Service in 2009 and 2012 and shown to have small effects on recidivism.

Countries, including Spain, France and the United States, also provided references to general resources.

Spain's General Secretariat of Penitentiary Institutions, a department of the Government of Spain in charge of the Prison Administration publishes detailed annual general reports, including the evaluation data on all mental health and drug addiction programmes in prison overseen by the Sub-Directorate General of Penitentiary Health. Interventions for people who use drugs in prison in Spain have followed since the mid-1990s the country's comprehensive drug policy standards. The report addresses topics such as methadone prescription, the distribution of clean injecting equipment and other harm reduction interventions.

France has addressed the issue of addictive behaviour in custody since 1999 in successive national drug strategies, the latest of which (the 2018-2022 National Plan for Mobilization against Addictions) calls for strengthening prevention, access to treatment and care and harm reduction for people in prisons[xii]

The ***United States*** provided a list of evidence-based resources:

- Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf

- TIP 44 Substance Abuse Treatment for Adults in the Criminal Justice System https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4056.pdf
- Opioid-related treatment, interventions, and outcomes among incarcerated persons: A systematic review https://pubmed.ncbi.nlm.nih.gov/31891578/
- Understanding the importance of organizational and system variables on addiction treatment services within criminal justice settings https://pubmed.ncbi.nlm.nih.gov/19356862/
- Treating substance use disorders in the criminal justice system https://pubmed.ncbi.nlm.nih.gov/24132733/
- Health and economic outcomes of treatment with extended-release naltrexone among pre-release prisoners with opioid use disorder (HOPPER): protocol for an evaluation of two randomized effectiveness trials https://pubmed.ncbi.nlm.nih.gov/32321570/
- OUD Care Service Improvement with Prolonged-release Buprenorphine in Prisons: Cost Estimation Analysis https://pubmed.ncbi.nlm.nih.gov/32982339/
- Estimating the impact of wide scale uptake of screening and medications for opioid use disorder in US prisons and jails https://pubmed.ncbi.nlm.nih.gov/32050112/
- Massachusetts Justice Community Opioid Innovation Network (MassJCOIN) https://pubmed.ncbi.nlm.nih.gov/33483222/

3. Conclusions and Recommendations

Responses to the NV request show that the awareness of the need for a high-quality response to mental health/drug use disorder treatment in prison is rising. In particular, countries confirmed:

- Principle of equity of care is widely acknowledged;
- Inter-ministerial collaboration exists, and synergies are documented.

Good practices in relation to drug use disorder treatment for people in prison settings were reported:

- Most countries assess mental health/drug use disorder on intake;
- There is a growing recognition of the need to diagnose co-morbidities;
- Treatment approaches are becoming comprehensive;
- Most countries strive to provide continuity of care;
- In some countries, the range of interventions for people with drug use disorder in prison is widening beyond the treatment of dependence and addresses social needs and other health risks;
- Evidence-based treatment reduce risk of death (e.g. from overdose) after release.

Despite this progress, the responses received did highlight a number of challenges:

- There are large differences in treatment provision, e.g. availability of opioid agonist maintenance treatment among countries that responded to the NV
- Some interventions are less common, such as the involvement of external (including NGO) service providers or the systematic assessment of suicide risk;
- It remains unclear whether all countries agree that prison health should be treated as an inseparable component of public health.

In light of the NV analysis that has been carried out on the responses received, a number of recommendations can be suggested:

Recommendation 1: Support the implementation of evidence-based decision-making/practices;

- Make relevant information and tools (treatment toolkits, accredited assessment tools and guidelines) fully accessible, e.g. through a database, and support adaptation to the context of different regions.

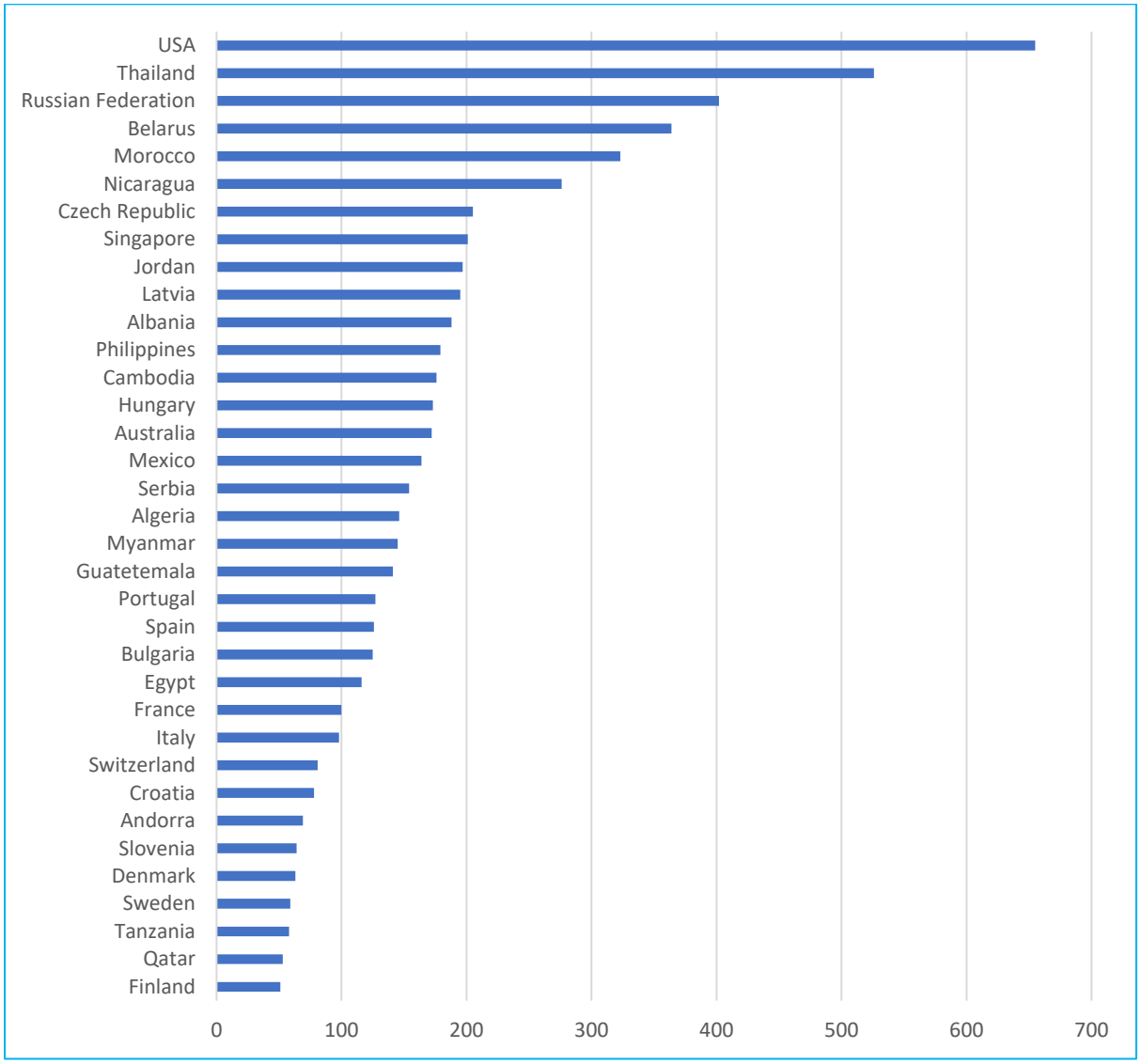
Recommendation 2: Invest much more in training, research and evaluation

- Strengthen the awareness and capacity of prison staff regarding drug use disorders and associated mental health disorders;
- Make use of new digital options for cost-effective dissemination of information and capacity building (access to knowledge and training is no longer restricted by location);
- Improve monitoring systems;
- Conduct additional research on feasibility, effectiveness and scalability of evidence-based interventions for treatment of drug use disorders and associated mental health disorders in different socio-economic contexts.

Recommendation 3: Forge more inter-sectoral partnerships/inter-ministerial collaborations

- Raise awareness for the importance of good prison health for public health and crime prevention (the "community dividend"[xiii]);
- Joint use of resources (no 'parallel' systems) will produce synergies.

Annex I: Prison population rates, 35 countries responding to the NV



Walmsley R. *World Prison Population List (twelfth edition).* Inst Crim Policy Res [Internet]. 2018; 12:1–19. Available from: www.prisonstudies.org

[ii] Yordi Aguirre I, Ahalt C, Atabay T, Baybutt M, Van den Bergh B, Chorgoliani D, et al. *Prisons and Health*. World Health Organization [Internet]. 2014;1–189. Available from: https://apps.who.int/iris/bitstream/handle/10665/128603/PrisonandHealth.pdf;jsessionid=9D8EB2F358676D0942F6EA53A5307F94?sequence=1

[iii] Ibid. Chapter 11: Durcan G & Zwemstra JC, Mental health in prison. Pp.87-95.

[iv] United Nations Office on Drugs and Crime. *Treatment and Care of People with Drug Use Disorders in Contact with the Criminal Justice System: Alternatives to Conviction or Punishment*. 2019.

[v] Yordi Aguirre I, Ahalt C, Atabay T, Baybutt M, Van den Bergh B, Chorgoliani D, et al. *Prisons and Health*. World Health Organization [Internet]. 2014, p.87.

[vi] Fazel S, Baillargeon J. The health of prisoners. *Lancet* [Internet]. 2011 Nov [cited 2010 Nov 25];377(9769):956–65. Available from: http://linkinghub.elsevier.com/retrieve/pii/S0140673610610537

[vii] Mace S, Siegler A, Wu K, Latimore A, Flynn H. *Medication-Assisted Treatment for Opioid Disorder in Jails and Prisons. A Planning and Implementation Toolkit.* National Council of Behavioural Health Vital Strategies. 2020. p. 132.

[viii] European Centre for Disease Prevention and Control (ECDC), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Public health guidance on prevention and control of blood-borne viruses in prison settings* [Internet]. Stockholm & Lisbon: ECDC & EMCDDA; 2018. [Figure 2, p.34] Available from: http://www.emcdda.europa.eu/system/files/publications/9103/Guidance-on-BBV-in-prisons-web.pdf

[ix] Chang Z, Lichtenstein P, Langström N, Larsson H, Fazel S. Association between prescription of major psychotropic medications and violent reoffending after prison release. *JAMA* - J Am Med Assoc. 2016;316(17):1798–807.

[x] Chang Z, Lichtenstein P, Langström N, Larsson H, Fazel S. Association between prescription of major psychotropic medications and violent reoffending after prison release. JAMA - J Am Med Assoc. 2016;316(17):1798–807.

[xii] Protais C, Model d'Arleux J, Jauffret-Roustide M. (2020). Drug Use: Practices, Consequences and Responses https://en.ofdt.fr/BDD/publications/docs/Thema-Prison-Synthese-EN.pdf

[xiii] Tavoschi L, O'Moore É, Hedrich D. Challenges and opportunities for the management of infectious diseases in Europes' prisons: evidence-based guidance. *Lancet Infect Dis*. 2019;19(7): e253–8.