



**Drug use and
risk behaviour in prisons and
upon release in four European countries**

Overdose upon release:
Challenges and strategies from (ex-) prisoners' points of view



-Final report-

March 2019



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Layout: Eva Stiekema (info@linguavision.de)

Source (cover): Heino Stöver

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Part 1 – Summary of project and country situations

1 Introduction

For prisoners with a history of drug use, and particularly opioid use, the risks related to drug use and especially overdose and death are extremely high in the immediate period after release due to high rates of relapse and lower opioid tolerance (Farrell and Marsden, 2008; Merral et al. 2010; Pierce et al. 2016; Marsden et al. 2017). Much still needs to be done in order to ensure that people with a history of drug use are sufficiently cared for when released from prison. Harm-reduction measures need to be in place for ex-prisoners to be able to readjust to freedom without relapsing into drug use and the extreme risk of fatal overdose when released.

The EU project 'My first 48h out' aims to address the gaps in the continuity of care for long-term drug users in prison and upon release, by supporting life-saving interventions for the prevention of overdose and the reduction of other risks related to drug use, and for the establishment of a treatment path that is not interrupted upon release.

The specific objectives of the project are:

1. To complement knowledge on risk behaviour for drug users in prison and upon release by giving a voice to drug-user communities through qualitative research in four European countries;
2. To advocate and promote the implementation of life-saving services for drug users in prison and upon release by producing hands-on guidelines for policy-makers and practitioners from prison health services on how to promote, initiate and manage services related to overdose prevention through naloxone programmes and related training and capacity building;
3. To educate grass-roots organisations and drug users, as well as practitioners working with them in prison and upon release on the risks related to drug use upon release and risk reduction practices, through the production of practical and accessible educational materials;
4. To produce and disseminate knowledge and good practice on continuity of care – including medical care and drug treatment (provision of substitution treatment, antiretroviral therapy (ART) and hepatitis treatment) and social support;
5. To co-construct and disseminate evidence and good practice on continuity of care and harm reduction in prison and upon release to a wider European public of different stakeholders, promoting active interaction between stakeholders from different countries, through a European 'knowledge and expertise web portal'.

Work on continuity of care and treatment, harm reduction and the prevention of deaths linked to drug use and overdose for people in the criminal justice system and in prison requires approaches that can meaningfully address the different groups of stakeholders and beneficiaries that have a say in the introduction, development, definition, design, delivery, monitoring and accessing of appropriate services. These involve: policy-makers in the area of health and criminal justice, prison administration

representatives and security staff in prison, health and social sector professionals working in the criminal justice system (such as those in government justice, interior, health or social services departments, and different organisational structures in different Member States), health and social sector practitioners, grass-roots organisations, NGOs and other services providing care for people who use drugs and clearly the end beneficiaries, the drug users, who will be meaningfully involved in the current project.

This report presents the results of one of the specific objectives of the project (1). A multi-country (Belgium, France, Germany and Portugal) qualitative study looking at issues related to: risk behaviour related to drug use upon release, prisoners' and drug users' perspectives, personal experiences of incarceration, individual risk reduction mechanisms, knowledge of risks and overdose prevention, and strategies to avoid risks when being released.

Approximately 30 prisoners and/or drug users with a prison experience were targeted for involvement in the research in each of the four countries. Focus groups and semi-structured qualitative interviews have been implemented in prisons and/or with drug users with a previous experience of detention currently attending community services.

2 Background

2.1 Generic background

Prisoners report much higher lifetime rates of drug use than the general population and more harmful patterns of use. Up to 31% of prisoners have injected drugs (EMCDDA 2015) at some point in their lives. In particular, the immediate period after release ('My first 48 hours out') is a critical time for action, when the cooperation between prisons, health care providers and NGOs is key to ensuring continuity of care and when targeted interventions can save lives from overdose and build a path towards engagement in further treatment and rehabilitation for drug users. This cooperation still needs to be improved in many European countries.

Sixty per cent of drug-related deaths occur within 12 weeks after release from prison (Merrall et al., 2010). In England and Wales, during the first week after release, female prisoners were 69 times more likely to die of drug-related causes, and male prisoners 28 times (Farrell and Marsden, 2008) than the general population of the same age and gender.

Preparing prisoners for release starts inside prison and needs to be continued after release without interruption through medical care and social support. However, this is not the case in many countries, due to patchy and ad hoc provision at the level of single prison establishments, with enormous differences between regions and countries around Europe.

2.2 Situation in the four counties

2.2.1 Situation in Belgium

Prison landscape in Belgium

The Belgian prison landscape consists of 35 prisons. Seventeen of them are located in Flanders, 16 in Wallonia and two in Brussels. Only eight prisons have a ward for women. In 2016, the average prison population was 10,619 prisoners. Men are clearly over-represented (>95%), 10,134 men vs. 485 women. The average prison capacity in that year was only 9,687, indicating an overpopulation in Belgian prisons. Of all prisoners, 33.4% were on remand, 57.7% were convicted and 7.4% were interned. The other 1.5% had another status. About half of the prisoners (56%), are of Belgian nationality (Directoraat-generaal Penitentiaire Inrichtingen, 2016).

Drug use in Belgian prisons

Drug use in prison is widespread (Carpentier, Royuela, Montanari & Davis, 2018). Research shows a high prevalence of drug use among prisoners and the lifetime prevalence of drug use among prisoners is much higher than in the general population (Fazel & Baillargeon, 2011). Also in Belgium, drug use and misuse are omnipresent in prison, although not much research has been done about it in Belgian prisons (Favril & Vander Laenen, 2017). In 1999, Belgium started to monitor drug use, in particular its epidemiology, in prisons. From 2006 until 2010, biennial monitoring was performed in all Belgian prisons, based on a large-scale survey among prisoners. The questionnaire included items about drug use (lifetime drug use, use in prison, products, ...), health-related problems (HIV, HCV, HBC, ...), risk behaviour (tattooing, piercing, sexual activities, ...), and opioid substitution treatment (OST) (before and during detention). Unfortunately, this monitoring was discontinued in 2010, only followed by fragmented monitoring attempts in parts of the country and in certain prisons (Plettinckx et al., 2014; Van Malderen, 2017).

The monitoring study in Belgian prisons between 2006 and 2010 pointed out that the lifetime prevalence of drug use among prisoners was around 60% (with around 45% being heroin users). The prevalence of drug use in prison amounted to approximately 30% (Van Malderen, 2011; Van Malderen, Pauwels, Walthoff-Born, Glibert & Todts, 2011). The study revealed that 36% of the drug users who used in prison, used several times a month to weekly or daily. Remarkably, 11.7% of the prisoners used a psychoactive substance for the first time during detention (Van Malderen, 2011; 2012; Van Malderen et al., 2011). Cannabis was the most commonly used drug in prison in 2010. Heroin, sedatives and cocaine ranked second, third and fourth, respectively. Van Malderen (2011) found that a higher number of detentions was related to a higher probability of drug use during imprisonment.

In 2016, a similar study was set up in all prisons in Flanders, with a large sample of 1,326 prisoners (Favril & Vander Laenen, 2017). This study confirmed the results of previous studies in Belgian prisons and showed that one third of all prisoners (34.8%) reported illicit drug use during their current period of incarceration. Regular use of illicit drugs and medication (21.1%) was two times as frequent as alcohol use (10.3%). One fourth of the respondents (26.1%) reported a history of substance abuse

treatment prior to incarceration. During the current detention, 57.4% of all drug-using individuals also took psychoactive medication (Favril et al., 2017).

Opioid use and injecting

An older study by Todts et al. (2009) on risk behaviour in Belgian prisons showed that 32.1% of the Belgian prisoners who were incarcerated in 2008 reported that they had used heroin during detention. One in seven (15.7%) even used heroin for the first time inside prison. Intravenous opiate use inside prison was reported by 8.7% of the respondents. The monitoring study in Belgian prisons between 2006 and 2010 pointed out that lifetime intravenous use (of any substance) in prison was estimated at around 15% (Van Malderen et al., 2011). In 2010, the main route of administration in prison was smoking (e.g. inhalation with a tube) (94%), and 6% injected drugs (Van Malderen et al., 2011).

Overdose

In Belgium, drug-induced mortality among adults (15–64 years) was 9.2 per million in 2013. Opioids were involved in 59% of all toxicologically confirmed drug-induced deaths that were reported in that year. Mainly males were the victims (EMCDDA, 2017).

Not much data about overdose is available for prison populations. Based on the prison monitoring study of 2010, Van Malderen (2011) concluded that 4% of the prisoners who used during detention had experienced an overdose. This is likely to be an underestimation because there were a lot of missing answers in the questionnaire. Overdose in prison can also occur as a manner of suicide. A recent study showed that suicide accounted for one third of all deaths in Belgian prisons between 2000 and 2016 and that 3.6% of the suicides in Belgian prisons happened through self-poisoning or intentional overdose (Favril, Wittouck, Audenaert & Vander Laenen, 2018). Suicides by self-poisoning are often misclassified as accidental overdoses or 'undetermined deaths', especially when individuals have a history of substance use disorders. This may lead to an underestimation of the number of suicides through overdose (Bohnert et al., 2013; Favril et al., 2018; Olsson, Bradvik, Öjehagen & Håkansson, 2016; Stone et al., 2017). Most suicides in Belgian prisons happen when individuals are alone in their cell.

Infectious diseases in prisons in Belgium

Prisoners are a vulnerable group when it comes to risk behaviour: they report harmful patterns of use such as drug injecting, unsafe sexual activities, tattooing, piercing, and so on. This behaviour increases the chance of transmitting infections to others. Also, contextual factors such as overcrowding, delayed diagnosis and treatment, limited access to soap or clean laundry and a lack of harm-reduction measures (such as syringes) inside prison contribute to an increased risk of transmission among prisoners (Todts, 2014).

Studies in European prisons demonstrated a higher risk of blood-borne virus transmissions in prisons as compared to the whole population (Stöver et al. 2019; Arain, Robbaeys & Stöver, 2014; Vescio et al., 2008). Higher rates of hepatitis C and other infectious diseases have been observed among prison populations than among the general population (Vescio et al., 2008; Michel. et al., 2015). In addition, HIV and TBC are known to be highly prevalent in prisons (Fazel & Baillargeon, 2011). In the Belgian

monitoring study in prisons (between 2006 and 2010), 15.2% of the prisoners admitted to being infected with HCV, although this is likely to be an underestimation since about 50% of the prisoners did not answer the questions about infectious diseases (Van Malderen, 2011). Half of the prisoners had never been tested before imprisonment. According to an evaluation by the Belgian Health Care Knowledge Centre in 2004, about 76% of the prisoners that used drugs intravenously were HCV-positive (Gerken, Thiry, Hulstaert & Robays, 2016). The HIV seroprevalence among injecting drug users in prison is estimated to be around 5%, and HBV prevalence rates are estimated at around 3% to 5% (Plasschaert et al., 2005; Van Malderen et al., 2011). Available data suggests that half or fewer of the people who have ever injected drugs have been vaccinated against HBV (EMCDDA, 2018).

The proportion of prisoners who are untreated for these pathologies is not exactly known, but is likely to be substantial. For example, for HCV, treatment was until recently only recommended in the advanced stages of hepatitis, but the percentage of prisoners treated appears to be very low in comparison with what would have been expected. This is surely a missed treatment opportunity (Mistiaen, Dauvrin, Eyssen, Roberfroid, San Miguel & Vinck, 2017). Several reasons can be put forward for the low involvement in treatment. First, there is no standardised or systematic screening of prisoners at entry or during imprisonment. TB screening is the only standardised screening that is systematically done at entry or during detention. A recent study by the Belgian expertise centre on public health demonstrated that only six prisons propose to screen for hepatitis and HIV at entry (Mistiaen et al., 2017). However, some prisons offer these screenings during detention. Second, in case of a positive screening, it is not guaranteed that infected individuals will receive treatment: sometimes they get no treatment for financial (budget for health services in prison is limited) or logistical reasons (treatment depends on the length of detention of the prisoner, a minimum of eight weeks is required) (Mistiaen et al., 2017). Also, vaccination is not systematically performed in prisons.

The monitoring of drug use and health risks in prisons clearly demonstrates that risk behaviour in Belgian prisons is certainly not negligible. Sharing needles and other paraphernalia is common (17–35%) among prisoners who inject drugs (Deprez & Van Malderen, 2012). Also ‘slamming’, or injecting drugs in a sexual context among men who have sex with men, has been observed among specific subgroups of drug users in Belgium (EMCDDA, 2018).

Prisons can play an important role in promoting public health and it is important to invest in harm reduction for injecting prisoners. They can help to detect, vaccinate and treat infectious diseases and offer a range of prevention measures such as free and voluntary testing for infectious diseases, distribution of condoms and sterile injecting equipment, treatment of infectious diseases, vaccinations, health education, and so on.

Care and support in Belgian prisons

The Directorate General of the Penitentiary Institutions is responsible for the Belgian prison system. The implementation of an integral and integrated prison drug policy is regulated by the Ministerial Circular Letter (18 July 2006), emphasising, among other things, a focus on the active detection of drug problems and related health and psychiatric problems (EMCDDA, 2017). Also, the principle of equivalence of service provision and continuity of care between prison and community settings has

been adopted in the Belgian Law of principles concerning the prison system and the legal position of prisoners (Basiswet 17/1/05). This means that prisoners are entitled to receive comparable (health) services in prison, and hence also comparable treatment for drugs problems, as individuals receive outside prison. Furthermore, the support provided should be modified according to the needs of the prisoners (Art.88). This was also emphasised in the recent UNGASS resolution: *'... and ensure non-discriminatory access to a broad range of interventions, including psychosocial, behavioural and medication-assisted treatment, as appropriate and in accordance with national legislation, as well as to rehabilitation, social reintegration and recovery-support programmes, 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.'* (UN General Assembly, 2016).

Health care in Belgian prisons is the responsibility of the Federal Public Service of Justice. A distinction is made between the provision of health care services to prisoners, which is the responsibility of the medical service, and the provision of medical and psychosocial advice, which is the responsibility of the psychosocial service (EMCDDA, 2017; Plettinckx et al., 2014). Following the recommendations of the World Health Organization, it is the political intention to shift the responsibility for the organisation and delivery of health care in prisons to the Minister of Social Affairs and Public Health (Mistiaen et al., 2017). WHO states that in order to achieve qualitative health care in prison, its provision cannot be isolated from health care in the community. Consequently, prison health services should be integrated in overall public health services (Gourdin, Vyncke, Felgueroso-Bueno, Eechaudt, Vander Beken, Vander Laenen et al., 2017).

Prison health care services are provided by nurses and (part-time) doctors. They deliver medical care and harm-reduction services in every prison, although in most prisons this is limited to basic medical services (Wittouck et al., 2014). In case of more serious medical problems, prisoners are transferred to one of the three prisons with a specialised medical section, or to a general hospital or health care institution (Plettinckx et al., 2014). Within 24 hours after prison entry, the Law of Principles of 2005 (B.S./M.B. 01.02.2005) and the Royal Decree of 8 April 2011 (B.S./M.B. 21.04.2011) foresee an assessment by a GP. During this medical intake (no needs assessment), limited attention is paid to drug use, psychopathology or medical issues (Plettinckx et al., 2014). When a prisoner states they are or were a drug user, potential interventions/treatment can be discussed. Later on, the medical/nursing staff take care of the follow-up of the prisoner. Members of the medical staff should provide new prisoners with information about drug use and related risks, treatment options, prison drug policy, and check whether they had prior treatment before detention (EMCDDA, 2017).

Also, the prison psychosocial services provide support to prisoners. Within four days after entry, a staff member of the psychosocial unit – this is a team consisting of psychologists and social workers – should have a conversation with the prisoner. The psychosocial service provides prisoners with information about their rights and obligations, about the rules in prison, about medical, juridical, social, psychological and family support and about the availability of a moral counsellor. In theory, all prisoners are briefly screened. The degree and content of the screening, however, depend on the size of the prison, the number of staff and time available. The psychosocial teams are merely responsible

for risk assessment, prevention of recidivism and social reintegration. They should take preventive measures and give advice as experts. Mostly they do not deal with drug problems directly, although they also have a helping role and should have so-called 'pre-therapeutic conversations' with prisoners in preparation of their release (Wittouck et al., 2014). This dual role (expert/evaluator versus care provider) often causes tension regarding confidentiality.

Psychosocial support for drug-using prisoners is provided by experts that are part of the prison health care team (that provides medical support), but also by external service providers (e.g. housing or drug services), although this support is only available for a limited number of prisoners. Various external service providers collaborate as consultants with prison services and provide some type of support to the prisoners in order to help them prepare for their release (Schiltz, Van Malderen & Vanderplasschen, 2015). The advantage of working together with external drug service providers is that prisoners already have a first contact with drug treatment services in the community. This is helpful when picking up the contact again upon release. In addition, experts specialised in specific drug-related issues (e.g. harm reduction) sometimes support prison health teams.

Although the objective is to implement a drug policy in prison that is similar to the drug policy outside prison (with a focus on prevention, reduction of harm, treatment and law enforcement), the reality makes it clear that interventions in prison are far from similar to those in the community, as was demonstrated in a European comparative study (Michel et al., 2015). The principle of equivalence is hardly implemented in Belgium and the availability of drug-related health services in prison is inadequate (Van Malderen, 2012). Also, there is high demand for mental health care and an insufficient offer of psychiatric care and psychological support in Belgian prisons (Mistiaen et al., 2017). Overpopulation can be regarded as one of the main reasons for the poor and unequal access to health care services in prison settings (Jürgens, Nowak & Day, 2011; Walker et al., 2014). Medical staff are overwhelmed by the high demand for care and it is not easy to organise the provision of services in this setting. Also, the lack of staff and lack of knowledge about drugs and related aspects among staff members in prison play an important role (Federaal Kenniscentrum voor de Gezondheidszorg, 2016; Vander Laenen et al., 2013). An overall, coherent and qualitative drug treatment offer for prisoners in Belgian prisons is not available for the moment and due to the economic crisis and associated savings, the limited capacity of drug treatment services in prison has been downsized further (Favril & Vander Laenen, 2013; Plettinckx et al., 2014; Vanhex, Vandevælde, Stas & Vander Laenen, 2014).

Medical care

In general

To increase the chances of reintegration in the community, it is important that prisoners are supported and prepared for their release right from the start of their prison sentence. Prisoners with a drug problem that have specific health needs in particular require specific medical care and a multidisciplinary approach (ECDC, 2011). Unfortunately, as mentioned before, (health) care and specialised drug treatment in particular are limited in Belgian prisons. Psychosocial support is so

limited that pharmacological treatment is now the main intervention for drug users (Favril et al., 2017; Vanhex et al., 2014).

Research shows that there is a high variability between prisons in terms of medical consultations with a GP and/or psychiatrist. The use of prescription drugs is high: 21% of all prisoners use anti-psychotic medication, 25% take anti-depressants and 31% receive anxiolytics (Mistiaen et al., 2017). It appears that these psychoactive substances are frequently prescribed to drug users. Favril & Vander Laenen (2017) found that one third of all Flemish prisoners who reported substance use during detention are prescribed psychoactive drugs: benzodiazepines (25%), anti-depressants (12%) and antipsychotics (10%).

Opioid Substitution Programmes

In Belgium, methadone and buprenorphine are the two substances authorised for opioid substitution treatment (OST). In the community, they are provided by specialised centres and general practitioners. Opioid-dependent individuals enrolled in OST can get their daily dose in a specialised centre or pharmacy, under the supervision of the pharmacist. Prescriptions are registered on an online database to avoid multiple prescriptions and to allow warnings to be sent to prescribers. Unfortunately, OST provided in prisons is not included in this database (EMCDDA, 2017).

Since 2006, OST is available in all Belgian prisons. Both detoxification and maintenance programmes are provided in prisons in order to enhance the social and personal functioning of opiate-dependent individuals (EMCDDA, 2017). To assure the quality of service provision, a technical protocol is used. OST programmes in prison include initiation of OST, but also continuity of maintenance treatment and reducing doses, where sentences are for more than one year (Van Malderen, 2012).

Studies on OST in prison settings showed that the use of OST as maintenance treatment in prisons can have similar benefits to those in community settings (ECDC, 2011). It offers the opportunity to reduce illicit opioid use and (related) risk behaviours in prison and a reduction in the number of drug-related deaths. Moreover, the continuation of methadone maintenance treatment during detention increases the willingness to receive (OST) treatment after release, which may protect against relapse into drug use and future imprisonment (Favril, Vander Laenen & Decorte, 2015; Larney et al., 2014; Schiltz, Van Malderen & Vanderplasschen, 2015; Stallwitz & Stöver, 2007).

In 2012, almost 4% of the Belgian prison population received OST, primarily methadone (74%) (FPS Justitie, 2014; Plettinckx et al., 2014). More recent studies have shown an increase: 6.8%–7% of prisoners receive OST now, although this may vary between prisons (up to 15% in some prisons) (Favril et al., 2017; Mistiaen et al., 2017). About 10% of all those entering prison declare that they follow an OST programme in the community, suggesting an overall lack of continuity of OST upon prison entry (Van Malderen, 2017). Despite the effectiveness of OST as a maintenance treatment, research points out that only two out of every three Flemish prisons offer OST for maintenance treatment (Vander Laenen et al., 2013), while all prisons provide it for detoxification (Favril & Vander Laenen, 2017; Vander Laenen et al., 2013). Most Walloon prisons offer both options. When prisoners

follow an OST programme before detention, the programme can be continued in almost all prisons. Alternatively, OST can be started up in almost all prisons (Vander Laenen et al., 2013).

It is crucial to link medical treatment (OST) with psychosocial support (Amato et al., 2005). Most Belgian prisons do not specify which type of psychosocial interventions they provide to clients in OST and report 'conversations with clients, guidance or social and psychological support and evaluation of the treatment' (Todts et al., 2009). Most prisons do not provide group therapy for individuals in OST. Training for staff involved in OST is not widely available: only half of the Flemish prisons and more than half of the Walloon and Brussels prisons provided training for staff. The training is usually limited, e.g. basic training for new staff (Debehets, 2011). In Wallonia, psychosocial support is provided by social workers, psychologists, GPs or educators, mostly at the demand of the client or when psychosocial professionals are available. A link with professionals outside prison is helpful, in order to facilitate continuity of care after release (ECDC, 2011). Medical and psychological treatment are increasingly linked and in a few prisons drug counselling is performed by addiction specialists (Van Malderen, 2017). Also, an experiment is running in three prisons to provide comprehensive support to drug users from prison entry onwards.

Conclusion

The provision of OST in prisons is not in line with the Belgian Prison Act of 2005 regarding the rights of prisoners. Vander Laenen and colleagues (2013) have compared the prison data of the self-report survey by Todts and colleagues (2008) regarding the prevalence of (injecting) opiate use in Belgian prisons with the number of OST clients in prisons, in particular those in maintenance treatment. This raised some serious concerns about the equality of health care in prison, the adaptation of care to the specific needs of prisoners (art. 88) and the right to continuity of care (art. 89). The current treatment offer is insufficient to guarantee the actual implementation of prisoners' rights (Van Malderen, 2012). The low prescription rate of OST can be regarded as a violation of international human rights and of minimum standards on the treatment of prisoners (Mistiaen et al., 2017). In most cases, pharmacological detoxification treatment is available in prisons, in contrast to maintenance treatment and psychosocial support. In addition, upon release, several problems are identified and community-based services often have to start treatment again once a prisoner is released (Vander Laenen et al., 2013).

Psychosocial support

(Psychological) support initiatives differ from prison to prison, depending on the policy of local directors and the goodwill of external services to offer services behind bars (Snacken & Tournel, 2009). Great variation can be observed between service providers collaborating with prisons. For example, some prisons work together with forensic welfare services, others with mental health centres or employment services. These external services provide support inside prison and help prisoners to prepare for their release regarding various life domains (such as employment, housing, ...). Also here, few specific programmes are available for drug users.

However, some valuable initiatives have been implemented and are still ongoing. First, in three Belgian prisons small-scale drug-free programmes are offered. For example, in Ruiselede prison, a

pre-therapeutic drug treatment programme ('B.Leave') is running, in which prisoners are prepared for reintegration and participation in a therapeutic community programme through education, therapy and sport. Also, relapse prevention and social skills training are provided (Plettinckx et al., 2014). Drug-free wings were set up in the prisons at Bruges and Hasselt (Plettinckx et al., 2014; Vereniging Geestelijke gezondheidszorg Limburg vzw, 2016). The regime of a drug-free wing focuses on structure, order, taking responsibility, relapse prevention and development of a prisoner's personal functioning. Working is mandatory and leisure activities (sport, education, ...) are of great importance in these wings (Plettinckx et al., 2014; Directoraat Generaal Penitentiarie Inrichtingen, 2016).

Second, some short-term motivational programmes based on cognitive-behavioural approaches have been set up in some prisons. The most recent example was the 'Drugs de Baas' project, which was part of the research project 'Process and Outcome Study of Prison-based Registration points' (PROSPER). These programmes focus(ed) on problem recognition and aim to increase prisoners' motivation to change. Most of these projects depend on temporary finances and are discontinued on conclusion of the project ends (Plettinckx et al., 2014; Vandeveldde, Vander Laenen, Vanderplasschen, De Clercq, Mine & Maes, 2016).

Third, a new pilot programme was started in three prisons in December 2017, specifically aimed at identifying and supporting drug users. It focuses on the screening of prisoners (regarding drug use, dual diagnosis and suicide risk) right from the start of their prison trajectory. This is likely to contribute to an accurate assessment of the problem severity and will serve as a baseline assessment for preparing an individual care trajectory beyond prison walls. As part of the project, medical staff and project collaborators are educated about the screening and support of prisoners with substance misuse problems (Kamer van Volksvertegenwoordigers, 2018).

Another interesting initiative for drug users in Belgian prisons were the centralised intake units (CIU). In 2011, these units were set up in all Belgian prisons and were intended for drug-using prisoners who were about to be released. One of the goals was to make a bridge between prison and (drug) treatment providers outside prison in order to facilitate participation in treatment and continuity of care upon release. The counsellors working for the CIUs worked for an external organisation. They clearly had a liaison function and their task was to give advice about (drug) treatment available in the community, to increase the motivation of prisoners to seek some kind of treatment, and to refer to community-based services (and arrange the first contacts with them). As the financial support for these CIUs stopped, its operation was discontinued in 2015, despite several positive outcomes demonstrated in the process and outcome study of the prison-based registration points (Vandeveldde et al., 2016). Recently (2017), a similar initiative was started, called 'Tandem'. This project replaces the centralised intake units, but has a broader scope since counsellors do not only support prisoners with drug problems, but also prisoners with other types of mental health issues. The aim of the project is to link prisoners to appropriate community services after detention (PopovGGZ, 2017).

Finally, more and more attention in Flemish prisons is being paid to maintaining or even strengthening the relationship between prisoners and their families. For example, child visits are organised, as well as family events on specific holidays. Some prisons organise Skype meetings to increase these

contacts, other prisons provide parental support through external services, and so on (Claes & Brosens, 2015). Some prisons also invest in education and training for prisoners, and provide training that leads to an official diploma. This should increase the chances of finding a job after release (Directoraat Generaal Penitentiarie Inrichtingen, 2016). Some prisons provide services focused on housing, leisure activities and so on. Unfortunately, these services and initiatives differ from prison to prison and are not available to all prisoners.

Conclusion

Various valuable initiatives are available for prisoners, but they often reach only a limited or even small number of prisoners. Only three Flemish prisons offer a decent drug treatment programme and a pilot project aimed at systematic screening and referral/treatment of drug users still needs to be evaluated. Moreover, not all activities are accessible to all prisoners and only a limited number of prisoners are entitled to some services. Overall, there is a lack of a proper treatment offer for drug users in prisons and continuity of care is even more exceptional (Vanhex et al., 2014; Vander Laenen, Vanderplasschen, Wittouck et al., 2013).

Harm-reduction measures

Besides medical and (psycho)social support, some harm-reduction initiatives are available in Belgian prisons. Below, an overview of those initiatives is given.

Testing, vaccination and treatment

In all Belgian prisons, prisoners are screened for TBC at entry (Federaal Kenniscentrum voor de Gezondheidszorg, 2016). Only six prisons provide prisoners with systematic screening for HIV and hepatitis at entry. Because of the high costs, active screening is not carried out for every incoming prisoner. Nevertheless, prisoners have the possibility to ask for a hepatitis and HIV test on voluntary basis (Michel et al., 2015).

A protocol that describes the steps that should be taken to detect and treat HVC is available in prison. Testing can be done in the prisoners' own prison, but when it seems the prisoner needs further testing, prisoners must go to a reference centre for HCV, HIV and TBC. This is located in one specific prison. After doing a liver biopsy, the doctor decides if treatment needs to be started (Favril, Vander Laenen & Decorte, 2015). Anti-retroviral treatment is available in all Belgian prisons, although it is not systematically proposed to prisoners (Plettinckx et al., 2014). Also, not all prisoners get information about the availability of post-exposition prophylaxis (Michel et al., 2015). A collaboration with AIDS documentation centres can be realised. For HBV, treatment (interferon therapy) is possible after diagnosis, but a systematic proposal for HBV vaccination is rarely done (Michel et al., 2015; Plettinckx et al., 2014).

Information/education about drug use and related risks

In theory, in most prisons, prisoners are sensitised to the effects and risks of (different) drugs and receive information about harm reduction (Michel et al., 2015). Information leaflets on the effects of drugs, developed by non-profit organisations, are available in every prison. These leaflets make prisoners aware about drug use, health problems and risk behaviour. Also, a booklet made for and by

prisoners about health, drug-related health problems, risk behaviour, overdose and so on is available in every prison. Sometimes information campaigns are launched to make prisoners aware of behaviour that increases the risk of contamination (such as tattooing, piercing, injecting drugs, etc.) (Van Malderen, 2011). In a few prisons, peers are involved in prevention programmes. Former drug users or people who might have experience of drug use and know other drug users talk to the drug users about topics such as AIDS, hepatitis, sharing needles, and ways to protect themselves against these diseases. By doing so, 'hidden populations' can also be reached and trained on health-related topics (FOD Justitie, 2017; Plettinckx et al., 2014).

Not only prisoners but also prison staff are provided with education, although limited, about drug use, including the effects of different drugs and drug policy in prisons. The aim is that staff members can manage as well as possible with the (behaviour of the) drug-using prisoners and can take care of their own safety.

Clean injecting equipment

Bleach or disinfecting tablets are provided in all Belgian prisons, but only at one location (Michel et al., 2015). Unfortunately, there are no needle and syringe programmes available in Belgian prisons (EMCDDA, 2017). Due to the lack of clean injecting equipment, the sharing of needles becomes more likely.

Contraceptives

To prevent the dispersion of infectious diseases among prisoners, condoms and lubricants have been available since 2009 in most prisons at the medical unit and in some prisons at other locations too (Michel et al., 2015; Favril et al., 2015; Reflectiegroep Zorg en Detentie, 2014). Female condoms are also available. Despite the availability, Van Malderen (2011) found that more than 1 in 2 prisoners (59.6%) never used a condom during sexual activities in 2010. It appeared that not all prisoners knew the risk factors for HIV and the risks related to fellatio without protection. Also, 30% of prisoners did not know where to get condoms from and 65.7% did not even know at all that prisons provided (free) packets of condoms and lubricants (Van Malderen, 2011). Sexual health programmes were found in only five prisons (Federaal Kenniscentrum voor de Gezondheidszorg, 2016).

Piercing and tattooing

The cross-national report by Michel and colleagues (2015) showed that interventions for the prevention of transmittable diseases through tattooing and piercing were rarely implemented in Belgian prisons. Risk reduction programmes for tattooing/piercing were available in only two prisons (Federaal Kenniscentrum voor de Gezondheidszorg, 2016).

Overdose prevention

Overdose is one of the topics in the information booklet (see above) that deals with health- and drug-related topics. The booklets are distributed by internal and external services during their contact with prisoners (Plettinckx et al., 2014). Besides this, no other specific measures for overdose prevention are taken in Belgian prisons. Naloxone is not provided in Belgian prisons or upon release.

Conclusion

Although some harm-reduction initiatives are available and more attention is paid to prevention, prisoners need to be better informed about drugs, drug-related problems, detection of infectious diseases and other health promotion initiatives (Favril et al., 2015; Memorandum Zorg en Detentie, 2014). The knowledge and skills of prisoners about prevention of HIV and other STDs, risks related to drug use and risks related to the sharing of injection equipment and equipment for piercing and tattooing can still be improved. This is an action point in the HIV plan for 2014–2019 (Favril & Vander Laenen, 2015). In addition, more attention needs to be paid to the training of sanitary/health staff (physicians, nurses), because now they lack the time and information to be able to provide effective harm-reduction services (Van Malderen, 2012).

Preparations for release

Despite good intentions and the involvement and many efforts of several service providers inside and outside prison, the transition from prison to the community still is too difficult in many cases. In theory, a case manager or the psychosocial service inside prison can help prisoners to determine which kind of support they need. Also, some external services (like forensic welfare work) try to help prisoners to prepare for release. They can give prisoners the necessary information and sometimes they already have contacts with support services outside to facilitate making connections with those services after release (Van Dam & Raymaekers, 2017). But in most cases, referral to health care and treatment services outside prison is only realised after release. Moreover, the strict distinction between health and psychosocial services does not support the reintegration and recovery process (Schiltz, Van Malderen & Vanderplasschen, 2015).

Preparations and support inside prison regarding medication and social administration (e.g. health insurance, finances, residence permit, official address) are very poor. As a result, a lot of time is lost upon release. Also, the day of release is often uncertain, especially for prisoners in pre-trial detention (Federaal Kenniscentrum voor de Gezondheidszorg, 2016). As a consequence, prisoners are sometimes released earlier than expected and re-enter the community unprepared. They are confronted with a lot of challenges upon release such as surviving without an income, having no medication (e.g. methadone) or proper housing, having nothing to do, no supportive social network, and so on. All these problems often already existed before detention, but are exacerbated because of and during detention. For example, it is difficult to take care of administration and to pay rent or debts from inside prison. In theory, prisoners can go to health care and social services in the community after release to receive support with housing, income, work, finding meaningful activity, etc., but often ex-prisoners appear not to get in touch with these services, they drop out quite quickly, or they cannot be helped immediately (e.g. because they do not meet some criteria or due to waiting lists) (Van Dam & Raymaekers, 2017). A combination of these factors hinders the effective reintegration of prisoners (Favril, Vander Laenen & Decorte, 2015; Polfliet, 2014; Weijters & More, 2015). Those that are released on probation sometimes link better with treatment services outside prison because they have a supervising officer of justice who can help them to connect with the right social services.

Good practice example: 'Bridges Inside/Outside'

To help prisoners bridge the gap between inside and outside prison, a new project ('Brug Binnen Buiten') was developed in Antwerp prison in 2017. The project started with an analysis of the needs of prisoners in order to support (ex-) prisoners on release as effectively as possible. In practice, a case manager or counsellor in prison can refer a client to the project. By doing so, prisoners will have an initial meeting with a professional, who gives them information about the project and helps clarify their needs. Then, the prisoner will be matched to a volunteer and agreements will be made regarding how the contact will take place following release. Once the prisoner is released, the volunteer will offer the ex-prisoner practical and psychosocial support regarding different life domains in the (immediate) period following release. For example, this can include help with practical stuff like paperwork, but also with building up a new social network, referral to social services, and so on. This approach intends to be proactive, outreaching and tight, but at the same time individuals' autonomy is supported and it helps build their confidence. The project starts from a triadic relation; at every step, the (ex-) prisoner, a volunteer and professional are involved. Although the project started only recently, the first results show a clear contribution to the quality of life of ex-prisoners and their participation in the community (Van Dam & Raeymaeckers, 2017).

It can be concluded that the bridge between inside and outside prison is insufficiently elaborated. Too little effort is put in continuity of care (De Pauw, De Valck & Vander Laenen, 2009; Favril & Vander Laenen, 2013; Vandeveldt et al., 2016). Throughcare initiatives are neither effectively implemented nor adjusted to the specific needs of prisoners. More efforts need to be invested in the Bridges Inside/Outside, with a focus on human and qualitative support of prisoners in the community (Brosens, De Donder & Verté, 2013; Van Dam et al., 2017; Van Haegendoren, Lenaers, & Valgaeren, 2001). Also, the Belgian state needs to strengthen and expand the care and support for drug users in prison, to provide more and better drug treatment services, and to strive for equal levels of support in prison as there are in the community (Vandeveldt et al., 2016). In addition, more aftercare services are needed to support (drug-using) prisoners during their reintegration and recovery process in the community.

2.2.2 Situation in France

Prison landscape in France

As of July 2018, 70,710 persons were detained in 182 facilities across the country. Around one third of this population were remand prisoners and 3.7% were female prisoners. Furthermore, overall occupation density was estimated at 118% (140% in remand centres) and 100 facilities showed an occupation density of greater than 120%.

Data available regarding opioid use, OST, and viral infectious diseases in prison.

Epidemiological studies collecting data on HIV/HCV/HBV prevalence in prison settings, the proportion of prisoners using opioids, or those treated with OST started to be conducted in France after 2000, initially using perfectible methodology. Therefore, it is difficult to obtain a strong trend due to the variability of study designs and the absence of a national monitoring system among prisoners. In the present brief review, the most representative study for each indicator is presented first, while describing the method and sampling design used to produce its results. The methods used for the other studies were described more briefly in order to remain as clear and concise as possible.

Prevalence of HIV, HCV and HBV (at prison entry and during incarceration)

HIV

As observed internationally, surveys conducted in France showed a higher prevalence of HIV and viral hepatitis in prison when compared to the community. In 2010, the Prevacar study was based on a two-stage sampling design to produce HIV and HCV estimates for the entire prison population in French and French overseas prisons (Semaille et al. 2013). The survey included data collection in 27 prisons at a national level and used information from the medical records of more than 2,154 prisoners. The HIV prevalence rate was estimated at 2.0% [0.9–4.2] (2.6% [0.7–8.8] in women and 2.0% [0.9–4.3] in men; 75% of prisoners were receiving treatment for HIV (Semaille et al. 2013)). Another study (Sannier et al. 2012) conducted at a local level among all the prisoners of one French prison reported a declared HIV prevalence of 3.9%. Other studies (Jacomet et al. 2016; Verneuil et al. 2009; Mouquet 2005) rely on data collected at entry, mostly declarative, and showed HIV prevalence ranging from 0.3% to 1.1%.

HCV

According to the Prevacar study, the prevalence of HCV was estimated at 4.8% [3.5–6.5] (11.8% [8.5–16.1] in women and 4.5% [3.3–6.3] in men, compared with an HCV prevalence in the general population estimated at 0.53% in 2011 (Pioche et al. 2011). Almost half of HCV-infected prisoners had chronic hepatitis C and 44% were receiving or had received treatment. Another national study conducted in 134 French prisons by the Ministry of Health based on self-declaration (Mouquet 2005) reported a prevalence rate at entry of 4.2% in 2003 (vs. 4.4% in 1997). Studies conducted locally showed similar results. One was conducted between 2004 and 2010 (data collected from HIV/HCV testing centres in the community and in prison) in three prisons in south-eastern France and reported

a pooled HCV prevalence of 5.3 % using ELISA tests among 5,957 prisoners (Roux et al. 2011) (with a decrease over time: from 7.9% in 2004 to 3.5% in 2010). Other studies (Jacomet et al. 2016; Verneuil et al. 2009) conducted locally and based on blood tests showed similar HCV prevalence, ranging from 4.7% to 4.9% (local prevalence estimates based on declarative data (Sannier et al. 2012; Jacomet et al. 2016) ranged from 2.6% to 3.1%).

A recent study (Remy et al. 2014) carried out in a prison in the south-west of France (among 330 prisoners) shows that the HCV incidence was estimated at 3 per 1,000 people per year.

A national report (Dhumeaux 2016) requested by the Ministry of Health was published in 2016; it offers a summary of the situation regarding HCV among prisoners and put forward several recommendations to improve its global care.

HBV

Regarding HBV, a study conducted in 134 French prisons by the Ministry of Health based on self-declaration⁵ reported a prevalence rate at entry of 0.8% in 2003 (vs. 2.3% in 1997). This value was similar to the prevalence of 0.6% reported by Jacomet et al. in 2016, using blood tests at entry. The Prevacar study did not include an estimation of HBV prevalence because the necessary markers were technically more difficult to obtain than for HCV or HIV. HBV data was collected in order to document HBV prevention and vaccination proposed in prisons in France and showed that HBV vaccination was available in 96% of prisons.

Screening

One of the main results of the Prevacar study was the fact that even if the HIV and HCV screening rates were high, for one third of all prisoners, the results of the test were missing from their medical records. A test may have been performed but the result was not recorded, it may have been offered but refused by the prisoner, or it may have been performed as part of a free and anonymous medical visit (cf. Semaille et al. Eurosurveillance 2013).

Opioid Substitution Therapy (OST) in prison

Since 1996, methadone and buprenorphine have been made available in French prisons for patients whose treatment was previously initiated outside prison. But up to 2002, only buprenorphine could be provided inside prisons (Michel 2013), except when authorised physicians had been consulted by the patient. Since 2002, all hospital doctors (including all prison doctors) have been authorised to initiate methadone in prisons. Regarding the organisation of health care in prison and OST availability, a report (Barbier 2011) was published in 2010 as part of the Prevacar study which showed that 100% of the facilities declared having access to at least one of the two types of OST (buprenorphine or methadone).

The proportion of prisoners in the Opioid Substitution Programme (OST) was estimated at 7.9% in the Prevacar study (Barbier 2011). (This is an estimate for the entire prison population in France, corresponding to 5,000 prisoners in the whole country.) By applying this proportion to the whole prison population in 2017 (68,432 prisoners), it would mean that approximately 5,400 prisoners are in OST today. However, there's a risk of underestimation since the proportion of prisoners in OST has

continued to increase since 1998 (2% in 1998, 3.3% in 1999, 5.4% in 2001, and 6.7% in 2004, according to a national study (Michel 2015; Michel et al. 2008)) but also in the community where the total number on OST is still increasing (Brisacier 2017) (for details, see annex 1). The proportion in 2017 might therefore be slightly higher than 7.9%.

A cross-sectional survey (Barbier et al. 2016) from the Ministry of Health implemented in 2014 based on aggregated data from medical units in 2012 in all French prisons (122 prisons, 174 responded, i.e. 70%) found that the proportion of prisoners on OST was 9% (5.5% with buprenorphine, 3.5% with methadone).

In 2010, 68.5% of prisoners in OST were treated with buprenorphine and the rest of them with methadone, according to the Prevacar study. The proportion of prisoners treated with methadone has increased each year since 2002, according to previously published data¹²

Opioid use in prison

The available data on drug use during incarceration is difficult to interpret. This is mainly due to under-reporting and a lack of representative samples in studies. Furthermore, while some studies attempted to measure the burden of drug dependence in French prisons (Falissard et al. 2016; Sarlon et al. 2012), few of them reported specific results on opioid consumption. A study conducted by Sannier et al. in 2012 in a single prison showed that among those prisoners who responded to the questionnaire (54.4% of the total prison population), 8.1% reported heroin use and 7.1% the misuse of opioid treatments (43.6% reported illicit drug use). Concerning opioid use at entry or just before incarceration, a study conducted in 134 French prisons by the Ministry of Health (Mouquet 2005) showed an important decrease in opioid use between 1997 and 2003 (from 14.4% to 6.5%). More recent studies (Sannier et al. 2012; Jacomet et al. 2016), conducted at very few sites showed prevalence rates at entry of 12.3% (in 2011) and 8.3% (in 2016).

Injection practices

Regarding injection practices, a study (Michel et al. 2018) based on the ANRS-Coquelicot survey (2011–2013) included a random sample of 1,718 people who used drugs (PWUD) in free society. In the sub-sample of PWUD declaring injection practices and at least one incarceration in the past, 14% [10.4–18.6] reported injection practices in prison. Moreover, among those who reported injection practices in prison, 40.5% [28.1–54.3] declared sharing needles/syringes while in prison.

Harm-reduction measures

A national survey conducted in all French prisons in 2009–2010 (Michel et al., 2011) on the accessibility and availability of harm-reduction measures underlined the gap between International but also French official recommendations, and the reality in prisons. Needle exchange programmes were not available, access to bleach was not consistent and even absent in some prisons, condoms were most often accessible only in the medical unit and without lubricant, post-exposition prophylaxis was poorly accessible due to a lack of information, and screening for HIV-HCV-HBV was rarely proposed after initial entry medical screening. OST was accessible in nearly all prisons and HBV vaccination proposed to all prisoners screened negative. ART was accessible in all prisons.

Despite the French Health Law approved in January 2016, which provides for the implementation of a series of harm-reduction interventions in the prison setting similar to those currently available in the general community, the situation had not really improved at the beginning of 2019 except for access to naloxone. The Ministries of Health and Justice could not reach a consensus on a decree concerning the implementation of this law in prisons, meaning that this law is currently without effect.

Special preparation at release during incarceration

In France, a governmental plan (2008–2011) attempted to enhance the continuity of care and to reinforce the preparation for release of drug users (Obradovic 2014; Gaubert 2014). They proposed to designate an addiction treatment centre in the community to be in charge of every prison. This “referent centre” is supposed to organise the continuity of care after release for all prisoners suffering from drug or alcohol problems. To this effect, a half-time social worker position is funded and allocated by the referent centre for every prison (adjusted according to the size of the prison). Furthermore, access to around 40 residential places for drug/alcohol users just released from prison have been organised in four specialised settings throughout France. These allow easier access to care and social support for homeless drug/alcohol users just after prison release but its duration is not supposed to exceed three months and the number of places is still very limited. Other localised initiatives have surfaced (Gaubert 2014; Obradovic et al. 2012) (one is replicating the “Housing First” experiment in the United States, for example) and are still being evaluated.

However, this government plan and the one that followed (Ministère de la justice 2010) did not include specific preparations for opioid users and overdose prevention. All specific preparations for release regarding this specific topic are therefore the responsibility of local staff.

Naloxone

Since December 2016, the Ministry of Health authorised the distribution of naloxone (only available until now as a nasal spray) by designating settings specialised in addiction medicine or emergency units, to be taken home by subjects at risk of overdose (or their friends/relatives). Naloxone delivery is free of charge. This measure includes the prisons’ medical units, and targets in particular previous opioid users during incarceration, and those who will soon be released (people released from prison identified at risk of opioid overdose by a prison medical unit). The process is still ongoing, with a condition of training for all doctors wishing to provide naloxone for their patients, and the distribution of naloxone in prison is far from being introduced in all facilities. It is thus too early to properly evaluate this new measure.

Health insurance and access to care for people who use drugs

In the community

OST is generally cost-free for drug users in the community through a special health insurance status (chronic disease status or cost-free access in medico-social addiction-oriented specialised settings entitled ‘CSAPA’). ART for HIV and anti-HCV treatment is free, and access to psychosocial services

(in CSAPA) is also free of charge. An exception is for drug users without documentation, where access to care is not always possible (except in the CSAPA settings where OST is free regardless of the status of the drug user). Take-home naloxone became available in all specialised settings very recently, and is free of charge.

Inside prison

The organisation of care inside prison is the responsibility of the Ministry of Health. Health fees are fully covered by the Ministry of Justice. HIV, HCV and addiction medicine consultations are available in some prisons only. Screening for HIV, HCV, mental health disorders and addictive behaviours is systematic at entry but is most often not repeated during incarceration.

The principle of equivalence with the community is considered as respected in terms of access to OST, ART for HIV, anti-HCV treatments and take-home naloxone upon release. Regarding psychosocial interventions for drug users, dedicated staff are not available in most prisons.

After release

Ex-prisoners get the benefit of health insurance for one year after release (but a procedure is necessary to obtain full health insurance coverage), except for those without documentation.

In theory, if prisoners have immediate access to the health insurance after release, the requested 'certificate of incarceration' is not always given upon release from prison and there is a delay (of at least one month) between release and access to full coverage of the cost of treatment. Ex-prisoners have the alternative to go in a medico-social specialist (CSAPA) setting where OST is provided for free, whatever the health insurance status. Nevertheless, this represents a gap in continuity of care for many prisoners. Treatment can be provided for few days following release, but this is not universal.

In daily practice, some barriers have been noted: obstacles to getting the certificate necessary to receive health insurance, getting a medical prescription at release, receiving treatment (except ART) for a few days after release, and being in contact with professionals in the community before release.

Since 2014 in France, as described earlier, a dedicated social worker from a CSAPA in the community is assigned to the continuity of care for prisoners with an addictive behaviour in each prison.

2.2.3 Situation in Germany

Prison landscape in Germany

The German criminal justice system and the enforcement of penalties differentiates between juvenile and general criminal law, providing diverse measures and sanctions for adult, young adult and juvenile offenders. However, the general law as outlined in the 'German Penal Law' (*Strafgesetzbuch*; StGB) and the Code of Criminal Procedure (*Strafprozessordnung*; StPO) also applies in principle to juveniles and young adults. Court levels are divided into local courts (*Amtsgerichte*), regional courts (*Landgerichte*), higher regional courts (*Oberlandesgerichte*) and the Federal Court of Justice (*Bundesgerichtshof*).

The administration of the penal systems/prison laws (Strafvollzugsgesetze) is regulated by the individual 'Länder' (federal states). This was regulated as part of the reform of federalism approved by the German Parliament in May 2006. Since then every federal state has adopted a new penal system law based on the German penal system law of 1976 (Strafvollzugsgesetz; StVollzG). The last federal state adopted a new law in 2014 (Berlin).

The German prison landscape consists of 179 prisons with room for a total of 74,386 prisoners, 5,341 of whom for women. Thirteen of these are open institutions for prisoners on day release. In November 2018, the average population in all prisons was 63,643 (4,397 of whom were women). Men are over-represented in the German prison population, as in other countries. Of all prisoners, 13,956 (896 of whom were women) were on remand, 48,204 (3,405 of whom were women) were convicted, and 1,483 (96 of whom were women) had another judicial status (Statistisches Bundesamt 2019; Walmsley 2018).

In Germany there is a special narcotics law (Betäubungsmittelgesetz, BtMG) as a part of the penal code. According to this law (article 35 of the BtMG), for those who are sentenced to imprisonment for not more than two years and who committed the offence on the basis of dependence of narcotics, suspended sentences are possible. This is based on the prerequisite that they have a confirmation of admission for special drug therapy. In March and August 2017, 226 prisoners (18 of whom were women) and 257 prisoners (9 of whom women) respectively were released from prison to start drug therapy based on article 35 of the BtMG (called 'therapy instead of punishment').

Drug use in German prisons

Using drugs in prison is widespread in Germany. Experts estimate a prevalence rate of 30–70% of drug use in the prison population (Jakob et al. 2012; Häßler 2017; Eder 2012). In Germany there was no official registration of drug users in prison until 2016. An earlier survey of prisoners showed that regarding opioids, 22.7% of prisoners used heroin inside and outside prison, 2.5% used heroin only inside, 12.5% used heroin only outside and 62.3% never used heroin (Eckert and Weilandt 2008). This survey also showed that 37.7% of the prison population were opioid users. In March 2016, the 16 ministries of justice started a prevalence study of data collection throughout Germany. The first results show a range of between 39% (Berlin) and 54% (Niedersachsen) of drug users among the prison population (Abraham 2017). No official report on the results has been published yet. At a later stage the data will show the number of prisoners who are substance users; substance misuse, released prisoners based on article 35 of the BtMG, and those in Opioid Substitution Treatment (OST) (Abraham 2017). Preliminary results show the following drug use prevalence when studying substance abuse in male sentenced prisoners (Berlin): the three most consumed substances besides nicotine and tobacco are cannabis (51%), cocaine (21%) and alcohol (18%). The three categories most frequently detected in relation to substance dependence were multiple substance use (40%), opioids (31%) and alcohol (20%). In contrast, among female prisoners the most frequently detected use related to drug dependence was the use of opioids (65%), followed by alcohol (18%) and multiple substance use (15%) (Abraham 2017).

Opioid use and injecting

A study by the Robert Koch Institute in Berlin, the German health monitoring institute, shows that 81% of opioid users in Germany had been in prison once in their lifetime. Some 32% had been incarcerated in the last 12 months, and the median time of imprisonment was three and a half years. It also shows that 30% of the people who were imprisoned used injectable drugs inside prison and 11% even started to inject drugs while in prison (Robert Koch Institut (RKI) 2016).

The nationwide data collection organised by the prison administrations mentioned above shows that 10–31% of male and 65–75% of female interviewees use opioids while in prison (depending on the type of detention) (Abraham 2017). It also reports that 10.7% of drug users were undertaking opioid substitution treatment (Abraham 2017). This clearly indicates that not all opioid users in prison receive OST therapy.

Overdose

In Germany the reported drug-induced mortality rates among adults were 22.2 deaths per million inhabitants in 2015. Opioids were involved in 80% of all toxicologically confirmed drug-induced deaths reported in this year, the majority of victims being male (84%) (EMCDDA 2017).

There is little data available for prison populations. Nevertheless, a study analysed drug-related deaths in Hamburg between 2003 and 2013, which detected a total of 643 cases (226 of which had a prison history). The study showed a higher risk of overdose after a prison experience, especially during the first 30 days after release. Table 1 shows the deaths in percentages in relation to the time from prison release to death. Some 13.3% died within the first 30 days after release (Burmester 2016).

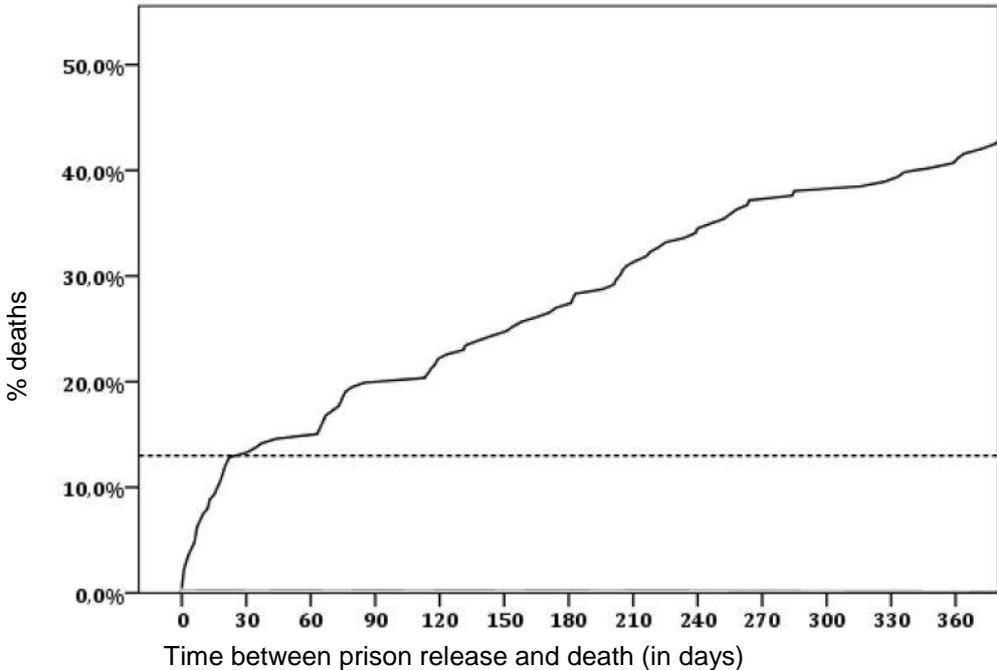


Table 1: Days between prison release and death (Burmester 2016)

Infectious diseases in prisons in Germany

Prisoners are a vulnerable group with regard to risk behaviour. They report harmful patterns of use such as injecting drugs, unsafe sexual activities, tattooing and piercing (Kamarulzaman et al. 2016). This increases the risks of transmitting infections to others. Studies have demonstrated a higher risk of blood-borne virus transmission in prison than in the community (Arain et al. 2014; Vescio et al. 2008). Higher rates of hepatitis C and other infectious diseases have been observed among prison populations than among the general population (Vescio et al. 2008; Michel et al. 2015). In European prisons the HCV prevalence in the prison population varied between 20 and 40% (Deutsche AIDS-Hilfe 2016). Also, HIV and TB are known to be highly prevalent in prison (Fazel und Baillargeon 2011).

There is no official monitoring of the HIV/HCV infection status of prisoners. A survey of over 1,500 prisoners found that nine out of ten prisoners are, according to their own statements, informed about their HIV- and HCV-infections. Of the surveyed individuals, 2% stated they were HIV-positive and 16.4% HCV-positive, and 9.1% (HIV) and 10.9% (HCV) said that they did not know their current status (Eckert und Weilandt 2008). One well-known risk for HIV and HCV infection in prison is intravenous drug use. Some 29.3% of prisoners injected drugs at least once during their time in prison, 21–24.9% of whom shared needles, syringes or other paraphernalia (Eckert und Weilandt 2008).

A recent study performed by the RKI shows that the risk of HCV among people who inject drugs (PWID) is higher for those who have experience of prison than for those who have never spent time in prison. The risks get higher with increasing duration and frequency of imprisonment. The study detected a 3.8-times higher risk of being HCV-positive among PWIDs with longer and higher frequency imprisonment (Robert Koch Institut (RKI) 2016, 2016).

HIV and HCV testing in prison settings is not widespread, but PWIDs were tested for HIV more frequently (23%) than HCV (8%) in the prison setting (Robert Koch Institut (RKI) 2016).

Prisons can play an important role in promoting public health. Therefore, it is important to invest in harm reduction for drug injecting prisoners. It can help for detecting, vaccinating and treating infectious diseases and offers a package of prevention responses such as free and voluntary testing for infectious diseases, distribution of condoms and sterile injecting equipment, infectious diseases treatment, vaccinations, health education, and information about infections and path of infection. Also the lack of continuity of opioid substitution treatment (OST) could be a risk for PWIDs, in terms of those who were in OST before imprisonment and do not receive OST in prison and vice versa. Both situations can lead to relapses into opioid use and facilitate risk behaviours such as high dose consumption of substances right after release, and drug use in prison settings without having the possibility to access harm reduction services (sharing needles and syringes) (Eckert und Weilandt 2008).

Care and support in German prisons

In general, according to the International Covenant on Economic, Social and Cultural Rights, everyone (including prisoners) have the right to 'the enjoyment of the highest attainable standard of physical and mental health' (ICESCR, Article 12).

In addition, according to the German penal system law, 'The physical and mental health of the prisoner has to be ensured. ...'¹ (StVollzG, Article 56). The articles in the 16 different penal system laws, regarding health, psychological and social care, differ little from each other. However, there is one main difference between care in the community and in penal institutions: the lack of free choice of a medical practitioner/psychologist/social worker. Apart from a medical service, prisons usually get offered different kinds of counselling and care services. Psychologists are asked to provide expertise regarding different types of offences and have to offer group or individual therapy, as well as psychological counselling. Social services provided in prisons includes social workers, social pedagogues, and debt and drug counsellors. Teachers only work in some prisons, and particularly in prisons for juveniles and in the educational facilities of prisons. Tasks that cannot sufficiently be performed by prison personnel can be assigned to external services. External drug and HIV/AIDS services in particular offer counselling and care services for prisoners (Taylor-Schultz 2007; Pohl 2013).

As a consequence of different regulations in the federal states, the scope and scale of health care, and social and drug services provision in prisons are very heterogeneous and differ significantly. One example of this diversified approach is prison-based needle and syringe programmes (PNSP) and OST. Only one prison-based needle and syringe programme (PNSP) exists in a women's prison in Berlin (JVA für Frauen in Berlin-Lichtenberg; this therefore relates to 1 out of 181 prisons) and while OST is available in most federal states, some (e.g. Bavaria) regularly discontinue and interrupt OST once people are incarcerated or only provide OST as a detoxification method, and not as a maintenance therapy (Stöver and Michels 2010). In general, one could claim that German prisons focus heavily (yet chronically fruitlessly) on reducing the supply of drugs instead of developing comprehensive strategies regarding demand and harm reduction (Neubacher et al. 2017).

Medical care

In general

In general, medical practitioners in German prisons are employed full-time. However, it is difficult to find appropriate personnel due to the working conditions and lack of career opportunities. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) regularly reports several shortcomings regarding the provision of medical care in prisons (CPT 2012).

¹ Translated from German : 'Für die körperliche und geistige Gesundheit des Gefangenen ist zu sorgen' (Article 56 (1) StVollzG).

In Germany, the supervisory authority of medical care inside prisons rests with the Ministry of Justice of every federal state (Hempel 2006). The health care of prisoners is regulated in all federal states in their penal code (Deutscher Bundestag 2016b). This is why some regulations are different from state to state. This is relevant for the description of the status of the German penal system law in general.

The responsible individuals for health care in prison, in practice, are nurses and doctors. In every prison there is a medical unit that provides at least basic health care. In case of acute or serious illness, the prisoner can be transported either to a prison hospital or to a hospital outside prison (Article 65 StVollzG). According to German penal law, prisoners should have a medical examination immediately after incarceration² (Article 5 Abs. 3 StVollzG). During their imprisonment 'prisoners are entitled to medical treatment when it is necessary to detect, cure, prevent their aggravation, or relieve illness.

² Translated from German: 'Nach der Aufnahme wird der Gefangene alsbald ärztlich untersucht [...]' (Article 5 Abs 3 StVollzG).

The treatment includes in particular:

1. medical treatment,
2. dental treatment including the restoration of dentures,
3. supply of medicines, dressings, remedies and aids,
4. medical and supplementary services for rehabilitation and stress testing and work therapy, as far as the interests of enforcement do not oppose³ (§58 StVollzG).

This part is inspired by Article 27 Volume V of the German Social Insurance Code (Article 27 SGB V), which includes in addition psychotherapy as a medical and psychotherapeutic treatment, dental restoration including dental crowns and superstructures, home nursing and home help, and hospital treatment (Article 27 SGB V).

In general 'a prisoner is not entitled to an implementation of a specific treatment requested by himself. The prison doctor decides at his own discretion whether a treatment is necessary or not'⁴ (Deutscher Bundestag 2016a).

Opioid Substitution Therapy (OST)

To increase the likelihood of a good reintegration into the community, it is important that prisoners are supported and prepared for their release right from the start of their prison sentence. Prisoners with drug problems who have special health needs in particular require specific medical care and a multi-disciplinary approach (ECDC und EMCDDA 2011). Studies on OST in prison settings demonstrated that the use of OST as maintenance treatment in prisons can have similar benefits as in community settings (ECDC and EMCDDA 2011). It offers the opportunity to reduce illicit opioid use and (related) risk behaviour in prison and drug-related deaths. Moreover, the continuation of substitution maintenance treatment in prison increases the willingness to receive (OST) treatment after release, which can protect against a relapse in opioid use and future imprisonment (Stallwitz and Stöver 2007; Degenhardt et al. 2014).

In Germany, methadone, buprenorphine, buprenorphine with naloxone (Subuxone®), codeine, slow release morphine and diamorphine are the substances authorised for opioid substitution treatment (OST). In the community, OST is provided by general practitioners and specialised centres. Opioid-dependent individuals can get their daily dose of OST in a specialised centre, at a special medical practice or at a pharmacy (take-home programme).

OST is available in German prisons, although significant differences between the federal states do exist. According to the EMCDDA, German prisons provided 'medication-assisted short-term detoxification, short-term detoxification without medication, abstinence-based treatment with

3 Translated from German: 'Gefangene haben Anspruch auf Krankenbehandlung, wenn sie notwendig ist, um eine Krankheit zu erkennen, zu heilen, ihre Verschlimmerung zu verhüten oder Krankheitsbeschwerden zu lindern. Die Krankenbehandlung umfaßt insbesondere 1. ärztliche Behandlung, 2. zahnärztliche Behandlung einschließlich der Versorgung mit Zahnersatz, 3. Versorgung mit Arznei-, Verband-, Heil- und Hilfsmitteln, 4. medizinische und ergänzende Leistungen zur Rehabilitation sowie Belastungserprobung und Arbeitstherapie, soweit die Belange des Vollzuges dem nicht entgegenstehen' (Article 58 StVollzG).

4 Translated from German: 'ein Inhaftierter (hat) keinen Anspruch auf die Durchführung einer von ihm verlangten bestimmten Behandlungsmaßnahme. Ob eine Behandlung notwendig ist, entscheidet der Anstaltsarzt nach eigenem Ermessen' (Deutscher Bundestag 2016a).

psychosocial counselling, antagonist treatment and OST' in 2008. But in some federal states, OST has been available only to people in prison who had received it prior to their imprisonment. Only six federal states provided additional psychosocial counselling in every treatment case (EMCDDA 2017) and only three of the sixteen federal states have a defined action regulation for dealing with prisoners who use drugs. Examples of the significant heterogeneity in OST provision in German prisons are the following: in Lower Saxony, the basis for substitution treatment is a 2003 decree of the penal system, while in Baden-Württemberg it is regulated by an administrative regulation from 2002. Baden-Württemberg was the first state to allow the use of diamorphine for OST (in 2011) (Deutscher Bundestag 2016a). However, this is being applied only in very few cases (mainly as a continuation of treatment started in the community). North Rhine-Westphalia (NRW) only had a restricted OST regime in prisons until 2010. Following this date, NRW elaborated a comprehensive concept that meets the prerequisites and objectives of opioid substitution therapy and action requirements granted to the prison physicians (Deutscher Bundestag 2016a). As a result of the treatment requirements, the number of prisoners who received OST increased from 1,000 in 2011 to 1,300 in 2013, and more than 2,000 in 2018, which is more than the sum of OST coverage in all the fifteen other states (Deutscher Bundestag 2016a). Today in NRW, approximately 2,600 prisoners receive OST, which represents around two thirds of the number of all OSTs in German prisons.

Federal state	Year of evaluation	Number of prisoners in the reference year	Approximate number of people with opioid disorder in prison (reported number or 30% of total male prisoners)	People with opioid use disorder in prison who receive OST N (approx. %): Coverage rate
Bremen	2016/2017	560	170	100 (59%)
North Rhine-Westphalia	2018	16,219	3,660	2,048 (56%)
Baden-Württemberg	2016/2017	6,788	2,000	800 (40%)
Schleswig-Holstein	2016/2017	1,150	350	122 (35%)
Hamburg	2016/2017	1,681	500	150 (30%)
Hesse	2016/2017	4,608	1,400	318 (23%)
Berlin	2018	3,368	1,010	236 (23%)
Saxony-Anhalt	2016/2017	1,641	490	40 (8%)
Rhineland-Palatinate	2016/2017	3,115	900	60 (7%)
Thuringia	2016/2017	1,532	460	31 (7%)
Bavaria	2018	11,389	3,420	239 (7%)
Saarland	2016/2017	787	240	2 (<1%)
Saxony	2016/2017	3,484	1,050	1 (<1%)

Table 2: People with opioid use disorder living in prison who receive OST. Overview of the individual German federal states (Schneider et al. (2018); Lehmann et al. (2018) World Prison Brief data, (2018) and 'Deutsche AIDS-Hilfe'). Source: Stöver et al., 2019

The following case shows that even if most of the states provide OST in prison nowadays, there is still a lack of medical care and OST in some states.

In 2016 an ex-prisoner won a case at the European Court of Human Rights (ECHR) against Germany ('WENNER vs. GERMANY'; (Europäischer Gerichtshof für Menschenrechte, Urteil vom 01.09.2016). Wenner did not receive OST in prison in Bavaria during his imprisonment, although he had been using heroin since 1975 and has been in OST outside prison. The ECHR judges ruled unanimously that this case was a violation of Article 3 of the European Convention on Human Rights (ECHR). This case shows the differences between the German federal states. The Federal German Government was asked by different politicians if the case 'WENNER vs. GERMANY' might have consequences regarding OST in prisons. The government answered: 'The penal system, including the health care of opiate-dependent prisoners, is, moreover, the responsibility of the states (Article 70 of the Basic Law). Legislative or sub-legislative initiatives and other measures in this area are therefore not considered by the Federal Government for constitutional reasons'⁵ (Deutscher Bundestag 2016b).

Psychosocial support

Besides the health care services, prison social services provide support to prisoners. Within the first week following entry, the social worker has to schedule a conversation with the prisoner, although in case of acute problems the conversation should take place as soon as possible (Freistaat Sachsen 2008). This is known as a 'Zugangsgespräch' (access conversation). During this meeting, the social worker should provide the prisoner with basic information about their rights and obligations, the rules in prison, availability of medical, juridical, social, psychological and family services, as well as the availability of a moral counsellor. In addition, the social worker will perform a 'Bedarfsklärung' (clarification of requirements), focused on drug use and psychological symptoms such as suicidal tendencies, but also on housing and the prisoner's relations to their family, partners and friends (Freistaat Sachsen 2008). If the social worker assesses the situation as problematic, he/she will contact the psychological service. The social worker is merely responsible for risk assessment, prevention of recidivism and reintegration, being responsible for risk assessment and giving advice as experts. They normally do not deal with drug problems directly, although they also have a role as helper and have to give advice in order to perform external drug counselling. This dual role (support and expert role) sometimes creates tensions, and therefore specific social services for prisoners who use drugs are delivered by professionals that are part of the prison health team, but also by external services (or external drug counselling in some states). The advantages of working together with external drug service providers is that prisoners can benefit from a first contact with community drug treatment services. This can be helpful for establishing continuous care after release.

The psychological service providers will participate in providing treatment and care for the prisoners (e.g. during the initial examination and integration plan). They will also elaborate psychological reports for prisoners sentenced for violent and sexual offences or drug offences, as well as imminently

⁵ Translated from German 'Der Justizvollzug einschließlich der gesundheitlichen Versorgung von opiatabhängigen Strafgefangenen liegt im Übrigen in der Zuständigkeit der Länder (Artikel 70 des Grundgesetzes). Gesetzgeberische oder untergesetzliche Initiativen und sonstige Maßnahmen auf diesem Gebiet kommen deshalb seitens der Bundesregierung schon aus verfassungsrechtlichen Gründen nicht in Betracht.'

loosening of prison rules. They are also responsible for prisoners who are violent and/or suicidal in case of specific incidents, and can provide individual and group therapy (Knorr et al. 2014).

Although the objective is to offer drug services in prison which are similar to services in the community (with the focus on prevention, harm reduction, treatment and enforcement), in practice interventions in prison are far from being similar to those outside. The principle of equivalence is hardly implemented and the availability of drug-related health services in prison is, in some states, inadequate. A comprehensive, coherent and qualitative drug treatment strategy is lacking in German prisons.

Harm-reduction measures

Besides medical and (psycho)social support, some harm-reduction initiatives are available in German prisons. Below, an overview of those initiatives is given.

Clean injecting equipment

There is only one needle and syringe programme available in German prisons, in Berlin-Lichtenberg (EMCDDA 2017). Because of the lack of clean injecting equipment, sharing of needles is more likely.

Contraceptives

To prevent the dispersion of infectious diseases among prisoners, condoms and lubricants are available in some prisons, but access is not guaranteed in all. In Duisburg, condoms and information about different harm reduction methods are freely available for all prisoners (Deutsche AIDS-Hilfe 2017). In Bavaria condoms can only be obtained via a medical doctor.

In 2006, a survey was conducted by the AIDS & Prison Working Group to evaluate the status of prison condom programmes in 2003 and 2005 within Bavarian prisons. At that time, approximately 13,000 people were held in Bavarian prisons. Twenty out of 32 Bavarian prisons with around 7,900 prisoners (including 105 women) responded to the questions. The results revealed that 40, 45 and 43 condoms were distributed among 7,900 prisoners in 2003, 2004 and 2005, respectively. Prison health care workers were asked about the prevalence of STIs, although most respondents answered 'I don't know'. However, it was estimated that 869 people in 20 surveyed prisons (out of 7,900 total prisoners) engaged in sexual activity each year. The researchers assumed that each sexually active prisoner has sex five times per year, and concluded that 4,302 condoms should have been distributed in these prisons.

Evidence shows that condoms are available in Bavarian prisons on demand. This method of condom distribution is somewhat effective, since many prisoners might hesitate to ask for a condom due to stigma. However, the number of distributed condoms, according to an outdated survey, in 20 Bavarian prisons (around 40 per year) is cause for concern. No accurate data is available on the prevalence of the major infectious diseases and STIs in German prisons. These issues highlight the need for updated statistics on condom provision and STIs in German prisons.

Piercing and tattooing

Interventions to support the prevention of transmission of infections through tattooing and piercing are rarely implemented in German prisons. There was a pilot project conducted by Deutsche AIDS-Hilfe in a prison in Cologne (Deutsche AIDS-Hilfe e.V. 2008), which implemented courses for prisoners and prison staff.

Preparations for release

Continuity of care in particular seems important for drug users. Several studies have shown that access to aftercare/continuity of care is essential for drug-using prisoners in order to achieve lower rates of drug relapse and criminal recidivism after release (Inciardi et al., 1997; Zurhold and Haasen, 2005). Prison settings can be a safe place for prisoners, and less healthy and safe habits may arise after release (Stevens et al., 2010). In Germany the federal states are responsible for preparation for release, and therefore it differs from state to state. In practice, this means that social services inside prison are generally responsible for preparations regarding release. In some states there are specific regulations, such as in Hesse (Bundesland Hessen 13.10.2011). Here, there is an agreement between all agencies involved in the justice and support system. The main installations are 'transition management' and 'discharge management'. Transition management is organised through assistance for offenders (external), while discharge management is organised by probationary services. People who leave prison on probation can be prepared by discharge management, while others may be supported by transition management. In any case social services inside prison are responsible for referring prisoners to these services.

2.2.4 Situation in Portugal

Prison landscape in Portugal

Portugal has a high occupancy rate in prisons and many experience overcrowding. On 31 December 2017, there was a total of 13,440 people in Portuguese prisons. The number of preventive detentions was 2,105 (15.3%) and the number of convicts was 11,335 (84.3%). In terms of gender, 93.6% were men and 6.4% women. This prison population has a ratio of 100,000 inhabitants to 130 prisoners (RASI, 2017: 156). Regarding the type of offences, crimes against property (29.3%), crimes against people (26.0%) and drug-related crimes (17.2%) continue to predominate (RASI, 2017: 157). Despite the decreasing trend in the number of people serving sentences for crimes related to drug trafficking, they still represented 17.2% of the prison population in 2017. However, one must not forget that many crimes against property (29.3%) are indirectly associated with drug use/trafficking. Other factors, such as the level of education, also reveal a standardising tendency among Portuguese prisoners, in that this population characterised by a low educational level – which is closely linked to disadvantaged social backgrounds. Consequently, poor school qualifications can lead to low-paid professions (which are socially and economically unsatisfactory) and to complicated life trajectories – in which risky behaviours leading to dependencies, delinquency and crime (and eventually, to imprisonment) are perceived as solutions or ways to compensate the aforementioned issues (Torres et al., 2016: 54).

Drug use in Portuguese prisons

Data from INCAMP 2014 indicates that 69.1% of prisoners stated that they had already used an illegal substance at least once in their lifetime, while among the population up to 64 years of age, this value represents 9.5% (Ferry, Vital and Urban, 2014: 100). In 2014, the number of male prisoners using drugs reached its highest, indicating an increase of 5% over 2007. During the same year, the number of younger users continued to grow (80%) and the percentage of older drug users decreased: from 51.1% to 40.1%. (Torres et al., 2016: 163–163). In 2014, the percentage of cannabis use (at least once in a lifetime) among drug users was 80.2%, which is significantly higher than the rate among all prisoners (55.5%). The decrease in heroin use already verified in 2007 (from 72.9% in 2001 to 54.4% in 2007 and to 38.1% in 2014) was also confirmed by this data. In terms of cocaine use, the trend is somehow similar: among the subset of individuals who reported having used drugs in their lifetime, data from 2001 shows that 70.9% reported cocaine use – dropping to 63.5% in 2007 and to 56.2% in 2014. Data also shows that in 2014 the rate of cocaine use was higher than heroin use, contrary to the data from 2001. All interviewed prisoners also observed an increase in ecstasy consumption, from 17% in 2001 to 19.9% in 2007, and 19.1% in 2014. LSD and magic mushroom use accounted for 15.4% and 11.7% (respectively) of the prison population surveyed, revealing percentages well above the declarations of use of the said substances in free contexts, thus reinforcing the specificities of this population (Torres et al., 2016: 166–168). In the same study, 41.7% of the participants reported being under the influence of drugs and 27.7% under the influence of alcoholic beverages when they committed the crime(s) that led to their arrest (Torres et al., 2016: 152). This study also concludes that the population of prisoners has a much higher number of lifetime consumption in all age groups and related to all substances. The discrepancy in all categories reinforces the specificity of the prison population, with more intense dynamics of drug use (Torres et al., 2016: 174). Another indicator of drug use in prisons is the confiscations made by prison guards. In 2017, the volume of hashish and cocaine appropriations increased by 92% and 36%, respectively, when compared to 2016; however, the percentage of heroin confiscated decreased by 36%. Prison guards also seized 61 syringes and 127 needles (RASI, 2017: 134).

The available data clearly demonstrate that contact and use of illicit drugs is much more common among prisoners than among the general population aged 15–64. Cannabis is the most commonly used illicit drug among prisoners, with 12–70% of prisoners claiming to have used at some time in their lives (Torres et al., 2016: 26). Moreover, in the study presented by Torres et al., declarations of ceasing drug use in the prison environment have decreased, meaning that the prison population seems to have more trouble with this process – especially when compared to 2007. In addition, it should be noted that about 40.8% of respondents do not intend to stop using drugs, which raises important questions about strategies for health promotion and treatment of dependencies (Torres et al., 2016: 29). Thus, the existence and continuity of support programmes to end dependency plays a crucial role in prison, namely in the development of ways to stop substance use.

Infectious diseases in Portuguese prisons

In addition to substance use, there are often certain and specific health problems among people who use drugs. The clinical record of the prison population frequently presents several physical health problems (HIV/AIDS, hepatitis, tuberculosis, etc.) as well as mental health problems (personality disorders, antisocial behaviour, depression, post-traumatic stress, psychoses and dependence on alcohol and illicit psychoactive substances). The living and hygienic conditions in prison, together with prisoners' risky behaviours, make them particularly vulnerable to the spreading of infectious diseases.

With regard to the prevalence of HIV infections, especially among people who inject drugs, European data reveals a social problem with more significant contours in prison. In fact, the available information (EMCDDA, 2012) indicates a high prevalence of HIV among the said target population both in and outside of prison. Moreover, the greater the proportion of prisoners who inject or have injected drugs, the higher the prevalence of HIV, especially when compared to the general population (Torres et al., 2016: 31). Data collected in 15 European countries since 2005 shows that the prevalence of HIV among individuals who have been arrested is twice as high as among those who have never been in prison. Also in the case of the hepatitis C virus, the prevalence was 50% higher among prisoners who inject drugs, especially when compared to people from the general population (Torres et al., 2016: 31). With regard to tuberculosis, prisons usually have higher rates, especially among people from marginalised groups, e.g. people who use drugs. Similarly to HIV and HV, the prevalence of tuberculosis is much higher among prisoners (Aerts et al., 2006). According to Baussano et al. (2010), the risk of becoming infected with tuberculosis in prison contexts is at least ten times higher than it is in the general population (Torres et al., 2016: 31).

Regarding risk behaviours in Portuguese prisons, there is still a lot of progress to be made. In the 2014 INCAMP data, there was an increase in the number of respondents who stated that they 'never' use condoms in the context of conjugal visits and/or other sexual contexts (Torres et al., 2016: 86). Since sexual practices are a taboo subject in prison environments, it is hard to carry out a diagnosis and it is not possible to accurately assess the degree of intensity of possible risk behaviours. It is known, however, that condoms provided by clinical services are requested only sporadically and access to them does not ensure the conditions of anonymity and confidentiality recommended by the National Plan of Action to Eliminate the Transmission of Infectious Diseases in Prisons. Also with regard to access to sterile material, a lack of knowledge seems to be common. With the exception of access to disinfectants, where only 22.8% admit to not knowing about this resource, 45.2% of the prison population does not know if they have access to syringes/needles, 46.9% ignore access to other sterilised material, and 36.5% are not aware of access to free condoms. The percentage of prisoners who claims to have access to disinfectant accounts for 53.4%, while for condoms this proportion is 31.5%. The proportion of prisoners stating to have access to syringes/needles is still very low (8.6%) (INCAMP, 2016: 79).

Mental health in Portuguese prisons

With regard to mental health, when compared to the general population up to 64 years of age, prisoners have more problematic mental health profiles, while also experiencing poorer social and physical well-being (Torres et al., 2016: 30). According to a study with 23,000 prisoners from 12 countries around the world, more than 65% of the respondents revealed mental disorders, ranging from personality disorder to profound depression and psychosis, increasing the risk of suicide (Fazel and Danesh, 2002; Birchard, 2001, Rouillon et al., 2007, Darke and Ross, 2002). In many cases, these personality disorders are caused by drug use (Arroyo and Ortega, 2012) in (Torres et al., 2016: 30).

According to the WHO publication 'Health in prisons: a WHO guide to the essentials in prison health' (2007), of the nine million people imprisoned worldwide, about half experience personality disorders, while one million prisoners suffer from serious mental disorders such as psychosis or depression. Almost all prisoners experience depression or stress symptoms. In addition, every year, thousands of them commit suicide during the period of detention.

In some cases, the incidence of mental health issues in prison contexts is caused by the confinement of individuals who already suffer from psychological conditions, which are often never diagnosed or followed up; in other cases, some develop mental problems during the period of detention, due to the factors inherent to the context of imprisonment.

Mental health is a major well-being issue in the Portuguese prison context. In fact, there are many problematic aspects associated with the psychological and emotional structure of the prison population – the most common solution being the prescription of psychotropic medication by family physicians. In addition, initial and subsequent screening for mental health problems is not performed and when the prisoners require specialised treatment in psychiatry, the answer is often the psychiatry unit of the local hospital, which usually has a considerably long waiting list for consultation and treatment.

In order to reduce the risk of mental health conditions and to promote mental health, the prison authorities, the health authorities and prison practitioners ought to work together, bearing in mind that the prevention and health care measures provided should be equivalent to those provided to the community in general.

Care and support in Portuguese prisons

In Portuguese prisons, screening is carried out on all individuals upon their arrest, including HIV, hepatitis and tuberculosis tests. In addition, those who are monitored by drug treatment services (IRC) also have regular tests for HIV and hepatitis detection, as well as drug screening tests.

In the study on addictive behaviour in prisons, where prisoners were questioned about the possibility of accessing services and programmes addressing infectious diseases and clinical screening, the percentage of positive replies was significantly high (81.4%), followed by responses regarding treatment for HIV/AIDS (67%), treatment for hepatitis C (61.8%) and finally hepatitis B vaccination (58.1%). Despite this, in terms of hepatitis B vaccination there was a significant number of 'no access'

declarations (32.5%). Although there is still some lack of knowledge, 67.1% of respondents said they have used clinical and screening tests, 39.9% said they have access to HIV/AIDS treatment programmes, 38.1% had access to hepatitis C treatment programmes, and 36% were vaccinated for hepatitis B (Torres et al., 2016: 79).

Although the treatment for HIV and hepatitis C is free, during the period of APDES intervention, the team detected several cases of prisoners who abandoned hepatitis C and HIV treatment – only returning to treatment after much effort put in by prison staff, APDES and peer educators. This shows that the access to treatment for these patients is not sufficient and that close and careful monitoring is necessary – with the collaboration of the various services operating in prison.

Regarding opioid substitution treatment, 48.1% stated that they had access to them, while 15.8% considered that they did not have access and 2.8% believed that they were not available in the prison they were in. More important, however, is that 33.3% of prisoners are unaware of whether they have access to the said treatment. As for other pharmacological programmes for drug use, the number of those who are unaware of its existence is even more significant (43.4%); 28.3% of the prison population admitted to having access to such programmes, 21.2% considered that they did not have access, and some (7.1%) said that this type of programme is not available at the facilities they were in (Torres et al., 2016: 78).

As for other drug treatment programmes (such as drug-free wings, self-help groups and psychological support), 34% of the prison population did not know if they had access, 30.6% of prisoners considered that they had access to them, 22.3% said they did not have access, and 13.1% of the respondents said that the prison they were in did not have this type of service. Finally, 50.8% said they did not know about overdose prevention programmes, while 24.6% said they did not have access to these programmes, compared with 14.4% who said they had access to them and 10.2% who considered that overdose prevention actions did not exist in the prison facilities they were in. The authors emphasise that these results show that there is still a lot to cover in terms of intervention: sometimes due to the lack of effective offers of a certain type of programme, and sometimes due to the need to implement or expand them, thus making it available to the prison population (Torres et al., 2016: 78). According to this study, 10% of prisoners surveyed had already suffered an overdose out of prison. Hence, it is important to address the prevention of overdoses and the time of release beforehand.

The data from this research also shows that prisoners with a history of psychoactive substance misuse (namely opioids) present a high risk of overdose, especially during the period following release. The risk of relapsing and the low tolerance to heroin and other opioids are some of the mentioned factors. In fact, and despite free access to OST (both in and outside prison), it is vital to promote monitoring and follow-up actions upon release, such as the distribution of naloxone kits, which is one of the preferred tools to prevent overdoses. In terms of the continuity of treatment, individuals can resort to Centro de Respostas Integradas (CRI), which is prepared to serve and monitor drug users/former drug users and is able to work with other services. For instance, prisoners serving their sentence in a certain prison can resort to the local CRI during their incarceration and then, upon their release, they can be transferred to a CRI in any other city.

Despite the increasing number of health care and treatment services available to prisoners in Portugal, there is still a long way to go. It is crucial to implement alternative and complementary services that can complement those that already exist, in order to improve the quality and coverage of interventions in such an important area as health care in prisons and the continuity of care.#

3 Gaps between national legislation and practice

National legislation and policies regarding health insurance, social services and access to care before, during and after a prison stay

A questionnaire (see appendix) regarding official legislation and policies on health insurance, social services and access to treatments for drug users in the community, inside prison and after release was submitted to each participating country through the respective research staff. Key individuals responding to the questionnaires* were also asked to report any gaps they could identify in practice between these legislation/policies and their implementation. The objective of this questionnaire was to help to disentangle the respective legislation weaknesses or poor legislation implementation, and to highlight the obstacles observed in the continuity of care and social services inside prison and after release.

Summary of responses to the questionnaire

Health Insurance and access to care for drug users in the community

OST is generally cost-free for drug users in the community in the four countries, through a special health insurance status in France and Germany, the national health service in Portugal, and by local agreement (with annual revision) in Belgium, where most of the time part of the treatment has to be paid by the patient. ART for HIV and anti-HCV treatment are free, and access to psychosocial services (particularly in medico-social specialised settings in France, and on a case-by case agreement in Belgium) is also free of charge. An exception is for drug users without documentation in France and Germany, where access to care is not always possible (except in France in the medico-social specialised settings where OST is free regardless of the status of the drug user). Take-home naloxone for OD prevention is not available in Belgium and Portugal, is available in a very limited number of settings in Germany, and became available in all specialised settings in France only very recently.

Health insurance and access to care for drug users inside prison

The organisation of care inside prison is the responsibility of the Ministry of Justice in Germany and Belgium, the Ministry of Health in France, and the Ministry of Health and the Ministry of Justice jointly in Portugal.

HIV, HCV and addiction medicine consultations are available in most prisons in the four countries (less in France and Belgium for addiction medicine consultations and for HIV and HCV in Portugal and Belgium). If screening for HIV, HCV, mental health disorders and addictive behaviours is

systematically proposed (except in Belgium), it is not repeated during incarceration except in Portugal, where it is repeated annually during incarceration and upon release. Psychosocial interventions, when available, are less formalised than in the community, with significant heterogeneity within each country.

In the four countries, health fees are fully covered (by the federal state in Germany, the Ministry of Justice in Belgium and France, and national health service as per within the community in Portugal).

In France, Belgium and Portugal, the principle of equivalence with the community is respected in terms of access to OST, ART for HIV, anti-HCV treatments and take-home naloxone upon release (take-home naloxone is not available in prison or in the community in Belgium and Portugal), but with limitations. In Belgium, for example, at least in Wallonia, prisoners awaiting judgement or with short sentences are usually excluded from anti-HCV treatment.

In Germany, OST is not available in some federal states and is provided to approximately 2,400 prisoners from around 20,000–22,000 who are presumed to be in need of OST (thus a coverage rate of approximately 10% compared to about 40–59% in the community). ART is provided to all prisoners who are in need of it. Anti-HCV treatment is very rare, often available only in prison hospitals, with a total of only around 100–200 prisoners treated annually (compared to around 9,000 prisoners who were tested positive for HCV) (Knorr, 2018 personal communication; Stöver et al., 2018). Naloxone is not available in the prison setting but is offered in some specialised settings in the community.

Regarding psychosocial interventions for drug users, the principle of equivalence is respected in Germany and Portugal but not in Belgium and France (where staff are not available in most prisons).

Health insurance and access to care after release

Recently-released prisoners have no special status regarding health insurance upon release (meaning that they go back to the usual community health insurance system, with its limitations and specificity for drug users, as described in the first part of this summary) except for in France, where ex-prisoners get the benefit of the health insurance for one year (but a procedure is necessary to obtain the full health insurance coverage), except for those without documentation.

- There is no delay to free access to the usual treatments in Portugal (the same national health service coverage applies inside prison, except if there is a waiting list in the drug addiction centre).
- In Belgium, ‘proof of detention’ that in theory gives immediate access to health insurance is provided upon release but covers only part of the costs of treatment. A local agreement is still necessary for full coverage of health insurance costs. In practice, in some municipalities, it is also necessary for ex-prisoners to prove they are still eligible for health insurance for some procedures lasting up to 30 days. OST is freely accessible in a limited number of specialised centres, creating a gap for other drug users.

- In Germany, ex-prisoners have to face a delay of nearly 30 days between prison release and gaining access to full coverage of the cost of the treatments, which relates to a major gap in the continuity of care.
- In France, whereas in theory prisoners have immediate access to the health insurance after release, the requested 'certificate of incarceration' is not always provided upon release and there is a delay (up to one month) between release and gaining access to the full coverage of the costs of the treatments. Ex-prisoners have the alternative to go to a medico-social specialised setting where OST is cost-free, whatever the health insurance status. Nevertheless, this also represents a gap for continuity of care for many prisoners.

A prescription and treatment for few days upon release can be provided in France, Belgium and Portugal, except for naloxone in Belgium and Portugal.

In daily practice, each country, except Portugal, reports some obstacles to ensuring continuity of care, particularly:

- In Germany, barriers to getting the certificate necessary to receive health insurance, to getting a medical prescription at release, to receiving OST for few days and to getting the addresses of professionals in the community or to being in contact upon release; ART, anti-HCV treatment for few days and naloxone are often not provided upon release;
- In France, barriers to getting the certificate necessary to receive health insurance, to getting a medical prescription upon release, to receiving treatment (except ART) for few days after release, to being in contact with professionals in the community before release;
- In Belgium, barriers to being in contact with professionals in the community before release, to getting health insurance, receiving a prescription or a treatment at release, with discrepancies between Flanders, Wallonia and the Brussels area.

Regarding the involvement of professionals or NGOs to specifically support the continuity of care at release:

- This service is provided for some prisoners in some federal states in Germany with professionals from the Ministry of Justice.
- Since 2014 in France, a social worker from a specialised medico-social setting in the community is dedicated to the continuity of care for prisoners with addictive behaviour.
- In Portugal, prisoners with an addictive behaviour are referred to the specialised centre they were in contact with previously, or with a centre that is able to start a follow-up later in the community; continuity of care is then organised inside prison with professionals from these centres.
- No specific interventions were identified in Belgium, except one project 'Bridges Inside/Outside' that was described above.

Limitations

Due to a generalised heterogeneity regarding health policy implementation in prisons in each country, the current picture probably does not precisely reflect the real situation in many prisons, but just gives

a global overview of what should be authorised or available. Data were cross-checked and additional key individuals were interviewed when necessary, but particular situations or specific aspects may have been missed.

Adherence to international recommendations

International recommendations regarding health care policy in prison settings are mainly based on the respect of a principle of equivalence with the community for prevention and care. In 2013, the WHO and UNODC also defined 15 key interventions to prevent HIV in prison settings (*'HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions'*, UNODC, Vienna, 2013). Considering the specific situation of incarcerated drug users, a clear gap still exists regarding prevention and care between the international recommendations and the national policies and their implementation. Needle and syringe exchange programmes, for example, are available in only one prison in Germany (Berlin) and not available at all in the other countries. In theory, continuity of care is possible for OST (except in some federal states in Germany), and ART for HIV and anti-HCV treatment in the four countries at prison entry and subsequent care is totally free inside prison. Specialised care (drug treatment, HIV, HCV, mental health) is most often limited, according to the availability of specialised consultations. Except for Belgium, screening is systematically proposed for drug use problems, HIV, HCV and mental health but is not repeated during incarceration. Regarding access to care inside prison, some clear limitations to the principle of equivalence with the community are noted. Upon release, a gap in the continuity of care due to health insurance access procedures (with the exception of Portugal), but also conditions of release (provision of the treatment for few days, prescription upon release, links with the community) are evident everywhere with an important heterogeneity in Belgium and Germany. Access to take-home naloxone upon release is possible only in France but is not yet fully implemented. HIV care adheres better to the principle of equivalence with the community. In federal countries, the heterogeneity is evident and reflects the political choices made at the federal state level. For example, in Germany, the availability of OST inside prisons depends on federal decisions. In Belgium, the key individuals interviewed described a very different picture in Flanders, Wallonia and the Brussels area, which is presumably more related to each federal commitment than to specific federal policy or regulation. Many limitations to policy implementation are also related to prison overpopulation, insufficient means or vacant jobs. In terms of continuity of care, Portugal seems to have the globally most 'fluent' organisation (except for naloxone, which is still not available), probably due to the fact that the health insurance system inside and outside prison is the same, as well as the context of drug decriminalisation.

4 Methodology

4.1 Research methods

This section presents the methodology of the multi-country qualitative study looking at issues related to risk behaviour in connection with drug use upon release, prisoners' and drug users' perspectives,

personal experiences of incarceration, individual risk reduction mechanisms, knowledge of risks and overdose prevention, and strategies to avoid risks following release.

4.1.1 Participants

The study sample consisted of 67 prisoners (including participants of the five focus groups) and 37 ex-prisoners. In order to be eligible for the study, prisoners had to meet the following criteria: being a recent and/or regular user of illegal drugs (other than cannabis), having had at least one prison sentence, speaking the language of each country sufficiently to do an interview, and being available and willing to participate in an interview or a focus group. Ex-prisoners were eligible if they had served at least one prison sentence, the last one of which was a maximum of five months previously, were recent and/or regular users of illegal drugs (other than cannabis), spoke enough Dutch, German, French or Portuguese according to the native language in each country to participate in the interview, and were available and willing to participate in the study. All participants thus had already experienced at least one period of detention and release (except one), which gave them the necessary knowledge and experience to report on the risks of drug use in prison and upon release.

The sample consists of 104 (ex-) prisoners in total, of whom 16 were female and 88 male. The female interviewees were only interviewed in France and Germany, while researchers in Portugal and Belgium did not reach any female (ex-) prisoners. The average age of the participants was 36.7 years (range 19–54 years). The interviewed prisoners and ex-prisoners had already served 5.3 (range 1–35) detention periods and had spent a total of 86.4 months (range 1–336) in prison on average. The former prisoners had been out of prison for an average of about 2.2 months at the time of the interview.

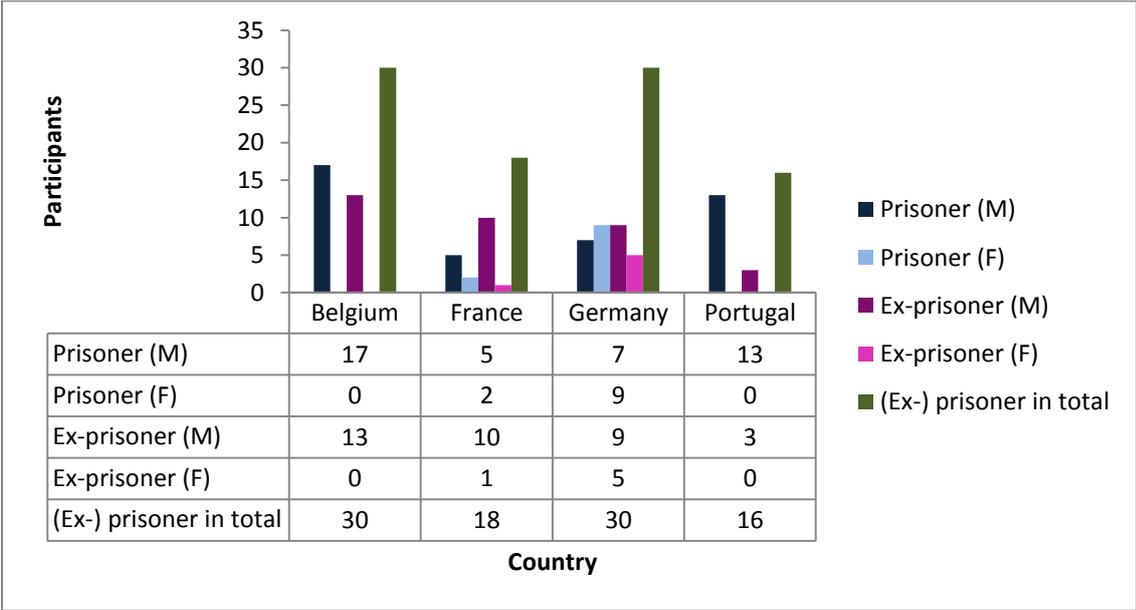


Table 3: Participants in each country

The primary drugs used by most respondents were cocaine and heroin, often in combination with other drugs like crack, speed, ecstasy and cannabis.

4.1.2 Procedure and data collection

The research took place between May 2017 and August 2018 in six prisons in total (two in Germany, two in Belgium, one in France and one in Portugal) and several organisations such as drug treatment centres (inpatient and outpatient), low-threshold drug centres and substitution ambulances in the community. The research continued until as many respondents (prisoners and ex-prisoners) as possible were enlisted. The planned number of 30 interviewees in each country was not achieved in Portugal and France because of several challenges (see also limitations and challenges).

The recruitment of (ex-) prisoners differed between the countries.

Prisoners were recruited through prisons after the researchers received authorisation for interviews in prisons. While researchers in Belgium had direct access to prisoners to inform them about the study, those in France, Portugal and Germany were reliant on professionals inside to approach suitable interviewees. In all cases the interviewees were informed in different ways (personal approach or via a flyer) about the study and that participation in the study was completely voluntary. If they were interested, the interviews took place immediately or at a fixed date in a room without the presence of staff, video or any other control measure.

Former prisoners were recruited through drug treatment services, residential treatment centres and harm-reduction services. Organisations were approached via email, telephone and personal contacts to help with the recruitment of recently-released prisoners (up to a maximum of five months). In some cases, flyers were distributed in these organisations, so that interested ex-prisoners could contact the researcher or the organisation's social workers if they wished to participate in the study.

In all cases before the start of the interview, the informed consent form was explained. Individuals were informed that there was no obligation to answer all questions and that participation could be stopped at any time during the interview. If the person agreed with the content of the informed consent, he/she could sign the form and the interview could start. Nearly all interviews were recorded using an audio recorder. Afterwards, the interviews were transcribed and anonymised. Only in Portugal were some interviews not recorded, since there was no authorisation to do so. In these cases the interviews were directly documented by the interviewer. After the interview or focus group was completed, participants received a small incentive (10 euro) in form of cash, gift vouchers or tobacco for participating in the study.

4.1.3 Instruments

Prisoners and ex-prisoners were interviewed using a semi-structured interview. In addition, focus groups were organised. The different methods were used to obtain both individual methods and statements within the individual interview and also to stimulate discussion within a group. A focus group interview serves, in particular, to make authentic utterances more likely during the shared

interaction and to allow the course of the discussion to point to topics that are important to the group (Tausch, Menold, 2015). The questionnaires used for these semi-structured interviews are available in the appendix, and were identical between countries. Insights from the literature review were the main source of inspiration for the interview scheme that was drawn up and used for the semi-structured interviews. The following topics were discussed: drug use and risk behaviour in prison and upon release, knowledge of the risks of overdose and methods to deal with overdose, individual strategies to deal with drug use, and related risks and experiences with release. Individual semi-structured interviews took between 29 and 120 minutes. One interview was stopped prematurely because of the heavy mental burden that the interview placed on the participant.

4.1.4 Data analysis

All interviews were transcribed by a researcher or a transcription office, and were read by the researcher. This was followed by an analysis using the qualitative software program NVivo. Based on the interview scheme, a tree structure (see Annex) was prepared for structuring the data analysis, constituted by units of meaning (nodes), and built in collaboration with all the countries involved on the study. Knowledge and experiences of (ex-) prisoners were collected and analysed per topic in each country. In the results section, the main themes are discussed. The results of all four countries are summed up in this section as all researchers had similar results and main themes after the analysis. In order to illustrate the results, literal quotations are used: quotations from prisoners are indicated with the letter PR, quotations by former prisoners with the letters EPR. In addition the letter M for male, F for female and BE for Belgium, FR for France, DE for Germany and PT for Portugal were added. Due to data protection and to preserve anonymity, the ages of the (ex-) prisoners were not added.

4.2 The research teams and the role of the Scientific Committee

The Scientific Committee (SC) was composed of prison health care specialists in the countries. The main objectives of the SC were to facilitate our scientific work via discussing our methodological approaches and our instruments (e.g. questionnaires) and to facilitate our access to prisons. However, only the Belgian member (a prison governor) could fulfil this task. The SC met once in person at our Paris meeting in October 2017.

4.3 Ethical issues and anonymity

Ethical issues have been discussed throughout the whole research project. In France ethical approval of the study had to be achieved. For France an agreement from CERES (Paris Descartes Ethical Committee) was obtained (no. 2017-44). For Belgium, ethical approval was provided by the Ethical

Commission of the Faculty of Psychology and Educational Sciences at Ghent University. Approval was not necessary in Germany and Portugal.

Guaranteeing anonymity was a major prerequisite in this study. In the interviews, sensitive data and information (e.g. about drug use in prison) was provided by the interviewees. This made the anonymisation process urgently necessary. Data and information provided in our reports can neither be allocated to a certain prison nor to individual prisoners.

4.4 Limitations and challenges

In general

In general, all countries faced several challenges in recruiting (ex-) prisoners. There were some difficulties with different ministries of justice and access to prisons or carrying out research (interviews and focus groups) with prisoners. There were also some difficulties finding ex-prisoners in some countries. These challenges led to a time lag during and at the end of the project.

Specific limitations and challenges for each country are described separately below.

Belgium

The recruitment of recently-released prisoners did not go as smoothly as expected, which forced us to adjust the original inclusion criterion of 60 days to a maximum of five months post-release. Multiple reasons were found for these recruitment difficulties. First, the release date of prisoners is often unpredictable. On several occasions it transpired that the researcher was aware of an upcoming release, but that the prisoner's sentence was again extended and/or the new release date was not known. Second, some prisoners could not be reached after release because their telephone number was no longer in use or they no longer lived at the address they gave to the researcher. Another important reason was that prisoners do not always find their way to treatment and support services after release. It is not uncommon for them to first take a period of 'rest' before they find their way to these services. Also, some prisoners who were just released did not want to participate in the study as it was still too difficult for them to talk about their experiences.

One of the main limitations is that the sample is not very diverse. Only Dutch-speaking (ex-) prisoners from two prisons were eligible for this study. One of the prison populations consisted of prisoners from a drug-free wing. No women were included in this study. In addition, the sample of ex-prisoners may be biased by the fact that only individuals who were already in contact with some type of service were recruited. It is possible that former prisoners who have not been involved in these services have other experiences after release.

France

Inclusion was supposed to cover a minimum of two different prison settings and cover demographic heterogeneity (male and female, young and old). Unfortunately, several problems arose by trying to reach prisoners with a drug history; first of all an authorisation from both the prison administration at

the national level, and from the head of medical unit inside the prison was needed. As a result, the authorisations for only one detention centre near Paris was possible. Once these were obtained, all the staff from the addictology unit had to be enlisted to find eligible and willing patients, and afterwards several dates had to be found where both the patients and a confidential office inside prison were available, which also proved to be difficult and reduced our sampling options (i.e. our ability to cover heterogeneity).

Mainly ex-prisoners in treatment centres that also provided housing (i.e. inpatients in residential treatment centres) were reached. In order to achieve a more representative sample outpatients were tried to be included, who experience much less thorough and regular care regarding their addiction. Such patients often live in unstable situations, and arranging interviews proved to be harder than expected, as both the patient to honour the appointment and a confidential space were needed to be available for conducting the interview. Several drop-in centres and harm-reduction facilities were contacted but the staff were often overwhelmed and they already lack office space for their own activity. Furthermore, financial incentives (service vouchers) were set up but this had only a moderate effect.

Focus groups were planned in this study but were ultimately not achievable either in prison or outside due to the aforementioned logistical and administrative constraints.

Germany

For the interviews with prisoners, an authorisation from the Ministry of Justice in every single state (Land) was needed. Therefore, an authorisation in four different federal states was requested. This part took 6–10 months for each state because of queries and reservations regarding the study. Two refusals and two authorisations were received. After receiving the authorisations every prison in both federal states had to be contacted, with only one in both willing to participate. Both prisons named a contact person for the researcher, which was helpful for the recruitment of prisoners.

In summary, it can be said that recruiting interviewees in a prison setting is accompanied with great administrative effort for the researcher regarding research applications and organisation. The prisons that did not participate explained that it would take a great effort and that they could not handle this because of a lack of staff.

For the interviews with ex-prisoners, only people in low-threshold drug treatment centres were reached. Several drug treatment centres (also inpatient) were contacted. One organisation was interested but explained that they had no ex-prisoners who matched the criteria (i.e. they had been released within the last five months). Mostly the organisations were not interested in participating because of the great effort it might take.

One of the main limitations is that the sample is not very diverse. Only German-speaking (ex-) prisoners from two prisons in two cities and three drug treatment centres in one city were eligible for this study. In addition, the sample of ex-prisoners may be biased by the fact that only individuals who were already in contact with some type of service (low threshold) were recruited. It is possible that

former prisoners who were not involved in these services or have been involved in high threshold services have other experiences after release.

The other limitation is that the (ex-) prisoners were mostly selected by the contact person in the prisons and organisations. It cannot be ruled out that there was any previous selection process.

Portugal

Regarding the limitations – namely concerning the prisoners – the main obstacle was finding people who met all the criteria (since many had not been arrested before). However, the greatest challenge was interviewing the former prisoners, since the majority did not provide any contact information that could be used to track them. Also, after release, some people prefer not to remember their time in jail, and they move away from anything that might remind them of this reality. It was very difficult to reach this target group because of aspects mentioned above. Additionally, there is an under-representation of women in Portugal's sample. The prison selected to perform the study has a very limited number of women prisoners (n=16) and none of them were available to participate. All the approached female prisoners claimed that they did not have the time to be interviewed due to very busy work schedules.

Part 2 – (Ex-)prisoners' points of view

5 Results

In this section, the main themes are discussed. The results of all four countries are summed up in this section as all researchers had similar results and main themes after the analysis. Specific differences between the countries are only mentioned if a main theme was very different to other countries.

5.1 Drugs and drug use in prison and after release

5.1.1 Context of use in prison

The availability of substances varies from prison to prison. While some (ex-) prisoners indicated that drugs are very easy to get, other (ex-) prisoners indicated that drugs are rare and mostly bad quality in prisons. Most interviewees reported easy access to cannabis and difficult access to other substances like heroin, cocaine and speed. According to the respondents, drug trafficking occurs during visits or via the prison staff. Drug trafficking inside is mostly associated with trusting other prisoners to get good substances, negative consequences, restriction, a lot of organisation and debts.

'Being heroin and coke, it will fail. It does not always roll here in this prison. If we talk about central prisons, there is more drugs inside than outside. Inside a large prison facility, the guards are the ones who get the drugs inside.' (PR, M, PT)

'..in prison it's like that, drugs are rare.' (EPR, M, DE)

'.. if I get something in prison, I have to 'trust' that this is what I want, what I pay for. And not long ago there was an incident, there was powder mixed in the package. This are such stories [...] that's really problematic.' (PR, F, DE)

Only in Belgium did drug use (cannabis) seem commonplace. (Ex-) Prisoners claimed that 'there are more drugs inside than outside' and that 'it is quicker to find drugs inside than outside'. According to various prisoners, the main way in which drugs get into prison is through visitors. This is facilitated by the fact that body searches are not really detailed. Some of the prisoners stated that the security staff, although not all of them, often close their eyes to drug use in prison, especially when it concerns the use of cannabis. According to the (ex-) prisoners, it is tolerated because prisoners are quieter ('less agitated') and because wardens have 'less work' in this way.

'Soon it will be my birthday. Then I'm going to sniff coke and the risk of being caught is minimal, because they make it really simple here. They close their eyes. If I go through some sections ... I think you have already noticed the smell of weed or hash here... You have to be honest... Some chefs close their eyes, but a joint is the least. Of course they know that, one chef is a bit milder than the other, but as long as you give them as little work as possible ...' (PR, M, BE)

Regarding the substances used in prison, most respondents frequently reported high use of cannabis. If (ex-) prisoners used other substances like heroin, cocaine, crack or speed, it was mostly more like a single occasion or rare use instead of regular consumption. Drug use happens in the cells, during the walk (in the courtyard) or anywhere where controls are less common.

'Except for cannabis, which becomes daily, regular. So we're not going to say it's because a lot of people smoke cannabis, but it's true that it's something quite common, that you find everywhere. Everyone smokes, so to speak.' (PR, M, FR)

Drug use and trafficking inside prison is often associated with negative consequences and fear of getting caught. The consequences of drug use and trafficking inside prison are mostly harmful and negative for users in many ways. Negative consequences could mean the loss of OST, private belongings and rights (such as free time). Losing OST was the consequence in nearly every case. Most respondents indicated that they had fears of using inside because of losing OST. These facts also lead to hiding their drug-taking from cellmates and wardens, which led to a negative experience of drug use.

'It's always tricky. People get themselves in debt, they cannot pay... they are going to pay with their body. I saw things that I do not know how they had the courage... even electric shocks. Drug use is very complicated in here because it gets you into debt, then if you get too hooked, you will want to smoke more and they will not give you methadone or subutex right away... The hangover has a lot of strength, it does not stop overnight. The pain is unbearable, you cannot eat... you drink water and it is cold inside, you shower with hot water and it is cold. I suffered a lot.' (PR, M, PT)

'Once in the years, because you lose so many things, so purchasing block, they turn your cell on the head, you lose your private clothes and so. It's not worth it for such a trifle.' (EPPR, F, DE)

'because if I had been positive, the work would have been gone, purchasing block, leisure lock and lock and disciplinary penalty, private clothes gone.' (EPR, F, DE)

In some cases respondents indicated different ways of dealing with drug use. The strictness of the rules in prison depends on the prisons, individual cases, prison staff (guards) and the substance.

'I was there for years, there are many guards who know that you smoke weed. The whole hall smells like that too. That does not interest them. But they say, 'Guys, go into your cells, do not run around here. As long as it's quiet and I do not have to write, I do not care if you smoke weed.' Yes, but they don't accept hard stuff. Smoking weed is OK.' (PR, M, DE)

In Germany, there are special controlling measures, such as urine testing. The main problem associated with drug use inside prisons in Germany is urine testing. Participants indicated that prison staff test prisoners' urine, especially that of drug users, to control drug use inside. This happens on a regular basis. If prisoners refuse the urine test, the test is automatically interpreted as positive. Positive urine tests have many negative consequences for the prisoners. First of all they are subjected to a disciplinary procedure. Possible consequences from the disciplinary procedure include loss of OST, loss of work inside, revision of cells, loss of private property, a block on purchasing, loss of benefits, visits only through partition, no leisure time (more time alone in cells), and many other things. On the other hand, they indicate that faking urine tests is easy and therefore not really useful for controlling drug use. This is despite the fact that faking urine tests is associated with the organisation of getting hold of clean urine, stress, disgust (using foreign urine) and fear of getting caught.

'B3: There was always fear in the neck B4: The worst thing is just to plug in foreign urine or something, that's just total. (B3: Asocial.) You would not do that outside, now seriously.' (PR, F, focusgroup, DE)

'That's too risky for me, if they took your urine and looking for something, then you're out of methadone, yes. And that's the worst thing that can ever happen to you [...] Because then everything is over.' (EPR, F, DE)

'Even these urine tests don't work because people consume and the urine test value shows that they're clean because there are so many tricks to get around that, and that's why I find it makes no sense whatsoever.' (PR, M, DE)

In France, some participants reported high levels of stigmatisation towards the prisoners who used drugs (cannabis excluded). They reported indirect experiences of other prisoners refusing to go in the yards or common areas of the prison in order to avoid a continuous verbal abuse, and therefore stayed in their cell all day long.

5.1.2 Reasons for using drugs in prison

The reasons for using drugs in prison are mainly to cope with negative feelings. Celebrating positive events with drugs is rare. Using drugs helps people in prison alter their minds and make things more bearable. It also helps people to cope with the experience of imprisonment.

Drug use also gives some people courage and induces the feeling that they still have the power to decide what to do, despite their freedom having been taken away. Others use to be able to focus better or to feel well again. For example, some prisoners claimed that writing a life story or drawing would never have been possible without amphetamines. Also, prisoners often smoke cannabis to be able to sleep or to relax. In addition, boredom is an important reason to use. According to some (ex-)

prisoners, boredom is the main reason why people look for drugs. The importance of a daily schedule, structure and activities was emphasised, because this is also seen as good preparation for the outside world. Whether one uses or not is often related to having a cellmate who uses. When a cellmate is using, the threshold to use as well is much lower. Drugs are already available, cellmates often offer it, and peer pressure also plays a role. The combination of bad news/boredom and being offered drugs (positive social context) by a cellmate persuades a lot of prisoners to use.

'Imagine, you are in a cell with someone, a user, and you don't want to know anything about drugs. But you get bad news, for example, now a case that is completely out of context: you get a life sentence. And right then, the other one is smoking drugs there. So, you feel bad and your cellmate proposes to smoke, then hey, you do that. So you smoke a little bit. That first time everything is OK, that second time everything's still OK, but that third time you're lost [and start using for a longer time].' (PR, M; BE).

Using drugs also helps prisoners to cope with the daily routine within the prison context, which is associated with hard times, being alone, not having anyone to trust or provide support, and/or coping with bad feelings (depression, black mood) and bad news from outside. Drug use also helps to make the time pass quicker and helps prisoners deal with their sentence.

'It's (daily life in prison) very difficult too. That's all under pressure. Depression, pressure. All psychopaths and cinema in your head. You're high and you need a thousand million things in prison. And if you really have no family here, that's hell, very simple, really. That's the way it is.' (EPR, F, DE)

'And especially when you get bad news from the outside and you have the chance to use. Then it's over, you do not need to talk about it anymore.' (PR, F, DE)

'There are people here who have never been on drugs but then they hang with people who do and start using, if they are available. If not, they try anxiolytics.' (PR, M, PT)

In some cases respondents indicated that resisting is hard inside because of the knowledge that drugs are everywhere. In Germany, (ex-) prisoners reported different dosages of OST or no OST as the main reason for using drugs inside.

'Because here everything is psychologically much more exhausting than outside. The women just cannot make it here, untrained and without OST. That's very clear. They always say, 'we want to have a drug-free jail', but actually do nothing against it and do not listen to the women.' (PR, F, DE)

*'B1: ... He just put me down from OST?
I: completely out?*

B1: Yes. I'm already half a year.

B3: And for a woman who used drugs for 30 years.

B1: No, 20. (Laughs) No, 24 years, nonetheless.

[...]

B3: And then you do not have to be surprised if we become criminal again, trying to bring drugs inside.' (PR, F, DE)

5.1.3 Differences between drug use inside prison vs outside prison

According to the respondents, the most common drugs (i.e. cannabis, heroin, cocaine, speed, and so on) are mainly used inside. Several interviewees demonstrated that depressants ('downers') (such as cannabis, benzodiazepines, heroin) are more popular in prison than stimulant drugs ('uppers') (such as cocaine and amphetamines). Most (ex-) prisoners reported the use of hash and weed on a daily

basis. In Germany, one prisoner mentioned new psychoactive substances (NPS) and reported a high availability of NPS, in prison and some (ex-) prisoners indicate the illicit regular use of Subutex© (OST).

Factors that affected the type of drugs used include pricing, getting to know new drugs, and availability. Substances like hash are less expensive and easier to get. Some respondents indicated that they learn to know new drugs in prison and eventually became addicted to them.

'But we often consume shore (heroin) here, so heroin and rarely cocaine, because this is very noticeable and very expensive in here. But otherwise only THC and shore and quite a lot Subutex©' (PR, F, DE)

'So, let's just say smoking weed and Subutex© are the main drugs.' (PR, F, DE)

'I say, actually of substance, you can get everything. Let's just say, maybe except cocaine, that's a bit more difficult. Can you come to everything. Just not like it is outside. You go and get in the moment, if you want it. Here it is then with a lot of patience sometimes connected.' (PR, F, DE)

In addition to changes in types of drug use, the interviews demonstrated changes in the frequency and/or intensity of drug use in prison. The same factors that lead to (changes) in drug use patterns affect the frequency and intensity of use, such as price, availability, boredom and individuals' mental states. Some prisoners are forced to reduce drug use or stop using completely, because of a lack of money and more important things inside like tobacco. Others only use when they get drugs for free (e.g. from a cellmate). Some also continue to use at the same frequency but reduce their dosages. Prisoners also mention that the frequency of drug use is related to the likelihood of detection and fear of being punished, but they also reported that they know when urine tests are more likely to take place (urine test only in Germany). For those who used illicit drugs before incarceration, most of them reported an almost total cessation of cocaine, heroin and crack cocaine (except in Belgium). Reasons for cessation included pricing, availability and motivation for using the time inside for different things. Although most drug users often use less in prison, the intensity of use is often higher: 'then of course it is a) more intense' (PR, F, DE). Other prisoners indicated that they set themselves new goals or wanted to use the time to regenerate or stop consuming completely. In individual cases they stopped using drugs (including tobacco and OST) completely to start a new life, even if they were fearful of relapse following release.

'No. I did not consume in detention. That's too risky for me, if the urine test is positive, then they say, 'you're losing methadone', yes. And that's the worst thing that can ever happen to you.' (EPR, M, DE)

'Heroin, cocaine that's it. There were breaks when I was in prison. What does the breaks mean? Two, three months and then again, not without nothing.' (EPR, M, DE)

'I see the positive, because I regenerated there (in prison). My body has regenerated and I was fit again. The stupid thing is, once I've been released, I've taken drugs again.' (PR, M focus group, DE)

'I had clean phases only once in the rehab (withdrawal) and otherwise, because I was so often in prison, you can count prison as withdrawal.' (EPR, F, DE)

Beside frequency, the meaning of drug use also differs inside. Drug use is often associated with fear inside and joy outside.

'Yes, in any case, that's just because you do not always have something here and then when you consume something then of course it is a) more intense and b) from the psyche is also much stronger, because of course, one also greater fear has to be caught. So that's why, how should I describe it? The first time you consume something here is actually nice, but it's not like being outside. So, outside, you have your peace and you can relax – you can enjoy' (PR, F, DE)

(Ex-) prisoners point out that approaches to drug administration may differ in prison from those in the community, since not all drug paraphernalia is (always) available in prison. Smoking and nasal consumption is the most common method of drug use among the interviewees inside. Medication is usually taken orally (swallowed) and nasally. Injecting drugs does not happen often in prison, since prisoners need visitors to bring in syringes or they have to steal them from the medical service. Materials for smoking and sniffing are often self-made. Prisoners sniff rather than base cocaine, because the elements that are needed for making base coke cannot (always) be found in prison. Mostly they report less intravenous consumption because of harm reduction reasons, but respondents also mentioned that they do it sometimes even if they have to share. Some respondents would rather stop consuming instead of consuming intravenously inside with a foreign (already used) needle/syringe. Some respondents also indicated that they learnt other ways of using because of lack of drugs (such as taking intravenously is more effective than smoking).

'I smoked heroin on aluminium foil. Before the detention. I did not consume intravenously. Do you know what I mean? I just did that here. I received "service" from others' (PR, F, DE).

'The time spent in prison made me see the dangers. I only shared tubes, but in prison I have seen people who are apparently healthy and then when you see they have hepatitis, AIDS... I do not make risks.' (PR, M, PT).

5.1.4 Medication and misuse

Medication and misuse differ between the countries. While respondents in France, Portugal and Germany reported only a few incidents of dealing with medication inside, respondents in Belgium stated they are often urged by other prisoners to 'pretend they are sick' and go to the doctor in order to obtain medication. In addition, medication is often stolen from other (sick) prisoners.

'I could say what I wanted. That is also the trick that happens there. For example, if you come into a cell and your cellmate is addicted to Valium, he would say "yes, you have to go to the doctor. Say that you are heavily addicted to alcohol, that you have shivers, that you cannot sleep." And then, the newbie gets pills and these are then stolen by someone else. Or a barter, medication is then exchanged for cigarettes. I think they should do more controls, because ultimately it causes more harm than good.' (EPR, M, BE).

In some cases respondents in all countries reported using tablets or organising benzodiazepines for themselves. More often (ex-)prisoners reported access to medication through psychiatrists or doctors inside during withdrawal and for mental health issues.

'.. you can fall into depression very quickly and then it's treated only with tablets.' (PR, F, DE)

'Get diazepam to sleep. Every, yes morning, noon, and evening, three times a day.' (PR, F, DE)

'There are a lot of people who were never drug addicts but they say they are in order to get methadone while in prison.' (PR, M, PT)

Besides hash, weed, heroin and cocaine, respondents indicated that benzodiazepines (such as Valium, Bromazepam and Tranxène), antipsychotics (such as Seroquel, Lyrica) and opioid substitution treatment (Subutex®; only in Germany) are often consumed. Commonly, prisoners use everything they can find to alter their mood. Medication is frequently prescribed by the prison doctor/psychiatrist and according to some prisoners, this medication is prescribed almost automatically, particularly at the beginning of the detention period. One prisoner said *'Well, I'm well supplied with everything'* (PR, F, DE). Sleep medicine is particularly popular.

'You take everything you get offered.' (PR, F, DE)

'No, the selection of substances like heroin here is not high and so on, it's rare. Only Subutex® and that is consumed through the nose.' (PR, M, DE)

5.2 Risk behaviour in prison and after release

5.2.1 Related to drugs

Using illicit drugs inside always contains risks in many ways for drug user.

Drug use and/or trafficking is prosecuted and brings negative consequences like loss of free time, OST, work and other privileges. Using drugs inside is mostly associated with the fear of getting caught and repression.

Access to consumption material like needle exchanges, syringes and clean material is not possible in any of the countries. Access to materials like sniff kits and naloxone was only reported by the respondents in Portugal. Most prisoners indicated that they know that methadone and/or Suboxone® is available in prison. In Germany, (ex-) prisoners reported having access difficulties to OST in some prisons and especially in some federal states in Germany. However, most respondents stated that there is no specific prevention of drug use and associated risks in prison, and prisoners do not receive information about harm reduction or other preventive measures (such as condoms, for example). There are some projects and training programmes in some prisons, such as those conducted by APDES in Portugal, which provide information for drug users and peer education inside, but there are no systematic education programmes or training for all prisoners regarding harm reduction in any of the countries.

'The materials exist, but it is cleaning material (bleach), the others do not. I had the information but no contact with the materials.' (PR, M, PT).

Even if there is no access to clean material inside, many drug users use material to inject, sniff or smoke drugs. In general, they indicated the use of tubes, filters, syringes, pipes, rolling paper and aluminium foil. All of them reported that they had to get the materials themselves, by either self-making

or stealing. They made use of common materials, such as pens or paper for tubes, and got aluminium foil from cigarette packs or chocolate packaging. Respondents indicated that access to clean syringes and needles is very difficult inside. They are very rare on the one hand because they have to steal them from prison staff (medical service), buy them from other prisoners (very expensive), or receive them from visitors or wardens. If they had tools, they tried to hide them from other prisoners. Access to tools inside is always illegal and in some cases the offered tools were already used.

'Regarding the risks, inside it is more dangerous. You need to have confidence with the nurse to get the syringe. There are vans outside to change the kit. Inside is more complicated [to be safe].' (PR, M, PT)

'There is much lack of care here, even on medication, they take from mouth to mouth, even with liquid methadone, they pass from mouth to mouth. One who is a consumer is forgetting about himself and can create a risk to public health.' (PR, M, PT)

'You can buy that. The cleaner (house worker), who cleans the doctor's room, steals and brings it to us. In custody you can do everything. You just have to have money.' (EPR, M, DE)

'A syringe with needle is worth inside, let's say maybe 100 euros and outside that costs a cent or five cents. Who has tools here, he is already king. I've had it quite a lot now, I think five, six times they found them in my cell, but that's nice if you have it.' (PR, F, DE)

Some (ex-) prisoners in Germany mentioned needle sharing programmes inside, which are no longer available but are still needed.

'At that time they had a needle sharing machine. At this point, people were able to pull in the used pump, open a drawer and receive clean tools. They tried that in another prison. But then our beautiful (prison management) came and said: "So, not anymore". For safety reasons. Then hygiene was not given anymore. There are now people who build a syringe from pens. The main thing is to bring it in the vein. [...] So, the hygiene is not there. Well, the risk of infection is quite high there.' (PR, M, DE)

According to the participants they were rather well informed about the risk of HIV and HCV transmission linked to the sharing of needles, straws and pipes. This information came mostly from other users in their personal network or from harm-reduction facilities outside prison.

'The other person who was taking heroin, who was injecting, told me: "Go to this address, call them, tell them you're going to pick up some equipment". And since it's anonymous there, I filled in a sheet and they gave me enough to do, even to snort they gave material. They were great on that, they taught me a lot of things, they showed me a lot of things.' (EPR, F, FR)

As a result of good information about HIV and HCV transmission linked to sharing tools, respondents mostly stated that they try to hide tools from others if they ever get any. But prisoners often share a cell with others so shared drug use and tools among cellmates is therefore not uncommon. Joints are shared in particular. Respondents indicated that they often use together simply because the drug is available in the cell and someone has tools. Some prisoners are (very) aware of the risks, while others know the risks but can't resist the craving. (Ex-) Prisoners indicated that they would never share material outside but sometimes inside prison, which is explained by the fact that injecting equipment is scarce in prison. In some cases they had rules before sharing like *'if someone has AIDS he must say that. If only HEPC it's OK, but not AIDS'* (EPR, M, DE).

'No, so I would never get the idea, I do not, I would never take another syringe. I take my own and that's it.' (PR, F, DE)

'And then there's still blood in it, you do not see or. And then you already see your dosage and you have to do it quickly, because when the guards come in, it's over. With a syringe then five people sitting in the room and inject that.' (EPR, M, DE)

'And lately I've seen it so often, that a syringe, I do not know how, wandered from one arm to the other. And you can talk about it, but that's just their addiction. And it's just stronger than anything else at this moment.' (PR, F, DE)

'It happened, it happened (sharing tools). We all know very well that we must avoid it, that it is very personal like a toothbrush. At the first take, provided we are not in too much of a hurry, we take precautions but as we keep on using, we lower our guard. We lower our guard and then there are also the tools that become defective and yes, we do share them.' (EPR, M, FR)

A reason that is more specific to incarceration was the need to use the substance very quickly and discreetly in order to not be seen by the guards or some other prisoners:

'People making homemade straws out of paper or something like that. And, in euphoria, you take a line and it's only after that you say to yourself: well, damn it. But it's too late. When you see that everyone did it with the same straw and you want the product, the desire is so strong that you even take the risk. I think I used and I didn't even see the risk.'

'On the outside, yes, I am careful. I prefer to take my time and go get it, make myself a straw. But in detention, since everything is done in secret...' (EPR, M, FR)

(Ex-) Prisoners reported that in some cases tools are passed on without cleaning them. Mostly they reported cleaning by boiling tools with a water heater in the cell.

'Boiled a syringe in water, put the water heater in the cell take it out and then quickly wipes off, because police might come.' (EPR, M, DE)

'Well, we used to have a syringe, a needle, if we were lucky, two of them, and then we got them with a water heater, we had a water heater like that, we screwed them up, we got the syringe with the needle and boiled it out. Then we pulled our stuff up or prepared, raised and injected, when you were done, back in the water heater, cooked again and then was the next turn.' (EPR, M, DE)

If the participants knew the risks of infection associated with the sharing of equipment quite well, putting methods designed to lower them into practice was more difficult. One prisoner described how he can set aside his 'risk-awareness', even when he is using outside. As if knowing about the risk was not enough, one should be able to apply harm-reduction measures when using.

'For the pipe, we change the tips. Knowing that sometimes we also do not change the tips but just turn the tip over. Does it really work? I'm not sure. We do, in quotation marks, some kind of... We take some kind of precaution, knowing that they are pretences. We kind of overlook all these things. Because drug use is a little bit of a lowering of guard too. It's like letting go, you know.' (PR, M, FR)

5.2.2 Other risk behaviour

Only respondents in Belgian prisons reported drug-related violence. The interviewees clearly demonstrated that drugs and cigarettes play a predominant role in the relationships between prisoners

and in the relationships between prisoners and security staff. Fights, injuries and extortion (e.g. prisoners who don't receive visitors may blackmail others) for drugs or cigarettes are common. The reasons for violence are multiple, but it usually concerns prisoners with debts to other prisoners, individuals who do not want to hand over or share their drugs, theft of drugs or cigarettes, tampering with or poor quality of drugs, and so on. Some prisoners also cite perverse effects of the 'drugs culture', such as obtaining privileges from prison staff when they are aggressive or go too far.

When talking about sexual risk behaviour with prisoners, they did not speak about sexual practices among prisoners. A taboo about sexuality among men was observed. Almost all prisoners know that condoms are available for 'intimate visits' and that they can be ordered from the list of deliverable products or just taken from medical service. According to the respondents none of them ever used condoms inside or had sex with prisoners (men). Female (ex-) prisoners did not know if there are any harm-reduction measures regarding sexual risk available inside.

In a German prison for women, the sharing of razors was very common according to the respondents in the sample. They reported that using a razor belonging to other people inside is easier sometimes than getting your own one (if they forget theirs). They all know about the risk of HCV but had wrong information about the time of risk ('if it's 45 minutes at the air, that it cannot happen anymore' (PR, F, DE)).

5.3 Overdose experience

5.3.1 Knowledge of risk factors for overdose

Most (ex-) prisoners know a lot about risk factors for overdose, while some are not aware of the risks at all. Almost all the participants learnt about overdose risks and prevention outside prison. Knowledge was mainly transmitted outside either by harm-reduction facilities or by the participant's personal network. Regularly, the misconception was observed that one can only take an overdose of heroin. Drug users who only smoke or take heroin nasally did not know or only rarely knew of any risks of overdosing. When respondents were asked about the main risks for overdose (OD), the following factors were discussed: a mix of different drugs (such as uppers and downers), exaggerating (taking too much, too high doses in a short time, as well as overly intensive use over a longer period of time), having never used before or not having used for a long time, drug quality, lack of knowledge about the product taken, the adulteration of substances by dealers or changes to the supplier, being greedy, and being clean at release.

'Smoke a stone (crack), come down again with Lyrica take a few benzos and then again stone and then it always goes back and forth and alcohol in between and eventually you pass out.' (EPR, M, DE)

'Ignorance about the strength. This does not work for me anymore. Ignorance about the correct dosage of a substance.' (EPR, M, DE)

'Once upon a release and once after a therapy discharge. Complete overconfidence. Not wanted, but was very close.' (PR, M, DE)

'When I was there, the first time, many people also died because they took the same dosage as they took before imprisonment. And your body is accordingly clean. And the substance has also become different outside. The substance is different every time.' (PR, M, DE)

'Also if you mix it. You may smoke a little and take a Subutex© pill afterwards and drop dead.' (PR, M, PT).

In France, apprehension regarding overdose following release was not spontaneously expressed by prisoners, and when a question was asked in order to explore the subject, they had a difficult time projecting themselves into this situation, since most of them were facing the prospect of treatment and total cessation of illicit drug use.

5.3.2 Managing an overdose

The majority of respondents had witnessed an overdose (OD) or had their own experiences of at least one overdose. A recurring behaviour pattern among (ex-) prisoners who witnessed an overdose is that they will first help someone who is overdosing to regain consciousness themselves, and only afterwards, when they don't know what else to do, will they try to call an ambulance. The latter is a consequence of users' fear of problems with the police and fear of punishment (e.g. being guilty of complicity, failure to render assistance to a person in danger, and so on), in case they are found with someone overdosing. Some people will run away immediately and leave the person who is overdosing alone, while others will try to call an ambulance first before they leave. Others used wet towels, first aid, fresh air or tried to inject the opposite substance (like heroin-cocaine) to manage the OD. Most of them expressed a lack of control over the situation.

'Usually the people who are witnessing it [an overdose] are users themselves, so then it is like: running as fast as your feet can do. They do not look around, they do not know what to do, but they are afraid to get caught themselves. But if he dies, then you are accessory. Refusing help to a person in danger, drugs supply, perhaps accusing you that the drugs came from you... So yes, that is ... I have always called immediately, I did what I could.' (EPR, M, BE).

'I looked through the door and saw how he was sitting there, his blue hands, head down. From one second to the next, I was not high anymore. Put his head up to the heater, then I took a wet towel and started chest compressions and mouth-to-mouth resuscitation.' (PR, F, DE)

In Germany, no one reported having called an ambulance in the case of an overdose. In all cases drug users helped the OD victim themselves with regard to overdosing in a private setting.

'And when I woke up, I just saw punches. My friend on top of me hitting me with a washcloth and said, "(name), get up, get up". You know, he got scared and so on. But did not come to ambulance.' (EPR, M, DE)

If respondents had had an OD, they tried to call friends. Mostly they had friends around or they had overdosed in a consumption room, and one respondent woke up directly in hospital after losing consciousness, without knowing how he got there since he was alone at the time.

'Yeah, it was 2014, I think. I had a leave, I had to visit a CTR [residential therapeutic centre] and the first thing I did when I left here [the prison] was to take the subway. I begged money in the subway until I arrived to [a train station in the city centre]. I found myself with €30 and I went to get some Skenan [opiate analgesic]. I injected myself with two Skenan even though I have been

stabilised with methadone for some time, and I am shooting myself 200 mg of Skenan. So I started to have my vision blurred, my heart slowed down. I had to sit down, with the head like a drum. The guy who was with me, he ran away, he was scared. He left me like that and it took me half an hour to control my breathing, to try to ventilate myself well, to tell myself: it's nothing, it'll pass. And really, my head, it was going to explode, I felt my heart sort of running off, but not running off like fast, it was really super slow. I was on the brink of a heart attack, I couldn't breathe.

How did it end?

I took it upon myself. I waited.

You weren't taken care of by paramedics?

No, it was no big deal, actually. And then there was another one too, it was opium. Actually, I was sick and I couldn't smoke it and I injected it. I almost died. Big sting, big pain and in the end, I had to take a deep breath. But there were four, five seconds when I was gone.' (PR, M, FR)

5.4 Last release experience

5.4.1 Challenges upon release

Individual level

(Ex-) prisoners make it clear that it is difficult, especially during the first days and weeks, to be back in the rush of present-day society and get 'up to date' with the latest developments. The longer one served a sentence, the more difficult it is, according to some (ex-) prisoners. It feels like an enormous confrontation with the speed and time pressure in our society, which is huge a contrast with the 'order and rest' in prison, where nothing seems to change. Handling the first days outside is very hard, according to the respondents, and some have the feeling that they have to learn again how to behave in contact with other people in society.

'After seven years I went outside and it seemed that I did not know how to walk.' (PR, M, PT)

'The first time that I was released was very strange, it seemed that I was on Mars, I had feelings of persecution. The second time was different, I already knew what it felt like.' (PR, M, PT)

'(...) at the same time it is confusing, we are closed in here for so long that it seems that we no longer belong to this world' (PR, M, PT).

Immediately after release a lot of things are expected of ex-prisoners, like administrative organisation, making contact with people in society and managing a life outside prison. In this regard respondents indicate a lack of internal motivation in order to approach services and engage in activities, or that they struggle to accept support.

'It's complicated, the number 1 factor for reintegration it is really me. I'm the one who has to ask for help. To not be afraid to talk about difficulties.' (PR, M, PT)

'(...) but I think I did not straighten up because I did not want it either.' (PR, M, PT)

Some respondents needed to cling to old habits, 'automatic reflexes', to cope with the transition, which meant turning to their previous activities and environments, such as drug use, friends who use drugs, or a criminal environment. Returning to former social networks, when they mainly comprise people working in drug trafficking and drug dealing, is most commonly related to being a consequence of a difficult time after release.

'The biggest challenge is not getting involved with certain types of people, ex-friends who can lead to crime and drug life again (...).' (PR, M, PT)

'I've never had such help or talk. The people I knew were also addicted to drugs. My business was to make money with these people and I would get myself into this world again. I really needed to be helped because if there isn't any and if one gets weak, one will be begging on the street, which is what you see the most.' (PR, M, PT).

'According to me, the big challenge is to reconnect with people. Again, it depends. If the person has done three months, that's fine. But for people who have done more than a year, more than 15 months, more than 18 months, more than 20 months, it is not easy to take a crowd bath. Stuff that's stupid, simple. The stress, the cars driving, all the noise. All that stuff is kind of stressful. The person may be led to consume just to calm down, for a start.' (EPR, M, FR)

Also the social network could negatively impact the release experience in a different manner. The negative emotional experience towards family or friends who the ex-prisoner does not meet after release, fear of stigmatisation from social networks and a lack of social network are reported as negative experiences upon release. The absence or attitude of some close relatives can lead to strong disillusionment.

'Upon the last release, I had to see my family who were supposed to pick me up, they didn't pick me up, and it didn't go well. I had emotional expectations, I thought I'd see them, they didn't come. I have five brothers, I had to see three, and the three didn't come for personal reasons. At this moment I was out of my mind. So what did I do? I started using again. I didn't go to my treatment centre so I was on the run and I eventually came back here [in prison].' (PR, M, FR)

'I will have to accept an aid for psychological support. I'm going to have to talk to doctor from the SRI [social reinsertion institute] to be more secure in the steps I'm going to take, to have some support. As far as employment is concerned, I'm going to have to take assertive steps, talk to some employers (...).' (PR, M, PT)

'One thing is your immediate family, then there are others, uncles and cousins... you have to explain what you did, why, reasons, why I committed the crimes, having to explain to the family that I am changed...' (PR, M, PT).

As a consequence, the interviews show that the main fear of the participants is a relapse after release because of the difficulties and challenges regarding the early days after release.

'My biggest difficulty is my own person - how do I show up? How am I going to look for work? How do I focus? At the level of my abilities, how society sees me and my own family. Another problem will be my own daily subsistence... If you do not have psychological help, relapse is immediate.' (PR, M, PT)

'I think my challenge will be not to commit..., not to go around in the wrong... to counteract this is a challenge.' (PR, M, PT).

Structural level

In addition to challenges at the individual level, structural bottlenecks may additionally complicate individuals' reintegration after release from prison. Housing and employment are usually major challenges. Having sources of support in the community (like drug aid systems, friends and family) is seen as very helpful in terms of financial support as well as for providing shelter. Arranging paperwork is also a major challenge in the first days after release. Getting health insurance and getting OST legally after release is particularly difficult. Finally, respondents mention mental harm from prison, sometimes the wish to go back to prison, and a lack of coordination and attunement between medical and psychosocial support services inside and outside prison.

Housing is one of the major challenges after release. Some respondents indicated that they lost their flat during imprisonment and did not know where to go after release. Respondents who had no housing before reported having no improvement in their situation after release. Most of the time, participants were without any lasting housing solution, even though housing was the major concern for them. Some struggled to find emergency accommodation in shelters and some were forced to sleep on the street. Others managed to prepare accommodation in treatment centres specifically designed for ex-prisoners with a history of drug use, or in low-threshold drug treatment centres. Finally, a few participants were given the possibility to reside in private accommodation.

'I've always had a roof over my head and I cannot handle it at all. Sounds stupid, but to live on the street, that's... I almost voluntarily go back in (crying) before I'm scared every day on the street that something happens to me while I'm sleeping somewhere.' (EPR, F, DE)

'Assure, methadone programme, very much, and job centre or social services. A few times it was too much for me alone, then I had the money in my hand and had to lie here and once you have consumed, you are so, then you cannot do it anymore. Yes, these are the most challenges actually.' (EPR, F, DE)

'After each release you have to imagine I'm scared to get on the street because there are too many people. These cars, the whole houses. Everything that happens out there is scary. This is frightening after months of locking up. People are disappearing from this street because they are just afraid to walk on the street. And that's the way it is, mental damage. Nobody asks about that, but that's the way it is. Detention is nothing but mental damage. You are treated differently and you are aware of that and one day the door is open and you go out.' (EPR, M, DE)

Interestingly, obtaining a private room was seen by some as a double-edged victory, as it gave them a sort of confidence and it made them drop their guard regarding their dependence on drugs, especially after the first time they were released. A participant tried to explain this phenomenon and underlined his need for support associated with housing, in order for the solution not be counter-productive:

'[The housing] helped you?'

Yes, it helped me. It helped me, but not that much.

Why?'

Because I received a few nights in a hotel and it gave me a certain freedom. I don't know how to explain it to you. It left me on my own. It gave me over to myself, I did what I wanted. But I didn't know addiction yet, so I thought: since I'm here, I sleep well, I'm quiet, and I'm going to go and use. And I kept using until the day I came here [in a residential treatment centre]. That was the release before last.

For you, it's not only having a home, but being surrounded in it, and being in care?

Yeah.

Housing alone doesn't help you as much, does it?

At first, but not now. Now I know, I have learnt a lot about products and addiction. So now I have the means to get away from the products.' (EPR, M, FR)

'I want to treat myself, I want to feel good so I can go on with my life properly. For that, I play the safety card. This autonomy card, i.e. moving into an apartment on your own, quickly, so to speak, I don't feel it especially. What I need is to feel it, to have a comfort zone. In prison, I have a comfort zone, I don't need to worry. Being at home with my parents, I might not need to worry, I would feel useful and gradually, I think I would take my life back.' (PR, M, FR)

Another major challenge after release according to (ex-) prisoners is a lack of support regarding the labour market and employment. Respondents indicated that it is very hard to get a job opportunity with a criminal record outside prison. Employment is often seen as an important part of reintegration because of daily structure and performing a task in the community. Mostly respondents reported a lack of support regarding measures that can help the situation in the labour market and a lack of possible jobs outside.

'After imprisonment, the biggest difficulty I encounter is the financial situation and employment.' (PR, M, PT)

'It's really finding a job. I'll try to get here in Portugal, if I can, I'll still try to study at night, if not I will emigrate.' (PR, M, PT).

'Accommodation, economic situation and employment. This is all together, everything related, employment in the middle and the others side by side.' (PR, M, PT)

Administrative procedures were also mentioned by interviewees, especially in regard to complexity and tediousness. To get the basic services such as identity documents, health insurance and welfare benefits, it is necessary and important to have a good understanding of the administrative organisations. They often started these procedures from zero: with no fixed address, no bank account and no proof of ID. Therefore, it made a usually laborious task a seemingly impossible one, and brought disappointment or frustration, which often leads to drug use after release.

Respondents also mentioned a lack of coordination and attunement between medical and psychosocial support services inside and outside prison.

'There was someone here [on the drug-free wing] who knew he had to wait another three weeks before he could go to K [a therapeutic community]. Instead of saying we'll keep you here for another three weeks, no, no, that day he had to leave [prison] and then he had to wait outside before he could go to K. That boy went outside and started using (again). K.: we'll see later about that. That boy came back [in prison] a month later. Then he had to wait six months again [before he could go back to K].' (PR, M Focus group, BE)

Finally, some (ex-) prisoners described a huge gap between the support they received inside prison and the support they got once out of prison. They experienced a brutal and difficult transition from relatively accessible, regular and well-defined support inside to a more volatile and sporadic support outside. It was as if the care inside was somehow 'passively' received, and health care outside prison

requires much more motivation, implication and active search. A treatment gap observed regarding opioid substitution illustrates this problem: in prison, users are called into the medical unit to be given their treatment each day, and a strict routine is installed, but once they are released they need to find a way to obtain OST without health insurance, and sometimes without prescription. If some medical units in prison sometimes give out treatment for two or three days on the day of release, it was rarely enough to make the bridge between prison support and that provided in the community.

'The problem is that I only had two days' worth of methadone on me and since I had to go to the third day [at an addiction treatment centre], not having treatment anymore [...] could be complicated. So the evening before, I took half of the treatment and saved the other half for the morning. But it's true that in the evening, I wasn't very well and I went back to my neighbourhood. I used, I smoked a little heroin to remove the craving. It wasn't really a desire I would have had if I had had all my treatment. But that's the way it went down. It didn't have much influence because I only used it once and then I resumed treatment normally. That's it, these things happen.' (EPR, M, FR)

'For the methadone, I had to go get it [in the medical unit, the morning of the release], but the prison guard told me, "No, you're not supposed to go to the medical unit". So I told him, "I'm telling you I have to go to the medical unit to get a prescription to get my methadone". And in the end, I didn't get that prescription. He said to me, "No, you're free, you're going out". He just didn't bother with it. When I got out, it was hard. But since I was only at 20 mg [of methadone] it was alright. I drank a little, I drank a bottle of wine when I went out, and I had taken some Valium [...]

That's why I was busting my head with Valium. I needed to, I had to get high. When I'm on methadone, I avoid it, even when I'm offered it. If I take Seresta [benzodiazepine] or anything, it's three, four pills, no more.' (EPR, M, FR)

'Yeah, family, [Support] through the family. And also, since we're talking about long incarcerations, it's also working with myself to tell me that, at some point, prison is no more a solution. Try to reintegrate [society] as best I can. But it's not easy because you have to deal with a lot of problems outside, like social security, to be able to take your substitution treatment, which is not done right away. When we go out of detention, they only give us three days of treatment, so if you don't have the chance to have a doctor who will prescribe your treatment, it's using drugs again until your treatment is back in place. And then, it's all the problems aside from this: administrative processes, to be able to collect money, to find housing, to find work. Especially for people with addiction, it is not easy because we often find ourselves confronted with that same problem of use. Finally, we use to cope. [...] That's it, above all, to cope. Even if it is not our desire, we use because we are unable to reintegrate society normally.' (EPR, M, FR)

Motives for drug use at release

Most participants recalled having used drugs in the two weeks following their last release. They pointed out the differences between the mindset they had before release and the one they had right after regarding their consumption: even when they are convinced they will stick to the treatment and not use again, they gradually make one concession after another and they very quickly find themselves in the same situation that they were in before incarceration. They mentioned an evolution between the first releases from prison they experienced and the subsequent ones: when they were younger, after release they felt the need to 'party' for two or three days, to compensate as quickly as possible for the privation they endured during incarceration, then they tend to be more careful about it and distrust this urge because the switch towards regular drug use could happen 'in a flash'.

(Ex-) Prisoners indicated that boredom and being without housing is an important pitfall to starting using again or continuing after release.

'That they have a place to sleep. I think that's very important. Otherwise the relapse is inevitable. Yes, that's very important to me.' (PR, F, DE)

'First of all, a roof over your head, because to 99.9 per cent there is a chance that... Who wants to live on the street? As a drug addict you will relapse because they cannot cope with that to deal with that and maybe feeling better, even though it's the wrong thing to do [...] feeling stronger at the moment.' (EPR, F, DE)

The importance of a daily schedule and having something to do (a job, hobbies) is often quoted. Another pitfall for relapse is having contact with the (old) user network. Often, there is no other (clean) network on which one can rely following release. These often include people who use drugs and thus act as an inducement to use again. People returning to their old neighbourhood to seek social support feared that they would run into a friend who was still using and could easily provide some drugs. Shelters providing emergency accommodation also increased the chance of meeting people who use drugs and were considered by the participants as a risk factor for relapsing into drug use. Also, when one is lonely and there is no (social) support at that moment, the step towards drug use is quickly made.

'I was released and I wanted to pick up again the outpatient drug treatment I had before detention, but my therapist was on leave. So, I wanted to work on it for three weeks, but I couldn't and then I lost control. I had a relapse. I met an old friend who was still using speed and ... Last time I was free again and I did everything well: I requested financial support and got two weeks of support. But the third week they told me I had to find my own way. I went back to my brother and used drugs, I shouldn't have done that. But it is difficult if you are in that circuit. Certainly if your brother is a user, most of my family are users ... Where can I go? You're in the middle of a struggle... You come out, have no home, I could stay with my brother, but I was also alone there, so what do you do to be able to talk to someone? I went to my cousin, but he also used drugs there. I lost myself. I thought I could handle it, but first it is one line [of coke], another line half an hour later and like this you're back again on drugs.' (PR, M, BE).

'As a result, the only possibility I had was to sleep in night shelters. Even with the best possible will, when you have to leave every morning... [it is not possible to book a bed in advance in some shelters]. This, in addition to a population of active consumers, in the end, I found myself with consumption again in my daily life. Even while working and trying not to sleep, in quotation marks, under the bridges, the consumption was there. It's not manageable.' (EPR, M, FR)

'The consumer is like a family, they support each other in consumption. So if you don't have any other support, you can fall into consumption quickly. You will seek support from your friends, from consumers. So that brings you to consumption.' (EPR, M, FR)

The last time you were released from prison, did you have a housing plan on release?

No [...]. So after that, it's the old acquaintances, and since we don't have new friends, because we're not well, we go to people who are not respectable. As a result, only they can hear us and we use again, we use again. And we're not moving forward. It is an excessive consumption, every day, to the point of no longer wanting to face problems, to the point of fleeing.' (EPR, M, FR)

Participants pointed out that inactivity immediately following release was an additional risk factor for drug use. Even when health support or administrative procedures were initiated, they report long periods of waiting for the social or medical support to move forward. During this post-release period,

they often lack a sustainable housing solution and cannot seek employment as their administrative situation is not in order yet. Given this context of uncertain outcomes and difficult transition, great amounts of unfilled time seemed to add anxiety or disorientation.

'So, I was outside. The problem was that, to pass the time, I started drinking, boozing. I started to inject again and said to myself: if I do one today and I do it for four or five days, it doesn't matter, I won't go back into craving. But in the end, the shots get closer and closer each time. As a result, I started going to bed very late at night, spending sleepless nights, missing appointments, totally forgetting that I had an appointment that day. In the end, it was a failure. I could see no more way out, except, once again, prison.' (PR, M, FR)

Some interviewees indicated a very strong motivation inside but a high craving after release. Also being 'clean' (especially after no access to OST inside) is an important pitfall to using drugs outside. They 'need' some drugs and a 'good cocktail' (cocaine and heroin at the same time) after release. In some cases, there was excessive consumption after release, in other cases less than before imprisonment.

'And these thoughts you had, what to do after release. Work, new life, looking for a flat and this and that. All this just disappears on the day of release. You'll forget that soon after you leave the prison a few yards away. That's so bad. That is madness. And then again and again drugs.' (EPR, M, DE)

'And I have that time, which I ended up with at the end, the first week I really celebrated. And I shot myself so hard (used so much) that I nearly died.' (PR, F, DE)

'But sometimes, when you didn't use drugs for a long time, there is also craving. Then you have to satisfy the addiction. Yes, and that's that, that's a real force to do this sometimes.' (PR, M, DE)

Difficulties (ex-) prisoners encounter when arranging things, such as employment and housing, are not helpful either and may trigger ex-prisoners to use again. Moreover, a number of respondents indicated that if medical treatment is not continued after release (because of a lack of health insurance), relapse is very likely.

'Because there are a lot of people here who get detained with no perspective, trying to build a perspective here, are thrown out and have no perspective again. They do not have a point of contact if they have a point of contact, yes, they have to wait half a year before anything happens here. It's clear they'll use drugs again, or what do I know, and become criminal.' (PR, M, DE)

'If you have a lot of money at release and no doctor anymore (OST), so what do you do first? You think "yes OK. I'm just getting the bare necessities, so I'm not on withdrawal." And what do I do then? That does not last that long.' (EPR, M, DE)

According to German (ex-) prisoners, the biggest challenge regarding drug use is the bridge allowance on release. In Germany, prisoners receive money on the day of release if they worked inside. They need to save it for the first month for living but it seems to be hard not to buy drugs with it.

'Because everyone gets released with money, it depends on how long they've been sitting. I had a lot bridging allowance. I worked for four years (inside). I've had over €3000, you can afford it (drugs).' (PR, F, DE)

Finally, the following example shows three important facts after release experienced by one participant.

- The urge to take drugs was balanced by the will to maintain the progress made during incarceration (a complete cessation of use) as a way to ‘taste it again’ without falling back into regular consumption.
- The stronger dose directly after release (withdrawal in prison), thinking it was ‘just the one’ before going back to abstinence.
- The change after a few releases, that the time period before going back to drug use became shorter and shorter.

‘It’s true that when you come out, you want to use, and also you don’t want to relapse into it because you feel like you’ve gotten out of it, because of the withdrawal done in prison. But we still want to try it again. So what we do, or what I did, is to try in one shot, knowing that the best one is the first and that from the second, we go into the plural and we go into the crazy thing. I wanted to put more than I could smoke, thinking that after that it would calm down. But what happened next was that the excessive dose I had put in, since I still wanted to rebuild afterwards, I couldn’t take it anymore. So I was using to [satisfy the need to] consume but at the same time I had a kind of frustration when I took it. But regarding the overdose actually, I see above all a story, in my case, it’s rather an excessive dose [to cope with] the craving. Every time I come out and start to use again, I use again within a period each time shorter than the last, and I use more. I want to consume more. Why? I don’t know.’ (PR, M, FR)

5.4.2 Positive experiences following release

Individual level

Most respondents had more negative feelings regarding release than positive, except in Portugal. As expected, very few people who had a home and good contacts with family and friends mentioned these factors as very positive related to the time after release, especially regarding drug use, motivation and structure. Having ‘someone who waits’ in the community helped them to ‘keep their mind off drugs’ and was reported as being very helpful and supportive in the time immediately following release. The respondents also noted that the social network was and is the main factor in enabling an easier and more positive reintegration, since they were the ones providing for their needs on release, namely social support, housing, supplies and finances, in cases where they had a social network outside, which was not the case for the majority of the (ex-) prisoners in our sample.

‘I came to the conclusion, that family is very important for any type of rehabilitation or reintegration, because they support such basic things as food or housing.’ (PR, M, PT)

‘When I arrived here [residential treatment centre], I was told, “You stay here for three weeks”. I said, “No, that’s not possible, I need to have a day or two to step back, to see my family”. For me, it is vital. All my life, it revolves around my family. For this I thank them by the way.’

And how did you manage the return to your family without Subutex® [OST]?

It was hard. Well... yes and no. Since I was with my family, I honestly didn’t think about it that much. I didn’t have such a headache, such anguish, such hot flashes. I wasn’t that bad, frankly. I even was surprised, I said to myself: I haven’t taken my treatment in four days, whereas in ten months I haven’t missed a day. But no, I didn’t have any problems with that, that’s good.’ (EPR, F, DE, FR)

Some respondents associated release with the sense of freedom.

'The moment of departure is a unique moment, so much joy that no matter how angry you are you forget everything. I did not miss anything [regarding the incarceration period]. I missed things when I was in prison. When you walk out the door, you have access to family, the most beloved ones. (...) The door being open is all good.' (PR, M, PT).

Structural level

On a structural level, the respondents reported very different experiences. As mentioned before, the majority of (ex-) prisoners had bad experiences, but some also had good ones. Besides housing, the major protective factor according to the respondents was finding a job after release. Work was associated with strong and varied support, since it was linked with reinsertion, the provision of an income stream and, most of all, an occupation. One of the ex-prisoners even presented the work as a way to 'find exhaustion at night', and to get back a normal 'rhythm' into his life.

Regarding access to health care, some participants conveyed positive experiences of coordination between professionals outside and inside prison, allowing them to feel more secure just before and after release. Some mentioned the leave they obtained from the prison administration to go and visit long-term residential treatment centres for a day. A prescription sheet provided before release by the medical unit in prison and/or treatment centre providing free OST (France) or OST for self-payers (Germany) was often mentioned as highly practical and reassuring by the interviewees, as receiving OST is one of the major challenges after release if they have no health insurance.

Some respondents referred to the training inside as a positive element for reintegration, including receiving information and identifying interests (for leisure time) for outside. Besides training inside, some respondents mentioned that the therapeutic community is a positive after release, in terms of the opportunity to meet other people who had recovered and were leading their own life autonomously.

'(...) there I worked with medical therapists, did small community work and then would move to live in an autonomous reinsertion home. I felt it was important, I met people who recovered and went there at weekends to talk about what they had already achieved.' (PR, M, PT)

In Portugal one ex-prisoner reported the importance of the social security system, since most of them leave incarceration without a job and the only income they have to deal with monthly expenses is the social integration payment (state financial benefit; current reference amount: €186,68).

Specificities of the residential treatment centres in France

Due to our recruitment strategy, participants could often recount an actual or recent stay in a treatment centre specifically designed to accommodate ex-prisoners with a history of drug use, during the first two or three months after their release from prison.

At the individual level, these facilities allowed them first and foremost to build a framework. Moreover, the training and numerous activities (such as sports, walking, buying groceries for the group, etc.) gave them two important things in their eyes: an occupation and an opportunity to progressively get back into the world, to make their transition at their own pace. One person interviewed inside a treatment centre described the steps he allowed himself during his stay: first an afternoon per week in the community, then one day per week, then going back to see an old friend who might still be using drugs, and finally trying to see his children again:

'I go crescendo, I go calmly. I put myself first. So, my first leave [from the residential treatment centre, where he went before the end of his prison sentence, as an "alternative sentencing"] it was more like taking personal points of reference, on me, my automatisms. When we come out the first time, we have our automatisms from before the incarceration. So, I have to take up other automatisms again. But I always had these automatisms when I first went out [from prison].

Is this the priority work point for you?

That's right, but it was working with the educational team. I worked on my emotions and feelings. I mean, I work very slowly. So I took half a day to start, after that it was a whole day, like next weekend. Afterwards, it's also to rehabilitate ourselves and to find out where we stand in terms of drug use patterns, it can be alcohol, it can be drugs. Now, regarding my close friend I don't want to directly confront myself with that, and go to his house, but I'll try to have a neutral place and try to have another relationship with him because he's still using. So far, I haven't gotten to that point with my children. We're going step by step because the children, if I go to see them right away it can be disturbing for them and it can be disturbing for me too in my approach, because I don't want to make the same mistakes I made. Thinking about my children is good, but you have to think about yourself first. If I am fine, my children, they will be fine too.' (EPR, M, FR)

5.4.3 Preparation for release

According to the respondents, a frequently heard story is that they are released unexpectedly, especially in cases where there was a short prison sentence. The release date is not known in advance, so ex-prisoners often end up on the street all of a sudden. They also reported very often that they had no support and were 'kicked out' of prison only with a bag and no plan to go. Some indicated that they would rather stay inside than being released without a plan.

'Sometimes it's really rude how quickly you have to get out there, you know. You've spent two months there and suddenly that door opens. They come to pick you up and then they start nagging like "come on, go faster". The first time it was just a cardboard box [they gave]: "take all your stuff" and suddenly you are standing there. I think you are allowed to do one phone call to your family. But yes, you always have to ask it yourself.' (EPR, M, BE).

'Nothing at all. Because nobody is actually doing it (support). There is no one and helps. You can go somewhere afterwards, yes. But then I'm already outside. Since I'm already out on the street and do not even know, I've got quite other things in mind first time where I sleep, or something, yes.' (EPR, M, DE)

'Yes, I can say so. I was put in front of the door. I did not know How? Where? What. I did not care to go to my OST so I could get my methadone the next day. And I have no ID card, no.' (EPR, F, DE)

'Well, nothing happened. You live there and then someday there is the day of release. And then you will be kicked out. And now, as I said, I'm short time – four months. Then I will go to a final sentence. And I wonder what it is here. They say preparation for release is made.' (PR, F, DE)

The majority of respondents indicated that preparations for release are often minimal. Most (ex-) prisoners felt uncomfortable on the day of release because of not knowing what situation they would face afterwards. Some indicated that they lost their flat during imprisonment or found their flat in bad condition after release. In some cases respondents reported that they were released on a Friday and that they had to wait until the next weekday for their OST. Most respondents indicated that they would

go or went to shelter homes or low-threshold drug treatment centres after release, which were associated with drug use, dirt and unhelpful contacts. On the other hand most respondents found a place to sleep in these places and reported useful contacts made with social workers and the possibility of accessing OST.

'I felt uncomfortable with the release. I felt uncomfortable going out at all, that was connected with fear. Maybe something happens to the gate that I have to go back to jail and that scared me the most.' (EPR, M, DE)

'In the meantime, my apartment is gone, as I said my registration address is gone too. [...] And I do not have a single plan yet.' (EPR, M, DE)

'If you're lucky, you have a good day, it was Friday, so it was too late for everything. I had to wait all weekend and then I was able to go to the job centre, submit application. I think we had previously sent a form there, but you still have to come over there anyway, you cannot do everything via post.' (EPR, M, DE)

'After the release, that is, where I was released, I am directly back in the (emergency dormitory / drug facility) and have contacted me, just for the reason that I am substituted and get methadone and have no apartment and therefore immediately registered here have that I get a place to sleep. Which I also got.' (EPR, M, DE)

If a prisoner serves a short sentence or chooses to serve the whole sentence (without being released early through provisional or conditional release), no reintegration plan is made with the prisoner in most cases. When they are handed a longer sentence, they are entitled to parole and exit permissions before release, which makes it easier to make the necessary arrangements. (Ex-) Prisoners indicated that they can work on a rehabilitation plan in that case: searching for a house, doing paperwork, looking for a job and restoring ties with the family are things that can already be picked up before release.

Most respondents reported a lack of support from in- and outside prison. Community networks were often mentioned as being helpful.

'It is still very recent [release] to draw conclusions; however, I do not think there is any kind of support after imprisonment.' (PR, M, PT).

'They did not support me at all. We leave and we have no support at all, we are just one number. We are forced to go to social reintegration every month, but they do not help at all, we have to find our own way. For me, institutionally, nothing was useful.' (PR, M, PT).

'My lack of knowledge of supports regarding social reintegration. Even when I say this, I only imagine what it is.' (PR, M, PT).

Some (ex-) prisoners indicated positive preparation for release. This was often associated with therapy after release or a special support like a social worker outside, transition management or family and friends. Only a few reported that they had the possibility for open prison measures, and many indicated that these measures were helpful for training for life outside.

'The last time I went out on a section 35, because I had no apartment outside. I prefer to go to therapy first because I have a better chance of getting an apartment from there.' (PR, F, DE)

'So I had a lot of support from here, and then I went to the job centre with them. So I did not have any hurdles, but I had a lot of support from the (open drug treatment, low-threshold

counselling centre) from the social workers I've had for years, so if I did not have them. Alone I would not have made that because I do not know or articulate myself that way and so on.' (EPR, M, DE)

'Thank god, my family supports me. About pastoral care, we can call at any time, if there are important phone calls. But you can definitely not count on staff inside.' (PR, F, DE)

5.5 Individual strategies to cope with risks associated with drug use

5.5.1 Dealing with substance use

The interviews showed that respondents have individual strategies to cope with risks associated with drug use. These coping strategies exist on an individual level but some strategies are often mentioned.

Some (ex-) prisoners indicated that it was helpful to change their lives. Changes in social life (daily structure, work, leisure time), contacts (friends, dealers) and housing were reported as being particularly helpful for changing drug use patterns. In the community, too, this strategy is applied and experienced as helpful: (ex-) prisoners break their contact with drug users and stay away from their old neighbourhoods. Having (new) clean contacts is definitely helpful. Some also reported a need to know about their own risk factors for drug use, while some also indicated that a realistic view is helpful (abstinence is not possible for them).

'I've been thinking a lot about what I'm doing differently and getting my life under control because I have three children and now I'm here and I have not had any contact with my children lately. I just thought about how it goes on, that I somehow take a flat and find work and that life goes on.' (EPR, M, DE)

'Hand on heart, I cannot do it without a substitute. What's so reprehensible to say I cannot do it. That's it. And I live with it legally and I can live with it. And I can also build a life for me with substitute. And that's what I recognised. And not thought, what do others think? And I filed that. I do not care what others think, that's my life.' (PR, F, DE)

'I gave it up, honestly, to completely stop with all this stuff. So I restrain myself, have totally limited myself. So with the retraction, sometimes alcohol drinking, yes, and take pills. So I'm careful that it will not be too much.' (EPR, M, DE)

Some (ex-) prisoners stated that they intentionally avoided visits from some people in prison (e.g. friends) to protect themselves from having drugs brought in. Another strategy to stay away from drugs in prison is having something to do. Participating in organised activities such as fitness, sport and cooking help prisoners to relax, reduce stress and distract their thoughts. According to several respondents, having a structure (with daily tasks and activities) is also very helpful in the outside world.

'I want to change my life for myself, so I stay away from the people who are still using drugs here.' (PR, F, DE)

According to several respondents, having a person of trust and/or children is of great help outside prison. Carefully preparing for someone's release is seen as a necessary condition. Several prisoners indicated that someone is lost when arrangements are only made upon release. Moreover, (ex-)

prisoners state that it is important to find a way to cope with the prison period and to recover from the stress they experienced in prison.

'They (fears of overdose after release) really exist and I thought so too, because I'm scared, but the only thing that helps me that I do not consume is when I go to my children. I know that I will not consume because when my children are there, their presence always makes me forget everything else.' (PR, F, DE)

'I know from experience how that works and what the risk is for me. So for myself from drug use. That's a small decision, you really have to prepare well for this dismissal. As I said, if we take drugs then lot of things can happen. I take these drugs because I know that happiness comes and then I can forget problems.' (EPR, M, DE)

In individual cases, the (ex-) prisoners had strategies like setting small goals for themselves, regular withdrawal, organising finances and administrative things before taking drugs after release.

'Assisted living, go to detoxification, transitional institution and make therapy, so small goals. If I set myself big goals that usually does not work.' (EPR, F, DE)

'I've been making my detoxes all the years I've been on heroin regularly. I tried to balance physically.' (EPR, F, DE)

'It helped me that you first think about yourself. So self-assessment also makes sense somehow.' (PR, M, DE)

I 5.5.2 Dealing with the risk of overdose

Regarding prevention and management, all participants have suggested measures to deal with overdose in general and especially during the period after release (from prison and/or therapy).

To reduce the risk of overdose, respondents indicated that it is common sense not to use too much or to take overly large dosages. A proven strategy is to stick to a certain dose. Another respondent states that you should only use one third of the normal dose if you haven't used for a long time. It is recommended to build up consumption gradually, first by using a little bit and then a little more later to reduce the risk of overdose, and/or to use a different way of taking drugs immediately after release, such as smoking instead of injecting.

'If I use drugs, so inject I do me half (of the usual dosage) or less than half and then I wait, what happens when I realise, oh, there is something wrong, then I stop.' (EPR, M, DE)

'I smoked heroin on aluminium foil.' (PR, F, DE)

'To be moderate in the consumption, especially when the substance is new or the last consumptions have occurred long ago.' (PR, M, PT)

'To use the drug in moderation. If I want to eat everything at once, I'm bound to go down. After using, wait a bit.' (PR, M, PT)

In addition, several (ex-) prisoners mention that it is important to 'know the drugs that you are using'. A proven strategy in Belgium is to have the drugs tested first (to know about purity and quality). An overdose can also be prevented by never using alone or using in a consumption room, in which case

someone else can help you if necessary. In Portugal, respondents have specifically argued for the provision of safe consumption sites as a structural measure to prevent overdose.

'I think there should be specific places to get these substances, where people would be medically assisted and have someone watching over.' (PR, M, PT).

'Take less. ... and always with another person, that one is there. [...] That's the first, if you go away (use) alone and you do not know the stuff.' (EPR, M, DE)

'The basic thing would be to know what you are going to use and how it is going to affect you. People should know what they are taking.' (PR, M, PT)

'Knowing what you are using. Many years ago I have seen people injecting and dying. They do not know, they think they are injecting cocaine and it is not cocaine. They do not really know what they are using.' (PR, M, PT)

One respondent found it helpful to have social control, like having a partner who controls use after release (by telling them 'Start using with reduced dosage').

'So my husband never lets me out of his sight. He always says, "You cannot do that, a whole bullet. That's too much!" and so on. And I always say, "No, that's not too much." But I swore to him, to our love, that I'll never do that again, a whole bullet. And I will not do it, because I promised.' (PR, F, DE)

The respondents, especially in Portugal mentioned emergency measures in case of an overdose like using salt or naloxone.

'I've seen a person with such a problem. The boy who was injecting stood there and never got up again. The other who was smoking took salt water and stuck it in and he woke up. I also know that naloxone prevents it.' (PR, M, PT)

'I know that when a person is having an overdose it is necessary to give salt and put the fingers in the mouth so that the tongue does not wrap.' (PR, M, PT)

Finally, abstinence was also reported by participants as the best way to prevent an overdose.

6 Summary

The following summary describes the results from the study sample as described in the methodology section. The results can therefore not be generalised to the larger prison population, as the interviews only took place in one or two prisons in each country and the sample size was small.

In summary, it can be said that using drugs inside prison is often associated with increased stress levels (e.g. because of fear of getting caught), but people used drugs inside anyway in each of the four countries. Urine tests in Germany make drug consumption more difficult, but they do not mean that prisoners stop using drugs in every case. Substances are available in every country, even if the main substance differs between countries and prisons. In all cases drug use/trafficking is not allowed, but is more or less tolerated inside, depending on country, prison and substance.

Reasons to use inside prison despite the potential negative consequences are mostly associated with bad psychological health and the effects of imprisonment, such as boredom, stress and loneliness.

The interviews showed a difference in the type of drugs used, frequency of use and ways of administration between inside and outside prison. Important factors for changes in drug use include the price and availability of substances and materials, fear of getting caught, and different motivations inside to stop using drugs. The type of drugs used inside were, according to the participants, mostly sedative drugs like cannabis and heroin. The frequency of drug use was lower than outside, with the exception of cannabis use in some countries. Some participants reported that cannabis use was sometimes even higher than it was outside. The methods of consumption were always more risky than outside regarding consumption material and setting.

The use and misuse of medication differ between countries. Using medication, especially benzodiazepines, antipsychotics and opioid substitution treatment (only in Germany) is very common in prison. Detailed information about dealing or stealing medication was only reported in Belgium. Access to medication inside prison is mostly achieved through medical staff (as part of the management of psychiatric or addictive disorders) or through other people inside who receive medication.

In all countries, there is no legal access to harm-reduction measures like clean materials in prison, which leads to risky behaviour (the only exception is a needle and syringe exchange programme in a women's prison in Berlin, Germany). In France, the distribution of naloxone has been authorised in prisons since 2017, but in practice it is far from being introduced in all facilities, and the training of professionals is still ongoing (at the time of the study). In the other countries there was no legal access to naloxone. Most prisoners in our sample were well informed about HIV and HCV transmission, and they indicated that they tried to share tools as little as possible, but also that there was no other way to use sometimes. Some of them clean their equipment with hot water or heat, but this does not happen all the time, especially if time is short due to fear of getting caught. Most respondents indicated that they would never share tools outside, because of easy access to clean material outside prison. The reasons for risk behaviour inside include difficult access to clean materials, stress while using and cravings. Other risk behaviours were reported, including violence and shaving. Most male respondents know about the availability of condoms inside prison (which differs from prison to prison), and whether condoms are more or less easy to get hold of (for free, anonymously, and so on).

Most (ex-) prisoners in our sample had knowledge about risk factors for overdosing. The knowledge differed from minimal to adequate. Information about risk factors regarding overdose were mostly received from other drug users and drug treatment systems in the community. They pointed out the following risk factors: a mix of different drugs (such as uppers and downers), exaggerating (taking too much drugs, overly high doses in a short time, as well as excessive use over a longer period of time), having never used before or not having used for a long time, drug quality, lack of knowledge about the product taken, the adulteration of substances by dealers or changes by the supplier, being greedy, and being clean upon release from prison.

Most drug users had already witnessed an overdose or had one themselves at least once. Managing an overdose is always associated with high stress levels and most of the time with a lack of control over the situation. Calling an ambulance is not common and happens only in very risky situations, because of fear of punishment.

The interviews showed a wide range of challenges upon release. In all countries (except Portugal), most respondents indicated far more negative than positive elements regarding the time following release. On an individual level, ex-prisoners have to cope with the 'world outside', the expected behaviour, the contact with social networks, the behaviour in the community and the fear of relapse. On a structural level, ex-prisoners need to organise many administrative procedures like insurance, employment, housing and medication. The main challenges according to the respondents are housing and employment, both of which, when sorted, lead to a better daily structure and motivation to start a new life. If these elements are missing completely or no support is available (drug treatment centres, family, friends, etc.), the risk of using drugs again increases. Other motives to use drugs upon release are having no structured activities, long periods of abstinence (craving), struggling with administrative procedures, long waiting times between release and support being provided outside, going back to old networks and feeling alone.

In addition to negative elements, there are some positive elements experienced at the point of release. Positive elements on an individual level are family, friends and housing. If the respondents had a social network outside, they pointed out that this is the main factor for an easier and more positive reintegration after release. Some interviewees also mentioned the sense of freedom as a positive element at release. In summary, some respondents had positive elements upon release, especially regarding OST, therapy, training and other helpful support from inside and/or outside prison. Since positive elements were rarely mentioned (except in Portugal), it seems that some structural elements may be positive but access to these measures is complicated or only possible for some prisoners.

According to (ex-) prisoners, there is a huge lack of support and preparation for release. In some cases, they had good support from professional networks but this support does not seem to exist on a structural and systematic level, as it was not provided for all prisoners. Preparation for release was more likely if the sentence was longer than one year, as all prisoners then receive a reintegration plan. A positive preparation was often associated with therapy after release or special support like a social worker/case manager outside, transition management, or family and friends.

Despite the facts and elements mentioned above, the interviews clearly show that drug users in and outside prison develop a lot of useful individual strategies to cope with risks associated with drug use. Respondents try to start a new life, make new friends, try to avoid the old negative social network, know about risks to their own body, and some are very clear about having a feeling for what is useful in order to cope with risks. They often mentioned family and friends and an organised and well-prepared release as helpful. Regarding overdose prevention, they reported that 'knowing the own body' and 'drugs outside' is the best way to avoid an overdose. Besides these strategies, using drugs in a safe environment like with friends or in drug consumption rooms is the best way for them to use safely, even in case of an overdose.

7 Conclusions and recommendations

Despite variance between the countries and prisons, and in spite of the substantial efforts to reduce the supply of drugs, drugs are easily available in most prisons and are used by a substantial number of prisoners, mostly in harmful and risky ways. These facts have to be acknowledged by prison officials and should lead to the introduction of harm-reduction measures in order to avoid overdoses and HIV/HCV/HBV infections, which do not only affect the health of prisoners, but also the health of society substantially.

The comprehensive package of harm-reduction measures (HIV prevention, treatment and care in prisons and other closed settings), issued by UNODC, ILO, UNDP, WHO and UNAIDS in 2013 consists of 15 key interventions:

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

With regard to overdose prevention, of the countries and prisons included in this research only France provided naloxone and training for overdose prevention before release. In France, the distribution of naloxone has been authorised in prisons since 2017, but in practice naloxone is far from being introduced in all facilities and training of professionals was still ongoing at the time of the study. In the other countries there was no legal access to naloxone. Despite promising experiences reported in Scotland and other parts of the world, this strategy of mortality prophylaxis is widely neglected. The use of opioids is the main cause of post-release mortality (Merrall et al., 2010). In order to respond to this challenge, a range of services needs to be introduced:

- Information, education and communication (IEC) strategies to point out the risks of relapse after release (especially peer-driven-interventions)
- Connections between health and social services provided inside and outside prison
- Continuity of medication-assisted treatment of opioid-dependent prisoners

- Re-uptake of medication-assisted treatment for opioid-dependent prisoners before release (approximately six months)
- Training on the management of drug-related overdose and the provision of naloxone kits before release.

Naloxone hydrochloride is an opioid antagonist capable of reversing overdose due to opioids, such as heroin or prescription opioids. Naloxone has no potential for abuse; its only major contraindication, allergic reaction to prior administration, is rare. For more than three decades, emergency medical personnel have administered naloxone as a standard pre-hospital treatment for opioid overdose. Naloxone has been available, on prescription, to at-risk drug users and their family/friends since 1999 through selected programmes around the world (Yokell et al., 2011).

The reduction of boredom, stress and loneliness seems to have a positive effect on drug use. The more that suitable measures like offering a daily structure, meaningful occupation and work, and the organisation of collective events are introduced, the more drug use will be reduced. Regarding different measures, the main focus during development and implementation should be on the specific needs of prisoners to meet every need.

Also, there are some strategies taken on an individual prisoner level upon release to prevent relapse. The availability of a positive social network with friends, partners, family members and so on is definitely a stabilising factor that needs to be prepared for prior to release.

Different patterns of drug use when entering prison from the community were clearly observed. In addition, the sharing of needles and/or other tools was more likely in prison than in the community, as there are no syringe exchanges or harm-reduction measures inside prison. Risk behaviour regarding drug use upon release and overdose risks needs to be discussed with prisoners. Prevention programmes need to address knowledge and support rather than fear of peers, boredom and other factors which lead to drug use inside or relapse upon release. Individual coping/harm-reduction strategies implemented by any (ex-) prisoner and knowledge of existing programmes should be used to develop suitable measures.

On a structural level, more efforts have to be taken to organise easy administrative procedures for re-integration into employment, housing, and stable and continuous medication, if needed. Reintegration into health care in Germany and France in particular needs to be improved, the example set by Portugal, where there is no delay to gaining free access to the usual treatment, needs to be followed.

Preparation for release (a reintegration plan) is a key to successful reintegration and should be organised for each prisoner individually, regardless of the length of sentence. Positive stabilising factors include the start or continuation of treatment after release, or the provision of special support such as a social worker outside, case or transition management, or family and friends.

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Annex

Key questions regarding national legislation and policies

Access to care and health insurance IN THE COMMUNITY

1. Can drug users benefit from special status regarding health insurance, allowing cost-free access to all medication related to drug addiction treatment? yes no
- 1.1. If yes, is it accessible for all drug users? yes no
- 1.2. If no, please state those who are excluded:

2. Considering access to treatments in the community:

2.1. OST

- 2.1.1. Is OST cost free for drug users yes no

- 2.1.1.1. If no, is there any alternative available for drug users without resources? yes no
please, explain

- 2.1.1.2. If yes, does this apply to all drug users? yes no

If no, please explain (migrants, subjects without official documentation....):

- 2.1.2. In the national health insurance policy, is there special status allowing free, long-term access to OST for drug users? yes no

- 2.2. ART yes no

- 2.2.1. Can HIV-infected patients benefit from cost-free treatment access? yes no

- 2.2.1.1. If yes, are some parts of the population excluded from this cost-free access? yes no
If yes, please explain:

2.3. Anti-HCV treatment

- 2.3.1. Is anti-HCV officially accessible to drug users? yes no

- 2.3.2. Is it cost-free for drug users? yes no

- 2.3.2.1. If no, is there any alternative available for drug users without resources? yes no
please explain

- 2.3.2.2. If yes, is it for all drug users? yes no

If no, please explain
(migrants, subjects without official documentation...):

- 2.4. Naloxone for overdose prevention
- 2.4.1. Is naloxone for OD prevention officially available in specialised settings for drug users? yes no
- 2.4.2. Is naloxone for OD prevention officially available for drug users to take home? yes no
- 2.4.2.1. If yes, are they cost free for drug users? yes no
- 2.4.2.2. If no, is there any alternative available for drug users without resources? yes no
please, explain

- 2.4.2.2.1. If yes, is it for all drug users? yes no
- 2.4.2.2.2. If no, please explain
(migrants, subjects without official documentation...):

Access to care and health insurance *INSIDE PRISON*

3. In your country, is the care organisation the responsibility of:
- 3.1. Ministry of Health yes no
- 3.2. Ministry of Justice yes no
- 3.3. Other (please explain) yes no

4. What kind of medical services are available inside prison?

- 4.1. Are some addiction medicine consultations available? yes no
- 4.1.1. If yes, in the majority of prisons? yes no
- 4.2. Are some infectious disease consultations available? yes no
- 4.2.1. Including consultations for HIV? yes no
- 4.2.1.1. If yes, in the majority of prisons? yes no
- 4.2.2. Including consultations for HCV? yes no
- 4.2.2.1. If yes, in the majority of prisons? yes no

5. Is screening for the following medical problems systematically organised at entry?
- 5.1. HIV yes no
- 5.2. HCV yes no
- 5.3. Drug use yes no
- 5.3.1. Who is in charge of this drug use screening?

6. Is the screening repeatedly available during incarceration or upon release from prison?
- 6.1. HIV yes no
- 6.2. HCV yes no
- 6.3. Drug use yes no

7. Are some external partners involved in the screening of drug abuse among entrant prisoners? yes no
7.1. Can you explain further?

8. In your country, does a prisoner have special status regarding health insurance inside prison compared to in the community? yes no
8.1. If no, can you provide details the status regarding care for prisoners?

- 8.2. If yes, please explain :
- 8.2.1. Does it include long-term drug users? yes no
- 8.2.2. Does this status allow free care inside prison? yes no
- 8.2.2.1. If yes, for all kinds of treatment? yes no (→3.2.3)
- Including OST? yes no
- Including ART? yes no
- Including anti-HCV treatment? yes no
- Including naloxone? yes no
- 8.2.2.2. Are some prisoners excluded from this health insurance coverage?
- Migrants yes no
- Subjects without official documentation yes no
- Others (please explain) yes no
- 8.2.2.3. In practice, are there any obstacles to the implementation of this policy for drug users? yes no
- If yes, please explain:

- 8.2.3. If no, what kind of treatment does it include?

9. Are the following treatments available in prisons in your country?
9.1. Is **OST** available in prisons in your country? yes no
9.1.1. If no, in which prisons and why:

- 9.1.2. If yes, in all prisons? yes no
- 9.1.3. If it is accessible, is it free of charge for prisoners? yes no
- 9.1.3.1. If yes,
- for all prisoners yes no
- for some prisoners only yes no
- please explain:

9.1.3.2. If no, what are the conditions for gaining access to care?

9.1.4. Does access to OST in prison respect the # principle of equivalence with the community? yes no
If no, please explain :

9.2. **ART**

9.2.1. Is ART accessible in all prisons? yes no
If no, in which prisons and why:

9.2.2. Is it free of charge for prisoners? yes no
If yes, for all prisoners? yes no
for some prisoners only? yes no
please explain:

9.2.2.1. If no, what are the conditions for gaining access to care?

9.2.3. Does access to ART in prison respect the principle of equivalence with the community? yes no
If no, please explain:

9.3. Is **Anti-HCV treatment** available in prisons in your country? yes no

9.3.1. If yes, in all prisons? yes no

9.3.1.2. If no, in which prisons and why:

9.3.2. If it is accessible, is it free of charge for prisoners? yes no

9.3.2.1. If yes,
for all prisoners yes no
for some prisoners only yes no
please explain:

9.3.2.2. If no, what are the conditions for gaining access to care?

9.3.3. Does access to anti-HCV treatment in prison respect the principle of equivalence with the community? yes no
If no, please explain :

9.4. Is **Naloxone** available in prisons in your country? yes no
9.4.1. If yes, in all prisons? yes no

9.4.1.1. If no, in which prisons and why:

9.4.2. If it is accessible, is it free of charge for the prisoners? yes no

9.4.2.1. If yes,
for all prisoners yes no
for some prisoners only yes no
please explain:

9.4.2.2. If no, what are the conditions for gaining access to care?

9.4.3. Does access to naloxone in prison respect the principle of equivalence with the community? yes no
If no, please explain :

Access to care and health insurance AT PRISON RELEASE

10. Does a “just-released” prisoner have special status regarding health insurance? yes no (→6.2)

10.1. If yes, can you please explain:

10.1.1. How long will the ex-prisoner benefit from this status? _____ months

10.1.2. Does this apply to all prisoners? yes no

10.1.2.1. If no, can you please explain the subpopulations excluded?

10.1.3. Does this status allow cost-free treatment after prison release? yes no

10.1.3.1. If yes, does it include

- a. OST yes no
- b. ART yes no
- c. Anti-HCV treatment yes no
- d. Naloxone yes no

10.1.3.2. Does this free access begin immediately after prison release? yes no

10.1.3.2.1. If no, how long does the administrative procedure to gain access to free treatment usually last for?

10.1.3.2.2. Do prisoners have alternatives to getting access to free treatment awaiting end of procedures? yes no

If yes, can you please explain:

10.2. If the prisoner has no special status after prison release, what is their status regarding health insurance after prison release?

10.2.1. Is free access to the following treatments possible?

- a. OST yes no
- b. ART yes no
- c. Anti-HCV treatment yes no
- d. Naloxone yes no

10.3. Does a prisoner receive a health insurance certificate upon release? yes no

10.3.1. If yes, does this document by itself entitle them to receive treatment freely just after prison release from a pharmacy? yes no

10.3.1.1. If no, how long does the administrative procedure usually take before gaining free access to the treatment?

10.3.1.2. Meanwhile, do ex-prisoners have any alternative to getting access to free treatment? yes no

10.4. Can the prison medical unit provide treatment for several days before prison release to any prisoner scheduled for release? yes no

10.4.1. If yes, for

- a. OST yes no
- b. ART yes no
- c. Anti-HCV treatment yes no
- d. Naloxone yes no

10.5. In practice, upon prison release, does the prisoner frequently meet barriers to:

10.5.1. receiving a health insurance certificate yes no

10.5.2. receiving a medical prescription for continuity of care yes no

10.5.3. receiving pills for few days in prison while waiting for the prescription

- a. OST? yes no
- b. ART? yes no
- c. Anti-HCV treatment? yes no
- d. Naloxone? yes no

- 10.5.4. being informed on time of the date of release yes no
10.5.5. getting contact details of professionals for follow-up in the community yes no
10.5.6. being in contact with these professionals before release yes no
Any comments or further clarifications:

- 10.6. Who is in charge of delivering the following to the prisoner upon release:
10.6.1. Health insurance certificate (if applicable)

- 10.6.2. Medical prescription (if applicable)

- 10.6.3. Pills for few days (if applicable)

- 10.7. Do some professionals or organisations from the community officially have responsibility for the continuity of care just after release? yes no

- 10.7.1. Can you explain?

- 10.7.2. Do these professionals or organisations receive funding from

10.7.2.1. Ministry of Justice

yes no

10.7.2.2. Ministry of Health

yes no

10.7.2.3. Other (please explain)

yes no

Summary of results from key questionnaire

Health insurance and access to care IN THE COMMUNITY

	GERMANY	FRANCE	BELGIUM	PORTUGAL
• Special health insurance status allowing cost-free access to care for drug users	Yes	Yes	No; part of the treatment must always be paid by the client themselves	Health insurance free and universal and treatment cost-free when social condition is poor, whatever the status (drug user or not)
• Cost-free access to OST?	Yes	Yes	No, but possible local agreement if no resource	Yes
○ If yes, any exception?	Refugees	If no documentation, treatment is free in specialised settings		No
○ Possible long-term cost-free agreement?	Yes	Yes	No: annual review of the reduced contribution	No
• Cost-free access to ART?	Yes	Yes	Yes If certain conditions	Yes

			(health insurance) are met; limited for people without documentation	
• Cost-free access to HCV treatment? ○ Any exception?	Yes Drug users without documentation	Yes Drug users without documentation	Yes Only for advanced liver diseases	Yes
• Cost-free access to take-home naloxone?	Yes, but a very limited number of settings propose take-home naloxone	Yes	Naloxone not available	No, naloxone not available
• Cost-free access to social services (psychosocial interventions)?	Yes	Yes, in specialised settings and hospital	No, but possible on a case-by-case agreement	Yes
<i>Health insurance and access to care <u>INSIDE PRISON</u></i>				
	GERMANY	FRANCE	BELGIUM	PORTUGAL
• Responsibility of care organisation	Ministry of Justice	Ministry of Health	Ministry of Justice	Ministry of Health

• Existing addiction medicine consultations?	Yes, most prisons	Yes, limited number of prisons	Yes, limited number of prisons	Yes, majority of prisons
• Existing HIV consultations?	Yes, most prisons	Yes, most prisons	Yes, limited number of prisons	Yes, but not majority
• Existing HCV consultations?	Yes, most prisons	Yes, most prisons	Yes, limited number of prisons	Yes, but not majority
• Existing psychosocial interventions?	Psychologists, psychiatrists, social workers Often no formal intervention	Psychiatrists/psychologists, Withdrawal management, limited harm reduction interventions	Yes, limited services Psychotherapy, short duration programmes (1 prison), drug-free programmes (3 prisons)	Yes, not majority Psychology and drug treatment services
• Systematic screening for HIV, HCV, drug use, mental health at entry?	Yes	Yes	No	Yes for HIV, HCV, drug use but no for mental health
○ Who is in charge?	Medical doctors within 24/48h	Nurse, then medical doctor and if available, specialist in addiction medicine	Nurses	A case manager is designated for each entrant and refers to the sanitary drug team if drug use
• Any screening repeated during incarceration?				Yes for HIV, HCV
• External partners involved in the screening?				

	No	No	No	and drug use
				No
	No	No	No	
• Special status regarding health insurance inside prison?	Yes, the states cover the health-related services offered by HI outside	Yes, full coverage by the health insurance whatever the status of the prisoner (paid by the Ministry of Justice)	Yes, health insurance suspended in prison, penitentiary administration pay for health costs	No, follow-up included in the national health service
○ All medication cost-free?	Yes	Yes	Yes (naloxone not available)	
○ Some populations excluded?		No	No	
○ Some limitations?	No Some states do not provide OST	No	No	

Health insurance and access to care INSIDE PRISON (continued)

	GERMANY	FRANCE	BELGIUM	PORTUGAL
• Special status regarding health insurance inside prison?	Yes, the states cover the health related	Yes, full coverage by the health insurance whatever	Yes, health insurance suspended in prison,	No, follow-up included in the

	services offered by HI outside	the status of the prisoner (paid by the Ministry of Justice)	penitentiary administration pay for health costs	national health service
○ All medication cost-free?	Yes	Yes	Yes (naloxone not available)	
○ Some populations excluded?	No	No	No	
○ Some limitations?	Some states do not provide OST	No	No	
• OST available?	Not in all prisons	Yes	Yes	Yes
○ Principle of equivalence respected?	Not in some states	Yes	Yes	Yes
• ART available?				
○ Principle of equivalence respected?	Yes	Yes	Yes	Yes
• HCV treatment available?	Yes	Yes	Yes	Yes
○ Principle of equivalence respected?	Only in prison hospitals	Yes	Yes, except for prisoners awaiting sentence, at least in Wallonia	Yes
• Take-home naloxone available?	No		Yes, except for prisoners awaiting	
○ Principle of equivalence respected?				

		Yes	sentence	Yes
• Psychosocial interventions available?			No	
○ Principle of equivalence respected?	No		Yes	
	Yes	Yes		No
		Yes	Yes, but not in all prisons	Yes
	Yes		No	
		No, staff often not available		Yes
	Yes	No		
				yes

Health insurance and access to care AFTER RELEASE

	GERMANY	FRANCE	BELGIUM	PORTUGAL
• Special health insurance status upon release?	No	Yes	No	No
<u>If yes,</u>		Systematic health insurance coverage for one year following release		
○ Exceptions?		People without papers		
○ Allows free access to treatments?		Yes		
○ Any delay to getting the benefit?		At least one month for full health insurance coverage		
○ Existing alternatives if delays?				
<u>If no,</u>		Specialised settings (drug addiction centres, HIV clinics)		
○ Free access to treatment possible?	Yes		No, as before incarceration	Yes
○ Any delay?	Around 30 days (major gap for		No, but delay to getting local agreement when	No delay except if waiting list in the

	continuity of care)		no/low resources and in some municipalities where the ex-prisoner has to prove they are eligible for health insurance (up to 30 days)	centre
• Any certificate allowing access to health insurance given at prison release?	No	Yes, up to one month delay to get full health insurance	Yes, "proof of detention": allows immediate (partial) health insurance coverage in most cases	No

Health insurance and access to care AFTER RELEASE (continued)

	GERMANY	FRANCE	BELGIUM	PORTUGAL
• Can the medical unit provide treatment for a few days after release?	Only OST in some prisons No ART, HCV treatment or naloxone	Yes	Yes in theory, but limited at least in Wallonia. Naloxone not available	Yes, except take-home naloxone not available
• When continuity of treatment is impossible, is there any alternative access to cost-free treatment?	Yes	For OST and naloxone, in	Public Centre for Social Welfare can	National health service except in

	specialised centres For ART and anti-HCV treatments, in hospitals	vouch for the client and provide a social card	case of waiting lists	
<ul style="list-style-type: none"> • In practice, are there barriers at prison release? <ul style="list-style-type: none"> ○ To getting a certificate allowing health insurance ○ To getting a medical prescription ○ To getting treatment for few days ○ To informing sanitary unit of the date of release ○ To getting contact details of professionals in the community ○ To being in contact with professionals in the community before release 	<p>Yes</p> <p>Yes</p> <p>Only in some prisons (OST)</p> <p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p> <p>Yes (except for ART)</p> <p>Yes</p> <p>No</p>	<p>No</p> <p>Depends on the area, not often in Wallonia but yes in Flanders</p> <p>Yes, for OST given in a limited number of prisons in Wallonia (naloxone not available)</p> <p>No</p> <p>No</p> <p>Yes</p>	<p>No certificate</p> <p>No</p> <p>No (except naloxone)</p> <p>No</p> <p>No</p>

	Yes	Yes		No
<ul style="list-style-type: none"> • Who has the responsibility: <ul style="list-style-type: none"> ○ for the certificate allowing access to health insurance? ○ for the medical prescription? ○ to provide pills for a few days? 	Prisoner themselves	Prison registry service	Prison director (proof of detention)	N/A
	Medical unit	Medical unit	Medical unit	Medical unit
	Medical unit	Given to registry service for day of release (except ART)	Medical unit	Medical unit (eight days to one month)
<ul style="list-style-type: none"> • Are some professionals or ONG responsible for the continuity of care? <ul style="list-style-type: none"> ○ Funding? 	Yes, for some prisoners in some federal states	Yes, one dedicated social worker in every prison since 2010	No	No
	Ministry of Justice	Ministry of Health		

Who answered the questionnaires (January–June 2018)?

France: Laurent MICHEL, medical doctor, specialist in addiction medicine, director of the Pierre Nicole Centre (drug addiction centre) and researcher at Inserm, previously head of a psychiatric/addiction unit in a prison setting; Corinne GERBER, social worker at the Pierre Nicole Centre, responsible for follow-up of prisoners just released from prison, with phone support from other professionals for some technical aspects.

Germany: Heino STÖVER, social scientist, PhD and Professor of Social Scientific Addiction Research at Frankfurt University of Applied Sciences; Daniela JAMIN, researcher in social work, Frankfurt University of Applied Sciences

Belgium: Sara VAN MALDEREN, regional drugs coordinator in prisons, Regional Prisons Directors Team (Federal Department of Justice); Alphonse FRANSSSEN, addiction care coordinator, East Flanders, Orphée SYS (Ghent University); Claude DESCAMPS (case manager University Hospital Gent), Vinciane SALIEZ and Kris MEURANT (I Care, Brussels).

Portugal: Key medical questionnaire completed by prison directors and medical services, submitted by Andreia NISA (APDES).

Questionnaire for individual interviews with ex-prisoners

I. Demographic data

- Gender?
- What is your age?
- What is your education level?
- What is your current work situation?

II. Experience of incarceration

- Length of incarceration(s):
 - o How long have you been released from prison now?
 - o How many incarcerations have you had?
 - o Do you know the total amount of incarcerations you've had, expressed in months?
- Prison journey:
 - o What did your last prison journey look like? We want to know your experiences with regard to activities/occupations/relationships with other prisoners/psychological support.
 - o What do you think about the support you got in prison (with the focus on release)?
 - Which elements were helpful for you?
 - What could be improved?

III. Personal situation, health and social context

- Housing situation:
 - o What did your housing situation look like before your last period of imprisonment? (*Where did you live? Was it a stable housing situation?*)
 - o What does your current housing situation look like?
- Occupation and leisure time:
 - o How did you spend your days before you were in prison? (*employment, voluntary work, activities, etc.*)
 - o How do you spend your days now?
- Relationships:
 - o Can you describe your relationship (if applicable) with:
 - Your partner?
 - Your children?
 - Your family?
 - Other important people in your life?
 - → *Are these clean or using contacts?*
 - o Who supported you before you went into prison? And during your imprisonment?
 - o How did you keep in touch during incarceration?
 - o What kind of support did you get? What did this mean to you?
 - o What about that support now? Is it continuing?
- Health
 - o What is your HIV/HVC/HBV status? Choose between: I don't know – positive – negative – cured (*for Hep C*).
 - If positive, what was the date of discovery?
 - If negative, what was the date of the last test?
 - o Are you vaccinated against hepatitis B?
 - o How do you perceive your general health?

IV. Drug use (before/during/after prison)

- Drug use profile
 - o At what age did you start using drugs?
 - o Have you ever injected drugs?

- Can you give me a short but comprehensive consumption trajectory: we want to know about the main products you used in the past and that you use now, about the manner of use (*inhalation, snorting,...*), possible time of cessation of drug use,...
- Drug use in prison
 - Have you ever used drugs in prison?
 - If yes, what? What sort of the frequency?
 - If yes, did you ever inject in prison?
 - Did you use during your last period of imprisonment?
 - Did you alter your drug use during incarceration in terms of:
 - products (*explore here also NPS*)?
 - ways of using drugs (*injecting, snorting, ...*)?
 - Have you ever used equipment to use drugs in prison?
 - If yes, what (*straws, syringes, needles, cups, filters, water, crack pipes,...*)?
 - How did you get this equipment in prison?
 - Have you ever manufactured this equipment yourself? How did you learn how to do it?
 - Have you ever used drugs together with other people:
 - In the community?
 - In prison?
 - How? We want to know if you shared snorting, smoking or injecting equipment with others. (*Explore both in prison and in the community*)
 - If you shared equipment, how did you clean it? (*Explore both in prison and in the community*)
 - Do you have different sharing practices in the community than in prison?

V. **Overdose experience** (*“overdose” is defined as being unconscious and in need of external help*)

- Risks
 - Do you know the risk of overdose associated with drug use?
 - According to you, what factors contribute to an overdose? (*Aim: what is their knowledge of the risk of overdose associated with drug use?*)
- Overdose experience
 - Some people worry about overdosing on drugs when they get released, while others don't. What about you, did you/do you worry?
 - Have you ever had an overdose?
 - If yes, how many times?
 - If yes, was it in the community or in custody?
 - How did you deal with the overdose?
- Preparation
 - Did you feel prepared for release when it came to overdosing?
 - What do you think can help to prevent overdose?
 - Did you ever receive any information, advice or education about overdose risk?
 - If yes, from who (*friends, prisoners, health staff...*)?

VI. **Health care and social support**

- Medical support
 - Were you supported by any medical services in prison? (*explore GP, nurses...*)
 - If yes, who and what for?
 - What was the frequency?
 - Are you supported by any medical services now?
 - Did you take opioid substitution therapy in prison?
 - If yes, which medication?
 - If yes, since when?
 - If yes, how were you using your prescribed medication (*dosage, patterns... investigate possible misuse*)
 - And now? Are you still on OST?

- Did you take any other treatments/meds in prison? (*ART, mental health, e.g. benzos*)
 - If yes, which medication?
 - If yes, since when?
 - If yes, how were you using your prescribed medication (*dosage, patterns,...* investigate possible misuse)
 - Do you take any treatments now?
- Social support
 - Were you supported by any social services in prison?
 - If yes, which ones and what for? (*explore psychological support, housing, jobs,...*)
 - What was the frequency?
 - Are you now supported by any social services? Which ones?
 - Did you attempt any particular (therapeutic) activities concerning drugs in prison?
 - If yes, which?
 - If no, why not?
- Other
 - Were there any other services that supported you in prison?
 - If yes, which and what for?
 - What was the frequency?
 - Do you receive support from any other service now?
- Harm reduction
 - Have you received information/advice on harm reduction when entering prison or at other times during your incarceration (*condoms, bleach availability/syringes/sniff tools, naloxone, etc.*)?
 - If yes, what information/advice?
 - Did you have the opportunity to have access to tools? In what context?

VII. Release

- Release experience
 - Can you tell me about your last release experience? In general we want to know what went well, what went badly and what was missing?
 - Can you tell me about your experiences with community services immediately after your last release?
 - What could be improved when it comes to release?
- Challenges following release
 - According to you, what were the challenges during the immediate post-release period (the first 24 hours – the first week)?
Ask about difficulties concerning:
 - *Health care services*
 - *Finding accommodation (housing)*
 - *Financial situation*
 - *Finding a job*
 - *Alcohol/drug use*
 - *Keeping/building relationships (partners, friends, family members)*
 - *Avoiding criminal activities*
- Preparation
 - Did you feel prepared for release the last time when it came to:
 - Health care
 - Finding accommodation (housing)
 - Financial situation

- Finding a job
 - Alcohol/drug use
 - Keeping/building relationships (partners, friends, family members)
 - Avoiding criminal activities
- If no, what were the things that made it hard?
- Reintegration
 - According to you, what factors help with reintegration? What helped you?
 - When you think about the challenges related to reintegration, can you think about some services that were or could be helpful for you (and your family)?

VIII. Overall concluding question

- What would the perfect (drug) care service for prisoners look like?
- How can services be improved, with a focus on release and continuity of care?

Questionnaire for individual interviews with ex-prisoners

I. Demographic data

- Gender?
- What is your age?
- What is your education level?
- What is your current work situation?

II. Experience of incarceration

- Length of incarceration(s):
 - o How long have you been released from prison now?
 - o How many incarcerations have you had?
 - o Do you know the total amount of incarcerations you've had, expressed in months?
- Prison journey:
 - o What did your last prison journey look like? We want to know your experiences with regard to activities/occupations/ relationship with the prisoners/ psychological support.
 - o What do you think about the support you got in prison (with the focus on release)?
 - Which elements were helpful for you?
 - What could be improved?

III. Personal situation, health and social context

- Housing situation:
 - o What did your housing situation look like before your last period of imprisonment? (*Where did you live? Was it a stable housing situation, ...?*)
 - o What does your current housing situation look like?
- Occupation and leisure time:
 - o How did you spend your days before you were in prison? (*employment, voluntary work, activities, etc.*)
 - o How do you spend your days now?
- Relationships:
 - o Can you describe your relationship (if applicable) with:
 - Your partner?
 - Your children?
 - Your family?
 - Other important people in your life?
 - → *Are these clean or using contacts?*
 - o Who supported you before you went into prison? And during your imprisonment?
 - o How did you keep in touch during incarceration?
 - o What kind of support did you get? What did this mean to you?
 - o What about that support now? Is it continuing?
- Health
 - o What is your HIV/HVC/HBV status? Choose between: I don't know – positive – negative – cured (*for Hep C*).
 - If positive, what was the date of discovery?
 - If negative, what as the date of the last test?
 - o Are you vaccinated against hepatitis B?
 - o How do you perceive your general health?

IV. Drug use (before/during/after prison)

- Drug use profile

- At what age did you start using drugs?
 - Have you ever injected drugs?
 - Can you give me a short but comprehensive consumption trajectory: we want to know about the main products you used in the past and that you use now, about the manner of use (*inhalation, snorting,...*), possible time of cessation of drug use,...
- Drug use in prison
- Have you ever used drugs in prison?
 - If yes, what? What sort of frequency?
 - If yes, did you ever inject in prison?
 - Did you use during your last period of imprisonment?
 - Did you alter your drug use during incarceration in terms of:
 - products (*explore here also NPS*)?
 - ways of using drugs (*injecting, snorting, ...*)?
 - Have you ever used equipment to use drugs in prison?
 - If yes, what (*straws, syringes, needles, cups, filters, water, crack pipes,...*)?
 - How did you get this equipment in prison?
 - Have you ever manufactured this equipment yourself? How did you learn how to do it?
 - Have you ever used drugs together with other people:
 - In the community?
 - In prison?
 - How? We want to know if you shared snorting, smoking or injecting equipment with others. (*Explore both in prison and in the community*)
 - If you shared equipment, how did you clean it? (*Explore both in prison and in the community*)
 - Do you have different sharing practices in the community than in prison?
- V. **Overdose experience** (*“overdose” is defined as being unconscious and in need of external help*)
- Risks
- According to you, what factors contribute to an overdose? (*Aim: what is their knowledge of the risk of overdose associated to drug use?*)
- Overdose experience
- Some people worry about overdosing on drugs when they get out, while others don't. What about you, did you/do you worry?
 - Did you ever have an overdose?
 - If yes, how many times?
 - If yes, was it in the community or in custody?
 - How did you deal with the overdose?
- Preparation
- Did you feel prepared for release when it came to overdosing?
 - What do you think could help in preventing overdosing?
 - Did you ever receive any information, advice or education about overdose risk?
 - If yes, from who (*friends, prisoners, health staff...*)?
- Naloxone
- Did anyone inform you about the possibility of receiving a kit to treat for overdosing that you can take home?
 - Did you ever receive one?
 - If yes, when? In the community? In the prison setting before release? In prison for use inside prison?

VI. Health care and social support

We are now going to ask you some questions about your experiences of care services before prison, during imprisonment and after release.

- In general
 - o Do you remember whether a needs assessment was carried out when you entered prison?
 - If yes, who did it?
 - When did they do it?
 - What did they include in this assessment?
 - o Do you know if an individual integration plan was ever made?
 - Who did this?
 - Were you involved in it?
 - What did it include?

- Medical support
 - o Before you entered prison, did you get any medical support in the community?
 - If yes, what and what for?
 - o Was this continued in prison? *If no previous support*: Did they initiate any medical support in prison?
 - Specify which medical services support(ed) you in prison
 - What was the frequency?
 - Which ones weren't continued?
 - o Do you receive any medical support now?

 - o Did you take opioid substitution therapy before you entered prison?
 - If yes, what medication and since when?
 - o Was this continued in prison? *If no previous OST: did OST start up in prison?*
 - If yes, was it the same medication?
 - If yes, did you have to wait long before you got it?
 - If yes, how were you using your prescribed medication in prison? (*dosage, patterns... investigate possible misuse*)
 - o Are you still taking OST?

 - o Did you take any other treatments/meds before you entered prison? (*ART, mental health, e.g. benzos*)
 - If yes, what medication and since when?
 - o Did this continue in prison? *If no previous support: was any other medical treatment started in prison?*
 - If yes, was it the same medication?
 - If yes, did you have to wait long before you got it?
 - If yes, how were you using your prescribed medication in prison? (*dosage, patterns... investigate possible misuse*)
 - o Are you still taking ...(name of other treatment)?

 - o Can you tell me something about access to medical services:
 - in prison?
 - in the community? – Especially in the first 24 hours and up to the end of the first week out.

- Social support
 - o Before you entered prison, did you get support from any social services in the community?

- If yes, which ones and what for? (*explore psychological support, housing, drug treatment, financial support, jobs, training...*)
 - What was the frequency?
 - Was this social support continued in prison? *If no previous support: Did you get any social support in prison?*
 - Specify what kind of social support you continued to receive in prison.
 - What was the frequency?
 - Which ones weren't continued?
 - Did you attempt any particular (therapeutic) activities concerning drugs in prison?
 - If yes, which ones?
 - If no, why not?
 - Do you receive any kind of social support now?
 - Can you tell me something about access to those kinds of social support services:
 - in prison?
 - in the community? – Especially in the first 24 hours and up to the end of the first week out.
- Other
 - Were there any other services that supported you before you went to prison?
 - If yes, which ones and what for?
 - What was the frequency?
 - Were these continued in prison? *If no previous support: Did you get support from any other services in prison?*
 - Do you receive support from any other service now?
 - Can you tell me something about access to that service?
 - In prison?
 - In the community? – Especially in the first 24 hours and up to the end of the first week out.
- Harm reduction
 - Have you received information/advice on harm reduction when entering prison or at other times during your incarceration (*condoms, bleach availability/syringes/sniff tools, naloxone, etc.*)?
 - If yes, what information/advice?
 - Did you have the opportunity to gain access to tools? In what context?
- Family support
 - Was your family/partner/any other important person involved as a source of support during imprisonment or involved in the support services?

VII. Release

- Challenges on release
 - According to you, what were the main challenges you faced during the immediate post-release period (the first 24 hours – the first week)?
Ask about difficulties concerning:
 - *Health care services*
 - *Finding accommodation (housing)*
 - *Financial situation*
 - *Finding a job*
 - *Alcohol/drug use*
 - *Keeping/building relationships (partners, friends, family members)*
 - *Avoiding criminal activities*

- Preparation
 - o Did you feel prepared for release the last time when it came to:
 - Health care
 - Finding accommodation (housing)
 - Financial situation
 - Finding a job
 - Alcohol/drug use
 - Keeping/building relationships (partners, friends, family members)
 - Avoiding criminal activities
 - o If no, what made it hard?
 - o How (else) did you prepare yourself/what helped you?
 - o What role did your family/partner/other important people play in your release?
 - o How could you have been better prepared?

- Release experience
 - o Can you tell me about your last release experience? In general, we want to know what went well, what went badly and what was missing?

- Experience with community services
 - o Can you tell me about your experiences with community services immediately after your last release? We would like to hear a detailed description of continuity of treatment after release (*health care, drug treatment, housing...*).
 - o In particular, could you gain access immediately and freely to your OST, ATV, Hep C, naloxone?
 - If no, how much time did you need for each treatment?
 - What were the obstacles to getting the treatment?
 - Did you need to stop your treatment for any time?
 - Did you need to use the black market to buy your treatment (opioid substitution treatment)?
 - Did you receive your OST or ARV treatment for some days before release from the prison medical unit?
 - o How was the access to other services (e.g. drug treatment, housing...)?
 - Have you had any contact with or received contact information from specialised settings before release?
 - Did the professionals in the prison setting contact professionals in the community to ensure continuity of care after your release?
 - Did you benefit from leave to visit professionals in the community before release or did you have any phone contact with them before release?
 - What was good?
 - What could be improved?

- Reintegration
 - o According to you, what factors help with reintegration? What helped you?
 - o What are the obstacles to reintegration?
 - o When you think about the challenges related to reintegration, can you think about some services that were or could be helpful for you (and your family)?

VIII. Overall concluding question

- What would the perfect (drug) care service to prisoners look like?
- How could services be improved, with a focus on release and continuity of care?

- What else do you think is needed to increase the likelihood of social rehabilitation and integration for prisoners?
- What would you suggest to improve prevention inside prison and on release?

Questionnaire for prisoner focus groups

I. Demographic data

Number of people present:prisoners
focus group leaders

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	...
Gender						
Age						
Length of incarceration						

II. Experience of incarceration

- What does the prison journey look like: what is done with regard to:
 - Activities
 - Occupation
 - Relationships with prisoners
 -
- What do you think of the support you get (with a focus on your release)?
 - o Which elements are helpful?
 - o What could be improved?
 - o Do you have any suggestions how?

III. Drug use and harm reduction

- What are the main problems with drug use in prison?
- What are the main risks related to drug use in prison?
- Can you tell me something about:
 - o the changes in drugs when in prison?
 - o the changes in drug consumption patterns when in prison?
- Let's talk about sharing practices in prison now. Who wants to say something about this?
 - o Does it happen in prison?
 - o How?
- Are harm reduction tools (OST, syringes...) available?
 - o What about access to it?

IV. Overdose experience (*"overdose" is defined as being unconscious and in need of external help*)

- What are the risk factors for overdose, especially on release?
- Does anybody here have any experience with overdosing? *If no response:* Or does anybody know someone with any experience of overdosing?
 - o Did this happen in the community (when? just after release?) or in prison?
 - o How did you/did they deal with it?
- Before this happened, were you/they prepared when it came to overdosing?
- Is this (overdosing) a topic in prison?

- According to you, what would be a good thing in the prevention of overdose?

V. Health care and social support/services

- Can you tell me what kind of support is available in prison?
 - o *Give some input:* health care (OST, HIV, HVC)/psychological support/alcohol or drug treatment/housing/financial support/jobs/relationships (partner, children, friends, family)/leisure time/avoiding criminal activities/....
 - o Is it useful?
 - o What else is needed?
- Can you tell me something about the continuity of care:
 - o When entering prison?
 - o During imprisonment?
 - o (Just) after being released?
- Have you received information/advice on harm reduction when entering prison or at other times during your incarceration (condoms, bleach availability/syringes/sniff tools, naloxone, etc.)?
 - o If yes, which one?

Optional questions:

- Would you be in favour of the implementation of prison needle and syringe programs (PNSP)?
- Are you in favour of the availability of condoms/lubricants in jail?

VI. Release

- According to you, what are the challenges/difficulties during the immediate post release period (the first 24 hours out till the first week)?
 - o *Give some input:* health care (OST, HIV, HVC)/psychological support/alcohol or drug treatment/housing/financial support/jobs/relationships (partner, children, friends, family)/leisure time/avoiding criminal activities/administration/....
- According to you, what factors help with reintegration?
 - o What helped you last time?
- When you think about the challenges related to reintegration, can you think about some services that could be helpful for you (and your family)?
- Can you tell me about your experiences with community services immediately after your last release?

VII. Overall concluding question

- What would the perfect (drug)care service for prisoners look like?
- How can services be improved, with a focus on release and continuity of care?