Chapter 14
Criminal justice approaches to harm reduction in Europe

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Abstract

This chapter reviews the spread of harm reduction services in European criminal justice systems, and their evaluation. It begins with a discussion of the tensions and contradictions inherent in providing harm reduction services (which may accept continued drug use) in criminal justice settings (that do not). It then draws on research carried out for the Connections project, for its predecessor the European Network on Drug and Infections Prevention in Prisons and on the information gathered by the European Monitoring Centre for Drugs and Drug Addiction. It examines services such as needle and syringe exchange, opiate substitution and distribution of condoms and disinfectants in prisons. It also examines harm reduction services that have been developed in the context of police custody, and in the attempt to provide through-care and aftercare to drug users who pass through the criminal justice system. The chapter concludes that the tensions between harm reduction and criminal justice aims can be overcome in providing effective services to reduce drug-related harms.

Keywords: criminal justice systems, harm reduction, prison, decriminalisation, syringe exchange, opioid substitution treatment, arrest-referral.

Introduction

Harm reduction is often seen as conflicting with the use of law enforcement to reduce drug use, but there are ways in which policies and practice can develop in order to reduce harms related to drugs within the criminal justice system. The principle of harm reduction may also be applied to law enforcement itself. Drug prohibition can inadvertently increase the harmfulness of drug use as it means that users rely on illicit forms of supply and consume drugs of unknown purity and quality in a risky manner. It also creates artificially high prices, which stimulate acquisitive crime and facilitate corruption and violence. Given that drug markets cannot be eliminated, but may operate in ways that are more or less socially harmful, the key questions for law enforcement become: what sort of markets do we least dislike and how can we adjust the control mix so as to push markets in the least harmful direction? In this chapter, we leave aside more detailed discussion of the wider impact of drug law enforcement or criminalisation on societal levels of drug-related harm. We focus instead on the provision of services that aim to reduce harms done to drug users within the criminal justice system.

Many of the people who are caught up in the criminal justice system are highly exposed to drug-related harms (EMCDDA, 2009a; Singleton et al., 1997; Stöver, 2001; Rotily et al.,

2001; Møller et al., 2007; Stöver et al., 2008a; Dolan et al., 2007). These people do not lose their right to adequate and effective healthcare when they enter the criminal justice system (Carter and Hall, 2010). The ideal criminal justice system would therefore protect their health by offering the full range of healthcare approaches. Some European systems have been moving closer, in various ways, to achieving this, and we describe some of these developments in this chapter. We will examine how measures such as opioid substitution treatment (OST), needle and syringe exchange, and the provision of disinfectants and condoms have worked in prison contexts. We will look at issues of through-care and aftercare and we will explore how processes that follow arrest can divert drug users into treatment. Before looking at specific harm reduction measures we provide a short discussion of the inherent tensions between controlling drugs through the criminal law and efforts to reduce harms to drug users.

Tensions between law enforcement and harm reduction

There are at least two contradictions that hinder the effort to reduce harm through the criminal justice system. The first is the fact that criminal justice systems themselves produce harms. Of course, the criminal justice system also produces benefits to the extent that it protects people from crime and insecurity. But arrests, fines, community penalties, imprisonment and parole all infringe on individual freedoms and pleasures. The special pains of imprisonment have been a particular focus of criminological research (Sykes 1958; Mathiesen, 2006). The idea that these pains are justified by the need to reduce crime is challenged by the lack of evidence for the effectiveness of imprisonment, the most painful form of criminal justice intervention currently used in Europe (Tonry, 2004; Gendreau et al., 1999). It is well known, for example, that there is little relationship between imprisonment and crime rates (Kovandzic and Vieraitis, 2006; Reiner, 2000). Countries do not use prison as a direct, rational measure to reduce crime. Rather, they choose — through a complex process of ideological, moral, political and juridical negotiation — the level of pain that they are willing to inflict on their citizens (Christie 1982). If we choose the level of harm that we inflict, we can also choose to reduce it.

The second contradiction in pursuing harm reduction in the criminal justice system is that between the pursuit of abstinence and the acknowledgement of continuing drug use. Countries are obliged, through the UN drug conventions, to prohibit and to penalise the possession of certain substances. The criminal justice system is the process that puts these obligations into practice. It is very difficult for the same system to acknowledge that the people under its control continue to defy the law. Until the mid-1990s, for example, it was common for prison governors to deny that drug use was going on within their walls (Duke, 2003). More recently, it has been suggested by Phillip Bean (2008) that treatment agencies working with the criminal justice system should expect to subordinate their aims to those of the criminal justice agencies. Harm reduction approaches have traditionally been developed to meet the needs of people who continue to use illicit drugs, and therefore do not fit with the prescription that people under penal control should abstain. Some parts of the criminal justice system and some countries appear to negotiate this conflict more easily than others. This may be due to the different perceptions of the ideal

goal of abstinence. Within the prison system, for example, abstinence has a relatively high value, because it fits with the prison's goal of incapacitating the prisoner from committing further crimes (e.g. drug purchase and possession). Probation services, with a greater focus on rehabilitation and relatively less control of the person's behaviour, seem to have less emphasis on absolute abstention, at least in Europe. In the United States, drug use while on probation often leads to imprisonment. It is more often tolerated in European probation systems, as long as no other offences are committed (Stevens, forthcoming).

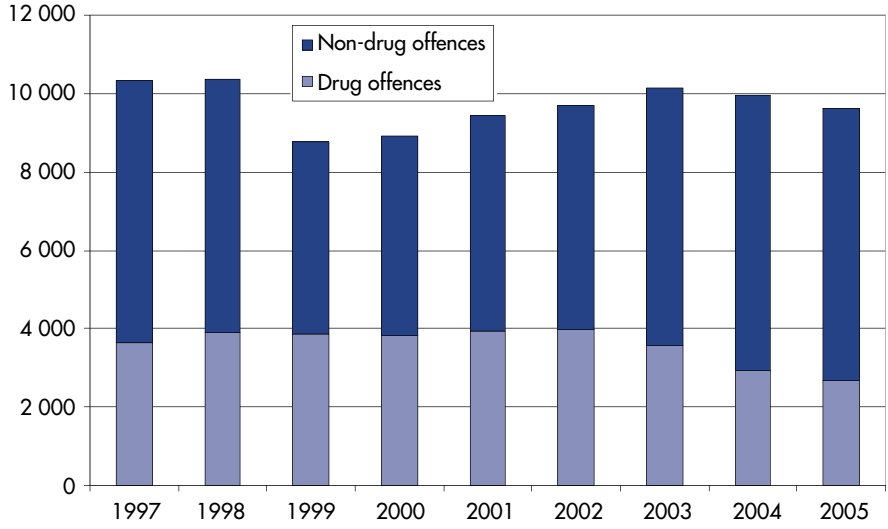
So how do we deal with these contradictions? First, it seems axiomatic that the best way to reduce the amount of drug-related harm that occurs inside the criminal justice system is to reduce the number of drug users who enter it. Drug users cannot cause harm (or be harmed) in criminal justice settings if they are not actually in these settings. The number of drug users in criminal justice settings can be reduced through decriminalisation of drugs, which means that no drug users enter the criminal justice system for possession offences (though decriminalisation of drugs would not necessarily reduce the number of drug users who enter the system for other offences, which could be reduced by developing diversion or alternative sanctions) (Stevens, forthcoming). Different European countries have tried various forms of decriminalisation. They include the Netherlands' expedient non-prosecution of cannabis supply at the retail level, as well as the non-criminal offences of personal drug use in the Czech Republic, Estonia, Italy, Spain and suspension of prosecution of personal use offences in Germany and Austria.

The most comprehensive process of decriminalisation so far has occurred in Portugal. From July 2001 people who are found by the Portuguese police to be in possession of fewer than ten days' personal supply of any drug have not been arrested, though the drug is still confiscated. They have instead been referred to regional drug dissuasion committees, which have the option of imposing warnings, fines, administrative sanctions (such as taking away driving or firearms licences), or — in the case of dependent users — referring them to treatment. Since decriminalisation, and the simultaneous expansion of prevention, treatment and harm reduction services, there have been dramatic reductions in drug-related deaths and HIV. Rates of drug use seem to have fallen among children, but risen slightly in adults, in line with pan-European trends. The respective roles of decriminalisation and the simultaneous expansion of drug treatment in producing these changes can be debated (IDT, 2007; IDT, 2005; Hughes and Stevens, 2007; Greenwald, 2009). But Figure 14.1 shows clearly that decriminalisation reduced the use of imprisonment for drug offences and led to an overall reduction in the prison population (IDT, 2006, Table 62). This reduction has also been accompanied by substantial reductions in the number of people using drugs and living with HIV within Portuguese prisons (Torres et al., 2009).

The second contradiction is just a more extreme form of the long-standing argument that harm reduction conflicts with the goal — still subscribed to by all UN members (ECOSOC, 2009) — of eliminating illicit drug use. Over time, there has been a gradual acceptance that harm reduction measures do not prevent people from achieving abstinence, but rather protect the health of people who will continue to use drugs, whether or not they

have the means to protect their health. This acceptance has been supported by decades of evaluative research on harm reduction measures outside the criminal justice system, including opiate substitution treatment (using methadone, buprenorphine or heroin itself) and needle and syringe exchange programmes (Hunt, 2003; Ritter and Cameron, 2005; Tilson et al., 2007; Kimber et al., 2010). As evidence develops on the use of such measures within the criminal justice system, we could expect that resistance to harm reduction within the criminal justice system will also subside. But we should not be too optimistic. The negotiations at the high level segment of the Commission on Narcotic Drugs in Vienna in March 2009 showed that resistance to harm reduction remains strong, even outside the criminal justice system. A glimmer of hope from that meeting can be perceived, if we look hard enough, in the commitment to provide treatment and 'related support services ... on a non-discriminatory basis, including in detention facilities' (ECOSOC, 2009).

Figure 14.1: Number of prisoners under sentence for drug and other offences in Portugal, 1997–2005



Source: Hughes and Stevens, 2007.

Harm reduction in the criminal justice system

Our exploration of existing harm reduction services in criminal justice systems starts in the place where drug-related harms of the criminal justice system are most acute: prisons.

In a report on the implementation of the European Council Recommendation (of 18 June 2003 ([1])) on the prevention and reduction of health-related harm associated with drug

([1]) http://europa.eu.int/eur-lex/pri/en/oj/dat/2003/l_165/l_16520030703en00310033.pdf

dependence ([2]) it was stated that a policy to provide drug users in prisons with services that are similar to those available to drug users outside prisons exists in 20 EU Member States and was about to be introduced in four countries (van der Gouwe et al., 2006). However, recent European monitoring data show that that the implementation of harm reduction programmes is quite heterogeneous in European prisons (EMCDDA, 2009a). Availability and accessibility of many key harm reduction measures in prisons lag far behind the availability and accessibility of these interventions in the community outside prisons (EMCDDA, 2009b).

Illustrating this gap most vividly is the provision — or lack thereof — of needle and syringe programmes (NSP), currently only implemented in five EU countries (EMCDDA, 2009c). The availability of opioid substitution treatment (OST) in prisons is low compared to the level of OST provision in the community in most European countries (EMCDDA, 2009d; see Figure 14.2). These findings support an earlier statement from the European Commission that:

> Harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equivalence adopted by UN General Assembly, UNAIDS/WHO and UNODC, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services.
>
> (European Commission, 2007, conclusion 5).

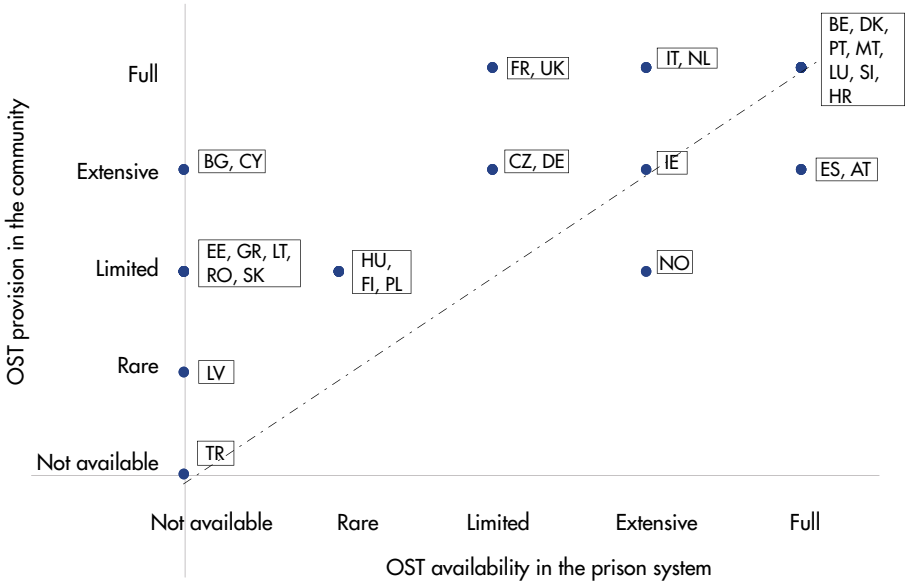
These findings also echo a 2008 WHO Regional Office for Europe report that monitored State progress in achieving Dublin Declaration goals. The Dublin Declaration commits the signatory States to take 33 specific actions — and in some cases meet specific targets — to address the HIV prevention, care, treatment and support situation across the region. The report found that, of the 53 signatory countries, condoms were available in prisons in only 18, syringe exchange programmes available in six and substitution treatment available in 17 (Matic et al., 2008). A more recent review (in 2009) by the International Harm Reduction Association (IHRA) found the situation has only marginally improved, with nine countries (out of 46) in Europe and Central Asia having syringe exchange in prisons and 28 substitution treatment (Cook, 2009; see also Cook et al., 2010).

Calls for an urgent and comprehensive response to addressing health risks within prison settings, including harm reduction measures (WHO Regional Office for Europe, 2005) are not new, and have been highlighted in international reports and policy documents spanning two decades (Parliamentary Assembly of the Council of Europe, 1988; UNODC et al., 2006; WHO, 1993; Matic et al., 2008). However, despite existing recommendations, guidelines and commitments made by governments and many others (Lines, 2008), only very few countries within the European region have come close to achieving the goals set out (Cook, 2009).

There are four key harm reduction tools for the prison setting. We describe each of these, including an example of best practice, below.

([2]) http://ec.europa.eu/health/ph_determinants/life_style/drug/drug_rec_en.htm

Figure 14.2: Provision of substitution/maintenance treatment (OST) in the community and availability of OST programmes in the prison system in 2007 in the EU (expert rating)



Notes:
This figure is available at: http://www.emcdda.europa.eu/stats09/hsrfig2.
Comments:
Data were not available for Sweden.
Rating scales:

Prison: expert rating of the availability of OST programmes in prisons in the country (and does not reflect level of OST provision in prison):

- Full: substitution/maintenance treatment exists in nearly all prisons.
- Extensive: exists in a majority of prisons but not in nearly all of them.
- Limited: exists in more than a few prisons but not in a majority of them.
- Rare: exists in just a few prisons.

Community: expert rating of the level of provision of OST in the community, in relation to the needs of target group problem opioid users:

- Full: nearly all problem opioid users (POUs) in need would obtain OST.
- Extensive: a majority but not nearly all POUs in need would obtain OST.
- Limited: more than a few but not a majority of POUs in need would obtain OST.
- Rare: just a few POUs in need would obtain OST.

Sources: EMCDDA, 2009d. Structured questionnaire on 'treatment programmes' (SQ27/P1), submitted by NFPs in 2008. Data for Malta is from DG Health and Consumer Protection, 'Final report on prevention, treatment, and harm reduction services in prison, on reintegration services on release from prison and methods to monitor/analyse drug use among prisoners', SANCO/2006/C4/02.

Needle and syringe exchange programmes in prisons

A position paper of the United Nations system identifies NSP as one component of 'a comprehensive package for HIV prevention among drug abusers' (Commission on Narcotic Drugs, 2002). In prisons, NSPs have been operating successfully for more than 15 years. A meta-analysis (based on 11 evaluations of the implementation of prison-based NSPs) revealed that none of the fears often associated with planned NSPs occurred in any project: syringe distribution was followed neither by an increase in drug intake nor in administration

by injection. Syringes were not misused as weapons against staff or other prisoners, and disposal of used syringes was uncomplicated. Sharing of syringes among drug users disappeared almost completely or was apparent in very few cases. These studies demonstrate both the feasibility, safety and efficacy of harm reduction including NSP in prison settings (Meyenberg et al., 1999; Stöver and Nelles 2003).

At present, NSPs have been established in prisons in nine countries worldwide (Lines et al., 2006), including six countries in Europe. Coverage of the national prison systems is, however, variable. In Spain, implementation of needle and syringe exchange is authorised in all prisons (see box below) and in 2006, programmes existed in 37 prisons (Acín García, 2008). In Switzerland, NSPs are available in eight of 120 prisons, and in Germany, Luxembourg, Romania and Portugal such programmes operate in one or two prisons. Other countries, including the United Kingdom (Scotland), are considering the implementation of pilot projects (EMCDDA, 2009a; Lines et al., 2006). A review published in 2007 stated:

> Prison NSPs have been implemented in both men's and women's prisons, in institutions of varying sizes, in both civilian and military systems, in institutions that house prisoners in individual cells and those that house them in barracks, in institutions with different security ratings, and in different forms of custody (remand and sentenced, open and closed).
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> (Stöver et al., 2009, p. 83)

Prison-based needle and syringe exchange programmes in Spain

Spanish prisons implement needle and syringe programmes (NSPs) via negotiated protocols and frameworks based on consensus among all actors involved. Following the positive experience of pilot projects, the Spanish government made a commitment to expand availability, and in March 2001 the parliament approved a green paper recommending NSPs in all prisons. This was followed by a directive, in June 2001, from the Directorate General for Prisons requiring all prisons to implement NSPs. In October, there was a further similar directive from the Subdirectorate General for Prison Health setting January 2002 as the target. In March 2002, the Ministry of the Interior and the Ministry of Health and Consumer Affairs jointly published guidelines, policies, and procedures, and training and evaluation materials, for the national implementation of prison-based NSPs. With these guidelines, every prison elaborates its own NSPs. In order to implement, follow up and evaluate the programme:

- a Commission is created, with the Director and vice directors (including sanitary vice director) and representatives of security staff of the prison, as well as representatives of the Drug Dependence and AIDS Regional Programmes;
- the needs of the prisoners and their patterns of drug use are assessed;
- the protocol for the NSP is developed; the attitudes of prisoners and staff are assessed;
- the implementation strategies are identified; and the evaluation designed.

(Stöver et al., 2007)

The Ministry of Labour and Social Security endorsed this process with additional guidance on reducing potential harm to prison staff (Ministry of Labour and Social Security, 2002).

Opioid substitution treatment

While opioid substitution treatment (OST) has become standard practice in community drug treatment services in many European countries (EMCDDA, 2009a), the implementation of OST in custodial settings in most European countries is still lagging behind the availability and quality of the treatment provision in the community (Kastelic et al., 2008; EMCDDA, 2009d).

Studies have indicated that OST initiated in the community is most likely to be discontinued in prisons (Stöver et al., 2004; Stöver et al., 2006; Michel, 2005; Michel and Maguet, 2003). This often leads to relapse both inside prisons and immediately after release, often with severe consequences, as indicated by high mortality rates after release from prisons (Singelton et al., 2003). Many studies have also shown the benefits of OST for the health and social stabilisation of opioid-dependent individuals passing through the prison system (Stallwitz and Stöver 2007; Larney and Dolan, 2009).

Substitution treatment has been widely recognised as an effective treatment for opioid dependence in the general community (Dolan et al., 1998; Farrell et al., 2001; Larney and Dolan, 2009; UNODC et al., 2006) and as having crime reducing effects (Lind et al., 2005). Despite this and the fact that methadone and buprenorphine have been added to the WHO model list of essential medicines (WHO, 2005), it remains controversial for prisons, particularly in Eastern European countries where substitution treatment also only exists on a low level in the community (van der Gouwe et al., 2006). Nevertheless, experience has clearly shown the benefits of this treatment in prisons (WHO et al., 2007; Heimer et al., 2005; Stöver et al., 2008b; Stöver and Michels, 2010).

In countries that provide OST in prisons, it is most commonly used for short-term detoxification, and less frequently as a maintenance treatment (Kastelic et al., 2008). In some countries, such as Austria, England (see box on p. 387) and Spain, substitution treatment is provided as standard therapy to many prisoners who began treatment in the community and are deemed likely to continue it after release (Stöveret al., 2004). In others it is either not available in prisons at all, although legally possible (Estonia and Lithuania), or only provided in very rare cases (Sweden). OST treatment that has been started in the community cannot legally be continued in prisons in Slovakia, Latvia, Cyprus and Greece. New substitution treatments cannot be initiated in Slovakia, Latvia, Cyprus, Greece, Portugal, Finland and Estonia (EMCDDA, 2009a).

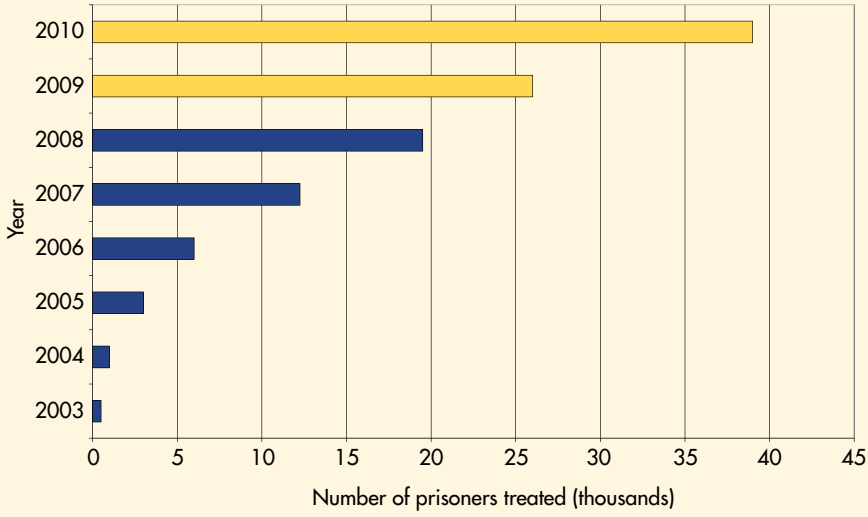
Acknowledgement that the benefits of substitution treatment in the community might also apply to the prison setting has taken years. The sources of the controversy — and the slow and patchy manner of the intervention's implementation thus far — can be traced first to the prisons' general failure to provide adequate healthcare, with limited resources for populations with high concentrations of poor physical and mental health (Møller et al., 2007; Bertrand and Niveau, 2006). Second, due to the parallel prison healthcare system (separate to the national health services in most countries), responsibility for a prisoner's medical treatment is often transferred to healthcare providers only after that prisoner has been released. Third, the ethos of coercion and incapacitation manifests itself in a strict abstinence-

based approach to drug use. Therefore, while opioid-dependent individuals in the community may be treated as patients and receive substitution treatment, in prison they continue to be treated as prisoners who are supposed to remain drug free. This double standard leads to frequent interruptions in treatment and inconsistency in dosages, especially as many opioid users spend substantial periods of time incarcerated.

Opioid substitution treatment (OST) in England

The number of methadone maintenance (OST) treatments started in prisons in England has increased from 700 in 2003 ([1]) to 19 450 for the year 2008. All 130 adult prisons in the country are now funded to provide OST. Approximately 26 000 treatments are anticipated for 2009, rising to 39 000 for the year 2010 (Marteau and Stöver, 2010).

Figure 14.3: Methadone maintenance treatments in prisons in England



The massive expansion of OST in prisons is the result of: a shift of responsibility for prison healthcare from the Home Office to the National Health Service; political and professional leadership and investment; and a strong investment in training and education of staff in prisons. With these efforts, the number of patients in prison-based OST has been increased substantially over the past two years (Stöver et al., 2008b).

This example shows that the Integrated Drug Treatment System (IDTS) has been welcomed by a large section of the health and criminal justice community. It has also helped the British government to avoid repeated litigation by drug users who have been denied the appropriate treatment (in the past, the government has had to settle cases on this) (Radcliffe and Stevens, 2008; Marteau and Stöver, 2010). A large research programme will evaluate the process and outcomes of the IDTS.

([1]) Refers to the fiscal year 2003–04 which runs from 1 March 2003 until end February 2004. All dates cited in this box follow this pattern.

Evidence shows that methadone maintenance treatment (MMT, the most studied form of pharmacological drug treatment) can reduce risk behaviour in penal institutions, such as reduced frequency of illicit drug use in prison and reduced involvement in the prison drug trade (Dolan et al., 1998; Kimber et al., 2010). Studies have also demonstrated that methadone maintenance treatment provision in a prison healthcare setting can be effective in reducing heroin use, drug injection and syringe sharing among incarcerated heroin users (Stöver and Marteau, 2010). A sufficiently high dosage also seems to be important for improving retention rate, which helps in the provision of additional healthcare services (Dolan et al., 2002).

There is evidence that continued MMT in prison has a beneficial impact on transferring prisoners into drug treatment after release. The initiation of MMT in prisons also contributes to a significant reduction in serious drug charges and in behaviour related to activities in the drug subculture. Offenders participating in MMT also had lower readmission rates and were readmitted at a slower rate than non-MMT patients. For example, a 2001 evaluative study of the methadone programme of the Correctional Service of Canada (CSC) concluded that participation in methadone programmes had positive post-release outcomes. The study found that opiate users accessing MMT during their incarceration were less likely to be readmitted to prison following their release — and were less likely to have committed new offences — than were those not accessing methadone. These findings have been supported by a more recent randomised trial from the United States. It showed that prisoners who started methadone treatment before release and continued after it were significantly more likely to stay away from illicit drugs in the first year after release. Their outcomes were better than those achieved by similar prisoners who received only counselling in the prison, than if they were transferred to methadone programmes on release (Kinlock et al. 2009; Stöver and Marteau 2010; Stöver and Michels, 2010).

Studies have shown that prison staff tend to support the introduction of OST to a higher degree than they support other harm reduction measures, such as syringe exchange (Allen, 2001). Greater knowledge of substitution programmes is directly associated with more positive attitudes towards it (McMillan and Lapham, 2005). This suggests that training for staff on all levels may decrease resistance to substitution programmes and contribute to patient-oriented, confidential and ethical service delivery. Institutional constraints can also be overcome by highlighting the benefits of a substitution programme for the prison itself (Stöver and Marteau, 2010).

Provision of bleach and disinfectants

Many prison systems have adopted programmes that provide disinfectants such as bleach to prisoners who inject drugs, as a means to clean injecting equipment before re-using it (see box on p. 389). According to UNAIDS in 1997, the provision of full-strength bleach to prisoners as a measure had been successfully adopted in prisons in Europe, Australia, Africa, and Central America (UNAIDS, 1997). The WHO further reported that concerns that bleach might be used as a weapon proved unfounded, and that this has not happened in any prison where bleach distribution has been tried (WHO, 2007).

However, disinfection with bleach as a means of HIV prevention is of varying efficiency, and therefore regarded only as a secondary strategy to syringe exchange programmes (WHO, 2005). The effectiveness of disinfection procedures is also largely dependent upon the method used. Before 1993, guidelines for syringe cleaning stipulated a method known as the '2x2x2' method. This method involved flushing injecting equipment twice with water, twice with bleach and twice with water. Research in 1993 raised doubts about the effectiveness of this method in the decontamination of used injecting equipment, and recommended new cleaning guidelines where injecting equipment should be soaked in fresh full-strength bleach (5 % sodium hypochlorite) for a minimum of 30 seconds (Shapshank et al., 1993).

All of these developments further complicate the effective use of bleach and disinfectants in prison settings, where fear of detection by prison staff and lack of time often means that hygienic preparation of equipment and drug use happens quickly, and that prisoners will often not take the time to practise optimal disinfection techniques (WHO, 2005). Furthermore, bleach is effective in killing the HIV virus, but may be less effective for the hepatitis C virus.

Training drug users to clean syringes with bleach may provide the user with false reassurance regarding the risk of re-using injecting equipment. Despite these limitations, provision of disinfectants to prisoners remains an important option to reduce the risk of HIV transmission, particularly where access to sterile syringes is not available. The Royal College of General Practitioners concluded that '[o]n current evidence it would be difficult to support a policy of not distributing bleach' (2007, p. 13).

By August 2001, bleach was provided in 11 of 23 pre-expansion EU prison systems (Stöver et al., 2004). Disinfectants are also made available to prisoners in Canada, England and Wales, Iran, Kyrgyzstan, Moldova, Turkmenistan, Switzerland, and some parts of the Russian Federation.

Provision of bleach in Austrian prisons

In all 28 Austrian prisons, anonymous access (in most parts of the prison system) to disinfectants in order to avoid the transmission of blood-borne viruses (BBV) via sharing of needles and equipment is provided. The Austrian Ministry of Justice stated in several orders ('Erlass') that beside condoms, the disinfectant Betaisadona should be made available freely and anonymously in all prisons. The primary purpose is the cleaning of injection equipment and the treatment of injection punctures. In this context the target group are not only drug users but also those prisoners involved in tattooing. Implementation, however, is varied, with limited staff resources being a factor.

Provision of condoms, dental dams, and water-based lubricants

Many prisons globally provide condoms to prisoners as part of their institutional health and STI prevention policies. This is in keeping with the recommendation of the WHO Guidelines, 'Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention. They should also be made available prior to any form of leave or release' (WHO, 1993).

Multiple barriers exist to the use of condoms in many prisons, and there is often poor knowledge among prisoners of sexual risk behaviour and risk reduction (MacDonald, 2005; Todts et al., 1997; UNODC et al., 2006). These barriers include prison rape, the social stigma attached to homosexuality and same-sex activities, and insufficient privacy to enable safer sex. Furthermore, condoms, dental dams, and water-based lubricants are often theoretically available but often not easily and discreetly accessible, at least not available on a 24-hour basis. Prisoners may be reluctant to access safer sex measures for fear of identifying themselves as engaging in such activities.

Evidence suggests that the provision of condoms is feasible in a wide range of prison settings (WHO et al., 2007). No prison system enabling condom distribution has reversed this policy, and none have reported security problems or any major negative consequences. Research also demonstrates the importance of identifying the factors shaping resistance among stakeholders and prison officials to introducing harm reduction measures in custodial settings, including condom distribution (Jürgens et al., 2009; Stöver et al., 2007). The orientation of ministries of justice, public opinion, and prison system financial constraints are all factors shaping staff acceptance or resistance to implementing harm reduction, and it is important to develop tailor-made strategies to address these (Marteau and Stöver 2010; Stöver et al., 2009).

Through-care and aftercare

Prison may be the place where drug-related harms are most visible and acute, but the vast majority of prisoners will one day be released. According to Williamson (Williamson, 2006) the major challenge for prison healthcare is:

> to enable continuity of care, within, between, on admission and upon release. Using the prisoner journey from pre-arrest to post release as a template it will be possible for local health and social care, and criminal justice communities to better plan continuity of health and social care, alternatives to imprisonment and long term support services.
>
> (Williamson, 2006, p.5)

Several studies have shown that effective and rapid access to aftercare for drug-using prisoners is essential to maintain gains made in prison-based treatment (e.g. Zurhold et al., 2005; Inciardi et al., 1997; Department of Health/National Offender Management Service, 2009). Prisoners are marginalised in society and tend to fall into the gaps between care systems and structures, which find it hard to deal with multiple needs. Care should be taken to overcome this tendency. From previous studies on recidivism following in-prison treatment (e.g. Inciardi et al., 1997), maintaining therapeutic relationships initiated in the prison into the post-release period would be likely to reduce recidivism and improve health outcomes. Prisons can be places of relative safety and health promotion for prisoners. Many people slip back into less healthy habits when they leave this structured environment. The box on p. 391 gives an example of a promising programme that seeks to avoid this danger.

The 'Through the Gates' service

Many prisoners, including a high proportion of those with drug problems, leave prison with no home to go to. This increases the likelihood that they will continue risky patterns of drug use and offending. In response to this problem, the St Giles Trust (a non-governmental organisation based in London) set up the 'Through the Gates' service. This service employs a team of caseworkers (half of whom are themselves ex-offenders) to work with individual prisoners. The caseworkers go to meet prisoners before they are released in order to assess their housing and other needs. They then meet the prisoner at the gate of the prison on the day of their release. The worker accompanies the client to initial meetings with the housing service, with probation officers and, when necessary, drug treatment services. In the first year of this service, 70 % of the homeless clients it worked with were successfully placed in temporary or permanent accommodation. Probation officers reported that the service dramatically increased the chances of successful resettlement. Some clients reported that it was the first time that they had been helped to step off the repetitive treadmill of imprisonment, drug use and crime.

The following conclusions were drawn by a multi-country survey of key informants on aftercare programmes for drug-using prisoners in several European countries (Fox, 2000):

- Aftercare for drug-using prisoners significantly decreases recidivism and relapse rates and saves lives.
- Interagency cooperation is essential for effective aftercare. Prisons, probation services, drug treatment agencies and health, employment and social welfare services must join up to meet the varied needs of drug-using offenders.
- Short-sentence prisoners are the most poorly placed to receive aftercare and most likely to re-offend. These prisoners need to be fast-tracked into release planning and encouraged into treatment.
- Ex-prisoners need choice in aftercare. One size does not fit all in drug treatment.
- Aftercare that starts in the last phase of a sentence appears to increase motivation and uptake.
- In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-prisoners are most likely to relapse and re-offend.
- Drug treatment workers must have access to prisoners during their sentence to encourage participation in treatment and to plan release.

As the mortality risks due to overdose are most critical in the first week after release (Singleton et al., 2003; Farrell and Marsden, 2008), all harm reduction measures to prevent overdose or drug-related infections should be available and accessible.

Earlier stages of the criminal justice system

As with prisons and through-care, the practice and policy of the police with regard to harm reduction varies throughout Europe, dependent on different legal backgrounds. What can be found all over Europe is a high level of formal or informal discretion (EMCDDA, 2002). The

police on the street can simply turn a blind eye towards illicit behaviour, or the official strategy of the police might pro-actively support harm reduction. The basis for these choices is a growing awareness of the adverse effects of control and custody with regard to the health of drug users and thus an increasing acknowledgment of all forms of support, assistance, counselling and treatment for this target group.

The introduction of policing practices that are more open to harm reduction interventions can contribute substantially to reducing some of the negative consequences of police patrolling, such as a reluctance to carry syringes and unsafe disposal, hurried and unsafe preparation of injection, and the potential for police attention to deter drug users from going to treatment centres (MacDonald et al., 2008). The availability of an injection location that is safe from police interference is a significant harm reduction measure (Kerr et al., 2008). Drug consumption rooms are an interesting model of accepting an unlawful behaviour (possession and consumption of drugs) for the sake of the health of the drug users. In most countries where they operate, these facilities are not only tolerated, but also demanded and supported by the police, who also facilitate their use (DeBeck et al., 2008). Furthermore, the police mostly see drug consumption rooms as a 'win–win' situation, as they spend less of their time dealing with users, and therefore have more resources available to target dealers. In addition, drug consumption is no longer taking place in the local area and causing public nuisance, but is taking place under hygienic and less visible circumstances (Stöver, 2002; Hedrich et al., 2010). The success of drug consumption rooms depends on the police agreeing not to target drug users within and around them.

There are other examples in Europe of structured combinations of harm reduction and crime prevention approaches. Arrest referral programmes, which first appeared in the United Kingdom in the 1980s and were expanded at national level by the Home Office Circular in 1999, are an example of a criminal justice-based programme that can introduce drug users to treatment and harm reduction services (Seeling et al., 2001). Arrest referral places specially trained substance use assessment workers in police stations to counsel and refer drug-using arrestees who voluntarily request assistance with their drug-related problems. Arrest referral schemes provide an access point for new entrants to services. Data from the national monitoring programme in England and Wales showed that half (51 %) of all those screened by an arrest referral worker had never accessed specialist drug treatment services (Sondhi et al., 2002). This implies that arrest referral is successful in contacting problem drug-using offenders at an earlier point than they might have otherwise considered using services. Outcomes of the arrest referral schemes included consistent reductions in drug use and offending behaviour among problem drug-using offenders who have been engaged in the scheme (Sondhi et al., 2002).

However, arrest referral often suffers from low rates of retention, with large proportions of the contacted drug users not going on to contact services (Edmunds et al., 1998). In England and Wales, the Drug Intervention Programme was supplemented by a system of case management of drug-using offenders and, since 2005, testing on arrest and required assessments in order to address this problem. These latter measures enable the police to require a person arrested for any one of a specific list of offences to undergo a drug test. If the test is positive for cocaine or heroin, the person can then be ordered to attend an

assessment with a drug treatment worker. The effect of these measures has not been evaluated. They have brought more drug users into treatment assessments, but many of them have been recreational users of cocaine who see no need to enter treatment.

At the stage of arrest, many drug users face risks associated with the seizure of their injecting equipment, as this increases the risks of syringe sharing the next time they use drugs. The provision of syringe exchange within police custody could reduce this risk. The revised 2007 ACPO Drug Strategy for Scotland, as well as reaffirming the support of police forces for harm reduction interventions, also acknowledges the role of the introduction of syringe exchange schemes in custody suites. As MacDonald et al. (2008) have stated:

> Research has demonstrated that the police can have a role in harm reduction provision, without necessarily compromising their legal and moral values. For example, they can encourage users in detention to make use of local needle exchange sites and provide information on their location, and they can use discretion in not arresting users at such sites, while consulting with the community on the need for such methods.
>
> (MacDonald et al., 2008, p. 6)

Early interventions have been implemented in many European states to avoid the negative impact of both continuous untreated drug addiction and conviction and possibly incarceration. 'FreD goes net' is a European network of such early intervention projects, which are diverting young drug users from police to counselling agencies to avoid adverse effects of the criminal justice system (LWL, 2009).

In a number of European countries legislation expands the options available to the courts for the diversion of drug-related offenders away from the criminal justice system to treatment, or for court-mandated treatment to form part of a sentence (EMCDDA, n.d.). Although data on usage of these options remain rare (European Commission, 2008), it seems they have historically been under-used (Turnbull and Webster, 1997). Few have been formally evaluated (Hough et al., 2003). Those that have been evaluated have tended to show that treatment that is entered through the legal system can be as effective as when people enter through other modes (McSweeney et al., 2007; Stevens et al., 2005). The under-exploitation of opportunities to divert drug users from the criminal justice system through alternative measures to imprisonment remains a major problem — particularly in new Member States of the European Union — which demands further investigation and action. In Cyprus in 2008, for example, a law had existed since 1992 that enabled drug-using offenders to be diverted into treatment, but no suitable treatments were in place and so the law was not used (Fotsiou, 2008).

Conclusion

The evidence and examples provided in this chapter have shown that it is possible to negotiate the tensions between law enforcement and harm reduction. Services have been successfully implemented that have reduced the harms experienced by drug users in the criminal justice system. However, implementation in many countries remains at the level of discussion, or small pilot projects. It is rare that countries actually practice the principle

of equivalence between services inside and outside prisons to which they have signed up. And the chances of rapid extension of harm reduction in criminal justice systems may seem to be low, given the current scale of economic uncertainty and strains on the public purse.

Nevertheless, given the frequent contact between drug users and criminal justice systems, and ongoing epidemics of blood-borne viruses linked to problem drug use, there is an urgent need for harm reduction services to be scaled-up. Reducing the numbers of drug users in prison will be the least costly means of increasing the proportion of prisoners who have access to harm reduction. It would reduce demand for drug services in prison and would free up resources to spend on harm reduction and other services, assuming that these resources are not diverted away from working with drug users.

Additional challenges remain. These include the need to develop and expand services for non-opiate users (such as methamphetamine users in parts of Eastern Europe, and cocaine/crack users in the United Kingdom; see Decorte, 2008; Hartnoll et al., 2010), as well as the challenge of involving drug users themselves in the design and delivery of harm reduction services (see Hunt et al., 2010), which are especially severe when those drug users are subject to the criminal justice system.

All elements of the criminal justice system have roles to play in the reduction of drug-related harm, including police officers, prosecutors, courts, prisons, probation services and non-governmental organisations that work with offenders. Harm reduction is a challenge for law enforcement, and law enforcement is a challenge for harm reduction. The contradictions between the aims of these two approaches cannot be wished away. However, we can protect both public health and individual rights to healthcare by acknowledging these tensions and finding ways to move beyond them to provide high-quality harm reduction services to all who need them.

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