

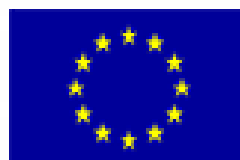


**Continuity of care for drug users
in prisons and beyond
in four European countries**

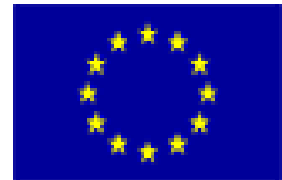


-Final report-

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Part 1 – Summary of project and country situations

1 Introduction

For prisoners¹ with a history of drug use, in particular 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). Much still needs to be done in order to ensure that people with a severe history of drug use are sufficiently cared for when released from prisons. Harm-reduction measures need to be in place for ex-prisoners to be able to readjust to freedom without relapsing back into drug use and to prevent the extreme risk of fatal overdose when released.

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

The specific objectives of the project are:

1. To complement knowledge of risk behaviour for drug users in prison and upon release by giving a voice to drug-user communities through qualitative participatory 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 the continuity of care – including medical care and drug treatment (provision of substitution treatment, antiretroviral treatment 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'.

¹ In the following report, people in or who have been in prison are referred to as prisoners, ex-prisoners or (ex-) prisoners.

Working on continuity of care and treatment, harm reduction and the prevention of mortality linked to drug use and overdose for people involved in the criminal justice system and in prisons requires a range of approaches. These should meaningfully address the different groups of stakeholders and beneficiaries that have a say in the introduction, development, definition, design, delivery and monitoring of and access to services for drug users in the criminal justice system. These involve: policy-makers in the area of health and criminal justice, prison administration representatives and security staff in prisons, health and social sector professionals working in the criminal justice system (depending on the Ministries of Justice, Internal Affairs, Health or Social Services and with various organisational structures in different Member States), health and social sector practitioners, grass-roots organisations, NGOs and other services providing care and support for individuals who use drugs, and clearly the end beneficiaries, drug users, who will be meaningfully involved in the current project.

This report shows the results of one specific objective of the project (4.). A multi-country (Belgium, France, Germany and Portugal) qualitative study, including elements of participatory research (user involvement). Two dimensions of continuity of care were evaluated in this study, since we were looking at the continuation (or discontinuation) of essential medical/drug treatment for drug users once released (in particular OST and ART) and the provision of case management, transitional care or throughcare upon release. This part aims to provide an overview of barriers as perceived by drug users and professionals working in prison and community services with drug users with a detention history, and strategies adopted in different countries to overcome these barriers.

Approximately 30 prisoners and/or drug users with prison experience, eight professionals working inside prison and eight working outside prison were targeted to be involved in the research in each of the four countries. Focus groups (prisoners) and semi-structured qualitative interviews were administered in prisons and outside.

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 Penitenciaire 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, Vandeveldel, 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 antidepressants 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%), antidepressants (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 Penitentiare 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; Vandevelde, 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 (Vandevelde 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 Penitentiare 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 practise, 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).

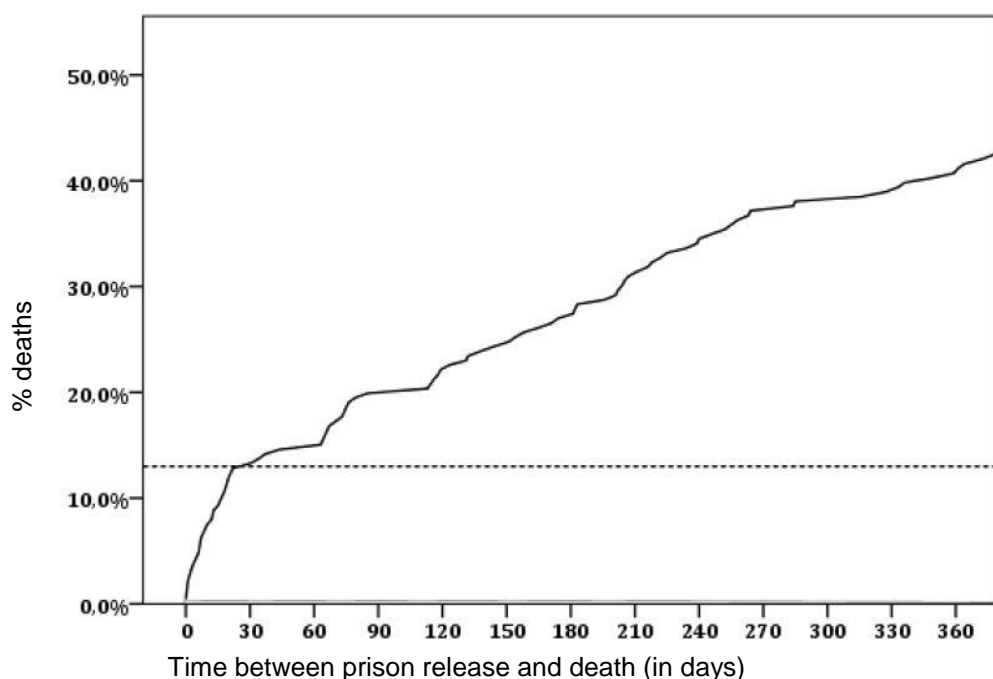


Table 1: Days between prison release and death (Burmester 2016)

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. ...'² (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

² Translated from German : 'Für die körperliche und geistige Gesundheit des Gefangenen ist zu sorgen' (Article 56 (1) StVollzG).

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).

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 incarceration³ (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.

³ 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 oppose'⁴ (§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'⁵ (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 und 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

4 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).

5 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'⁶ (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

⁶ 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 the continuation (or discontinuation) of essential medical/drug treatment for drug users once

released, the provision of case management, transitional care or throughcare upon release, and barriers and strategies adopted to overcome these barriers.

4.1.1 Participants

Several types of populations were to be included in this study.

- Former prisoners and prisoners who have already had at least one former prison sentence including release.
- Professionals, working inside and/or outside prison, who are involved in the reintegration of prisoners and former prisoners.

(Former-) prisoners

The study sample consisted of 67 prisoners (participants of the five focus groups included) 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 carry out 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 sentence of which was a maximum of five months ago, were recent and/or regular users of illegal drugs (other than cannabis), spoke enough Dutch, German, French or Portuguese 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 are female and 88 are male. The female interviewees were only interviewed in France and Germany, as the 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 a spent a total of 86.4 months (range 1–336) in prison on average. Former prisoners had been released on average about 2.2 months at the time of the interview.

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

Professionals inside and out

The sample consisted of 27 professionals working inside prison and 43 people working outside prison (see Table 3). The mean age of the professionals working inside prison was 42.6 years (range 30–65 years), while the age of professionals outside prison was 43.7 years (range 25–65 years). On average, all the professionals had 11.8 years of work experience in their current position (range 3 months–40 years). Social, medical and institutional sectors were represented (see Table 4).

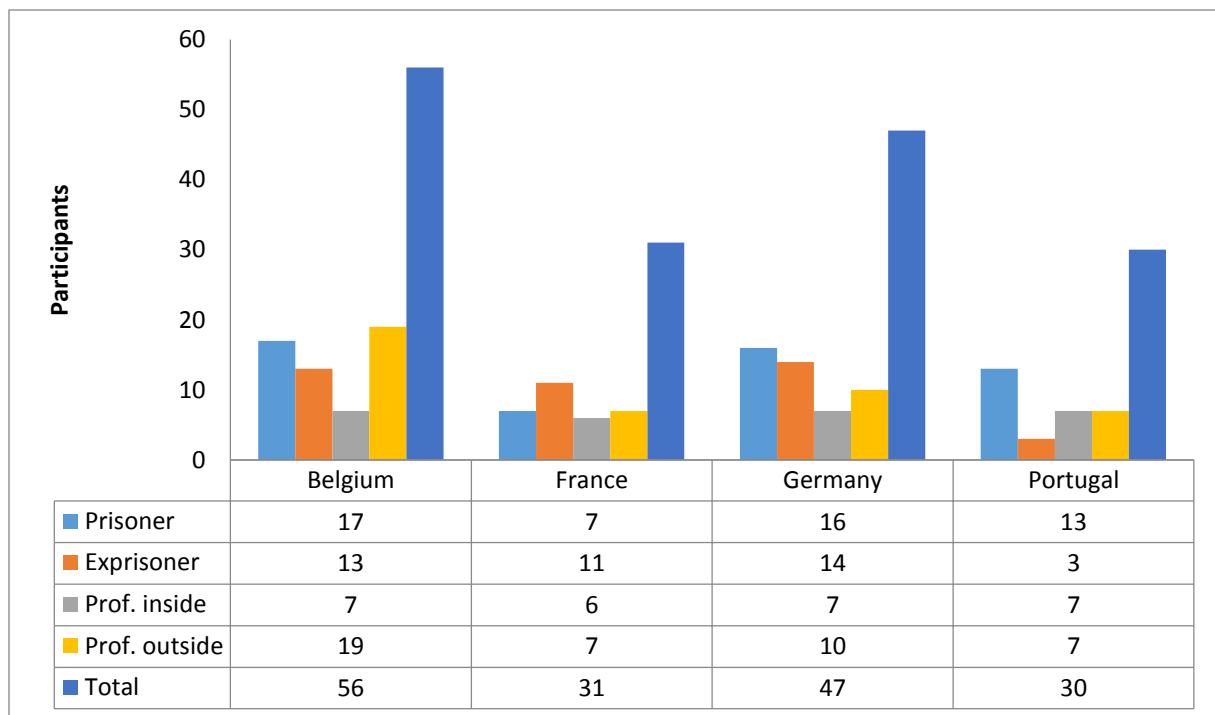


Table 3: Number of respondents in each country

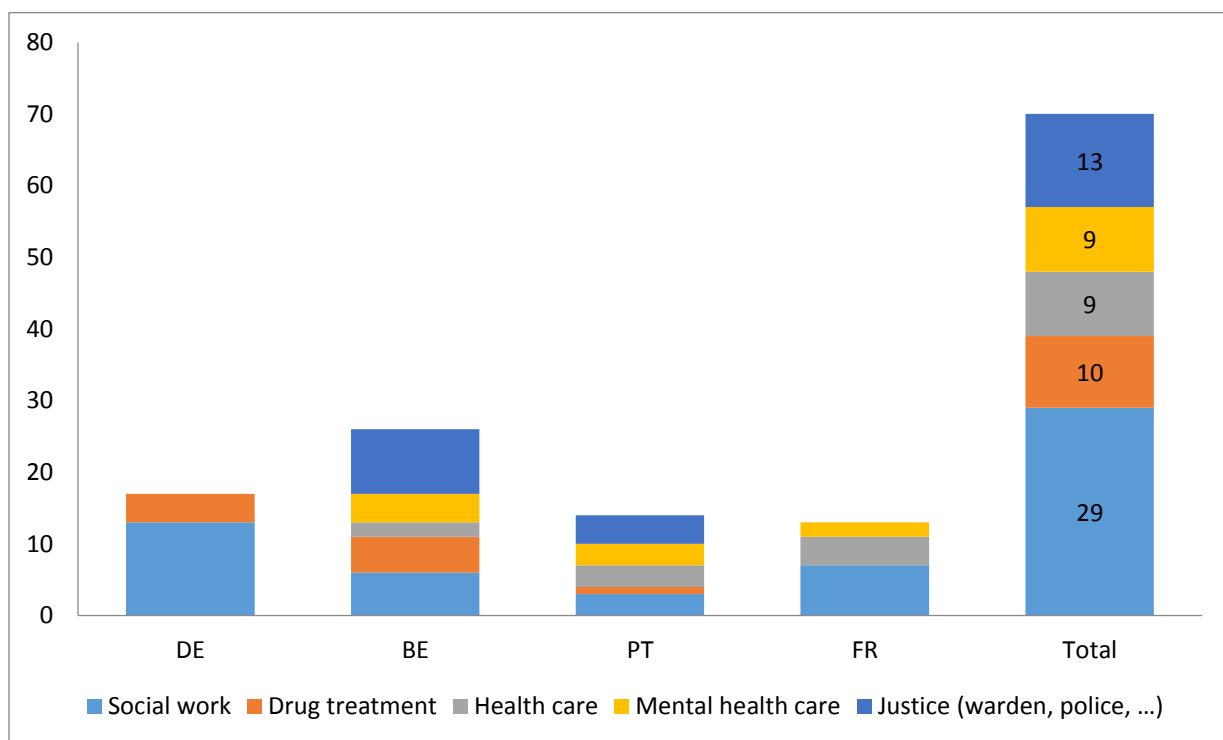


Table 4: Profession of participants (professionals in- and outside) participating in each country

4.1.2 Procedure and data collection

(Ex-) Prisoners

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 in the community. The research continued until as many respondents (prisoners and ex-prisoners) as possible were found. The planned number of 30 interviewees in each country was not reached 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 had to rely on professionals inside prison 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, they signed an informed consent form and the interviews took place immediately or at a fixed date in a room without the presence of staff, video equipment or any other control measure.

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

In all cases, the informed consent form was explained before the start of the interview. Individuals were informed that there was no obligation to answer all the 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 by using an audio recorder. Afterwards, the interviews were transcribed and anonymised. Some interviews in Portugal were not recorded, since there was no authorisation to do so. In these cases the interviews were directly documented by the interviewer. Afterwards, the interviews were transcribed and anonymised. After the interview or focus group was completed, participants received a small incentive (10 euro) in the form of cash, gift voucher or tobacco for participating in the study.

Our intention was to include ten ex-prisoners per country in this part of the study, for whom we added some more questions regarding continuity of care. However, since many other ex-prisoners and prisoners (who had at least one former detention and release) provided relevant information about continuity of care with regard to medical and psychosocial support and follow-up, we decided to include these respondents as well.

Professionals inside and out

The research took place between May 2017 and August 2018. Professionals inside prison were recruited through networks, personal contacts, ministries of justice, contact with prison staff and by using a method similar to snowball sampling. This procedure was very different from country to country, because of different procedures and needs for authorisation.

Professionals outside were recruited through the professional networks of the researchers, regional drug treatment coordinators and personal contacts with drug treatment centres.

In all cases, the informed consent form was explained before the start of the interview. Individuals were informed that there was no obligation to answer all questions and that participation could be stopped at any time. If the person agreed with the contents 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. In Portugal, were some interviews were not recorded, since there was no authorisation to do so. In these cases the interviews were directly documented by the interviewer.

4.1.3 Instruments

Prisoners and ex-prisoners were interviewed based on a semi-structured interview. In addition, focus groups were organised. The different methods (focus groups and individual interviews) 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 towards important topics of the target group (Tausch, Menold 2015). The questionnaires used for these semi-structured interviews and focus groups are available in the Annex, and were identical between countries. Insights from the literature were the main source of inspiration for the interview scheme that we drew up and used for the semi-structured interviews. The following topics were discussed: 1) drug use and risk behaviour in prison and at release, 2) knowledge of the risks of overdose and manners to deal with overdose, 3) individual strategies to deal with drug use and related risks, 4) experiences with release, 5) experiences with medical and social support (outside and inside prison), 6) preparation for release, and 7) suggestions for helpful support. Individual semi-structured interviews took between 29 and 120 minutes. One interview was stopped prematurely because of the heavy mental burden that resulted from this interview for the participant.

Different questionnaires were used for professionals outside and inside prison. The following themes were explored in both: medical and social support (outside and inside prison), preparations for release, experiences with release, collaboration between services, barriers to continuity of care and suggestions to overcome them. Interviews lasted for between 30 to 100 minutes.

4.1.4 Data analysis

All interviews were transcribed by the researchers or a transcription office and 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 meaningful units (nodes), and built in collaboration with all the countries involved in the study. Knowledge and experiences of (ex-) prisoners were collected and analysed per topic. In the results section, the main themes are discussed. In order to illustrate the results, literal quotations were used: quotations from prisoners are indicated with the letters PR. The letters EPR were used for quotations by former prisoners. In addition, the letter M for male and F for female were added. Due to data protection, it was decided not to add age or country in order to protect the anonymity of the (ex-) prisoners. For the quotations from professionals, PI was used for professionals inside and PE for professionals outside.

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 the methodological approaches and instruments (e.g. questionnaires) and to facilitate 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. Here, an agreement from the 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 for this study. In the interviews, sensitive data and information (e.g. about drug use in prison) was given by the interviewees. This made the anonymisation process urgently necessary. Data and information provided in our reports cannot be allocated to a certain prison or to individual prisoners.

4.4 Limitations and challenges

In general

In general, all countries were faced with several challenges to recruiting (ex-) prisoners and professionals in- and outside prison. There were some difficulties with different ministries of justice and the access to prisons or to carrying out research (interviews and focus groups) with prisoners and/or professionals inside. 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 from 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, the researcher was aware of an upcoming release, but the detainee'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 that they gave to the researcher. Another important reason is 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 we only recruited individuals who were already in contact with some type of service. Possibly, former prisoners who have not been involved in these services have other experiences after release.

France

The study 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 when we tried to reach prisoners with a drug history; first of all we needed authorisation from both the prison administration at the national level, and from the head of the medical unit inside the prison. As a result, we eventually managed to get the authorisations for only one detention centre near Paris. Once these were obtained, we had to solicit all the staff of the addictology unit to find eligible and willing patients, and then find several dates where both the patients and a confidential office inside the prison were available, which proved to be difficult and reduced our sampling options (i.e. our ability to cover heterogeneity).

We managed to reach mainly ex-prisoners in treatment centres that also provide housing (i.e. inpatients in residential treatment centres). In order to have a more representative sample, we tried to include outpatients with much less thorough and regular care regarding their addiction. Such patients often live in an unstable situation, and arranging interviews proved to be harder than expected, as we needed both the patient to honour the appointment and a confidential space 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, we set up financial incentives (service vouchers) but this had only a moderate effect.

Focus groups were planned in this study but were ultimately unachievable either in prison or outside due to the aforementioned logistical and administrative constraints.

Germany

For the interviews with prisoners, authorisation was needed from the Ministry of Justice in every single federal state. As a result attempts were made to get the authorisation in four different states. This part took 6–10 month for each state due to queries and reservations regarding the study. Two refusals and two authorisations were received. Following this, every single prison in both states were contacted, with only one in each willing to participate. Both prisons provided a contact person for the researcher, which was helpful for the recruitment of prisoners. In order to gain entry to one prison for the interviews, the researcher had to prove that they did not have a criminal record.

Seven professionals were recruited inside the prisons, for whom authorisation from the Ministry of Justice was also needed. Two other professionals were interested but they could not give interviews because of the missing authorisation from the federal state.

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

For the interviews with ex-prisoners, only those in low-threshold drug treatment centres were reached. Contact was made with several drug treatment centres (including inpatient centres). One organisation was interested but explained that they had no ex-prisoners who satisfied the criteria (5 months after release). Mostly the organisations were not interested in participating because of the significant effort it might take.

One of the main limitations of the study 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 feasible that former prisoners who have not been 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 prisons and organisations. It is not known whether there was any pre-selection process taking place.

Portugal

Regarding the limitations – namely concerning the prisoners – the main obstacle was finding people who fulfilled all the criteria (since many had not been arrested before). However, the greatest challenge was interviewing the former prisoners, since the majority do not leave any contact information that can be used to track them. Also, after leaving, 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 these aspects.

The team noticed some initial resistance to the questionnaire and some difficulty in creating distance and pointing out negative aspects – especially in the prison context – among some professionals of the state institutions; however, as the interviews advanced, they were more willing to give their honest opinions and points of view.

Part 2 – (Continuity of) care inside and outside prison

5 Results

The following part is based on findings from the four countries. Because of different political and legal backgrounds, the results are presented separately for each country. In some cases, there was no information for some countries. In these cases, respondents didn't say anything about the topic or there was no material to analyse.

5.1 Medical support available for users inside and outside prison

5.1.1 Health insurance

Belgium

This topic was not mentioned in this sample.

France

In prison, all prisoners are 100% covered for their medical expenses through a dedicated programme.

Upon release, however, almost all prisoners have experienced a discontinuation of care on discharge, even those with severe treatment. The difficulties relied not so much in their eligibility for full health coverage but on the effective opening of their rights to this coverage. While almost all prisoners were

entitled to 100% coverage for their OST and antivirals, a minority were able to exercise this right directly upon release from prison.

A certificate of health coverage is supposed to be issued when the prisoner is released from prison, but this was apparently rarely the case. In addition, this certificate was often not enough to obtain a free OST from any pharmacy. Furthermore, the procedures to get effective coverage were difficult to initiate before release, and once in the community, it implied showing a valid ID and a registered address (the latter was sometimes provided by NGOs and homeless shelters). In many cases, a sudden change in the date of release resulted in a cold 'dropping' into the community without transition or defined follow-up, and therefore without proper health coverage. All in all, access to the health insurance they were entitled to was not systematic and would take three months on average, according to professionals and patients.

'Normally, in terms of law, every prisoner must have with him/her a Social Security certificate that is given to him/her at the end of the imprisonment. With that, he has social protection as a prisoner, except that in reality, we almost never see these certificates. So I think it's also complex because, depending on the prisons where they are, there are not necessarily social workers who can inform them of these rights. Not all prisons have a social worker or educator, so they get out and have nothing. Personally, as soon as they are released, the first thing I do is actually to open rights. But to open rights, it takes three months to wait, so it's complicated.' (PE)

And how did the medical coverage go for you?

'It's been hard. It was hard, I waited six months. I had to pay for my medication at some point. Well, when you get out of here, you don't have your social security coverage. By the time you have all the papers the social security agency ask you [...] waited six months. I paid for my medication myself.'

Even the substitution treatment, you had to pay it?

'Yes, the Subutex®, I was paying 20 euro at the time.'

During the three, four-month gap?

'Exactly, by the time we got the papers done, it must have been three, four, six months. For the first two months, my pharmacist knows me, he said to me: "Yes, that's OK". But then it started to have a lot of unpaid medication on his computer screen, he showed me, he said, "Look, everything is in red"'. (PR, F)

As a result, the few specialised services delivering free OST in the community served as a backup solution for a lot of patients upon release, but required a daily trip to the centre. Furthermore, these treatment centres did not have sufficient financial resources to give HCV treatment freely (direct antiviral treatment cost around 29,000 euros for a whole three-month programme).

Germany

Continuity of health care after release is a huge problem in Germany. During detention, prisoners have in principle no right to claim social welfare, and this also includes health insurance. In prison they only have a right to cost absorption for medical expenses. To receive health insurance after release, ex-prisoners have to have a right to social welfare (this is not possible for people who are residing illegally in Germany) and they need to make an application right after release. It is not possible to start this inside because they need to attend in person when making the application. After this, it can take two to four weeks to receive the authorisation and health insurance is only possible with this authorisation. This means most ex-prisoners have no health insurance directly after release. Respondents indicate

that this is one of the biggest problems in terms of continuity of OST after release. Most respondents reported that this could also lead to illegal procurement of OST or drug use (relapse) after release.

'Exactly. And without insurance no substitution, means more consumption, means consumption relapse, is called fall in crime and this is not an all-round supply, but this is door opener you can almost say, we start from the beginning.' (PE)

'Because, the health insurance companies usually always need a copy of the release permit before they even take action. And logically, the detainee does not get the copy of the release permit until the day of release. This means, five minutes before the door opens. Or three minutes before the door opens. And then of course we can't do anything anymore. They have to apply for social welfare (job centre) and tell them that they are unemployed. And then they will also receive an ALG II application (social welfare/unemployment benefit), which is usually completed, or an ALG I application, if they have worked here long enough. Then this is the responsibility of the prisoners or the people to be released to apply for all that after release.' (PI)

In one case a respondent indicated that they cooperate with social welfare and a health insurance fund outside so they can provide health insurance upon release to all prisoners.

'They are, but they do not have health insurance on the day of their release. And for this we found a way, with the Jobcentre region (big city next to prison) and at the end unfortunately only with the AOK (health insurance fund in federal state where the prison is), where we said, after a structured procedure, thus the tasks became binding and clearly agreed that a substitute who is insured with the AOK in (state of the prison) can apply for benefits six weeks before his arrest, regardless of the local jurisdiction, regardless of the entitlement to benefits. He can make this application and it will also be decided soon.' (PI)

Portugal

The topic was not mentioned in this sample, as health insurance is not an issue in Portugal because public health services (under the national health system) are universal and tend to be free of charge.

5.1.2 Access to general support and care when entering prison

Belgium

Upon entry

When entering prison, prisoners meet within the first three days with medical staff (doctor, psychiatrist or nurse), the director, psychosocial staff and, in some prisons, a case manager. Everyone receives a welcome folder, including information about social services in prison and prison regulations. When entering prison, no needs assessment is performed and little attention is paid to prisoners' individual needs. Medication prescriptions are usually continued without checking the actual needs of the detainee. There is usually no contact with an individual's GP, unless a prisoner is involved in opiate substitution treatment. The only systematic screening that is performed shortly after arrival is screening for tuberculosis, which is repeated regularly during detention. Respondents state that there is little attention paid to their individual needs.

'I don't know why, but all those doctors they just bite your head off. It is like (...), they just see one after the other. You enter, next, out, (...). Yes, what is your problem? Paracetamol and ibuprofen, it is always the same. For everything. For every disease I have, I receive paracetamol. I didn't know this was a magic bullet' (PR, M).

During detention

Several professionals suggest that prisoners do not receive a medical consultation in time. Long waiting times are not unusual and doctor's visits are usually not well integrated into the daily planning. Often, wardens keep prisoners in their cells all day until they can go to the medical ward. Standard medical follow-ups are not provided and often only in severe situations will doctors intervene. According to the respondents, medical care in prison is mainly acute care, with little attention paid to prevention and psychosocial support. The main reason for this lack of support is lack of staff and insufficient time. Several prisons only have one (part-time) doctor and psychiatrist. Pharmacotherapy is the primary intervention and is often targeted at reducing symptoms. If one is taking medication before detention, pharmacotherapy is usually continued for a certain period, although prisoners state they receive different brands of medication.

Despite the attention paid to underlying psychological problems, causal factors are not dealt with. Prisoners state that medical care is better on specific wards for drug users or for mentally ill offenders. On these wards, the focus is on care rather than security, and medical treatment is combined with psychological support. Several prisoners appreciate the support by the care teams for mentally ill offenders, as they follow up offenders' mental state and help them in case of psychological problems.

France

This topic was not mentioned in this sample.

Germany

Upon entry

When entering prison, prisoners meet within the first day (except weekends) with medical staff (doctor, psychiatrist or nurse), the director, psychosocial staff and social worker. When entering prison, a needs assessment is performed, but little attention is paid to prisoners' individual needs. Prescription of medication is usually continued. The only systematic screening that is performed shortly after arrival is screening for tuberculosis and drug use. In some cases prisoners reported screening for HIV and HEP C, and professionals indicate that HIV and HEP C screening is offered to prisoners.

'That's what the medical service did right when I came in prison, yes. They just wanted to know what I consumed. And the rest is done only through urine testing. And then they take X-rays, just to protect themselves.' (EPR, M)

'Weight measure, measure blood pressure, listen to the lungs, cough and that's it, just the bare essentials.' (EPR, M)

'Prisoners are usually presented within 24 hours to the medical service, which of course especially for those who are or have to be medicated or where withdrawal patterns are to be expected and so, of course, is very important anyway, but overall it is also about to look, in which physical, possibly also mental state is a prisoner.' (PI)

'Of course, women will be offered a comprehensive test and, above all, test options, which of course includes an HIV and hepatitis test.' (PI)

During detention

Several professionals and (ex-) prisoners suggest that prisoners do not receive a medical consultation in time. Long waiting times are not unusual and doctor's visits are integrated into the daily planning for

prisoners on specific wings on particular days (except emergencies). To see the doctor prisoners have to write a request. Standard medical follow-ups are not provided and often only in severe situations will doctors intervene. According to the respondents, medical care in prison is mainly acute care, with little attention paid to prevention and psychosocial support. The main reason for this lack of support is a different 'health insurance' from outside. Prisoners are only entitled to receive costs for medical support if needed. Several prisons only have one doctor and one psychiatrist but a special medical station with beds in case of withdrawal or other intensive medical support. All prisons also have special doctors like dentists and gynaecologists from outside who visit at regular intervals. Prisoners have no free choice of doctors. If needed they are transported to the prison hospital or hospitals outside prison (emergencies and operations). Some (ex-) prisoners reported that they don't feel that they are taken seriously and that support is provided on a minimal basis.

'Yes, I am in AIDS care in the university clinic and then I am with Professor (surname of the professor) at the university because of my cancer and that has made all the JVA for me. They made me a top professor. They really worked hard.' (EPR, M)

'Otherwise, you always have to write concerns and then every house has a day his doctor's day. And if it's just more urgent or, then you can also go to the nurse in the morning or if at night is something you can be brought over to the infirmary.' (EPR, F)

'Yes, with ibuprofen, if you have a headache or whatever you have or if you have to go to the dentist, is always the most necessary. The minimal thing you could get.' (PR, M)

'Free choice of doctor, this does not work.' (PI)

Pharmacotherapy is the primary intervention and is often targeted at reducing symptoms. If a prisoner is taking medication before detention, pharmacotherapy is usually continued for a certain period, although prisoners state they receive different dosage of medication.

'Mediation in an external therapy, inclusion in a drug treatment, either women with depression, where then, for example, there must be looked at. Then there must be contact with the in-house psychiatrist, there must be established and then finds one, of course, there is a diagnosis and an indication for the medication.' (PI)

'There is then often a treatment with psychotropic drugs instead. So they'll get along then. So if there is a depression somewhere, then there are antidepressants. Or with sleep disorders or with any things. Well, I say I'm not an addiction doctor, but I know that there are relatively many psychotropic drugs prescribed. Because of sleep problems. Because of restlessness. Because of fears. Because all sorts of problems arise. And apparently it is easier for the medical service to treat people with medication than just a corresponding one, so in principle it is also to do psychotherapy or something like that. This will take place rather less. So there is such an institution psychologist, who also talks. But if a permanent treatment takes place? I'm not so well aware that it's happening.' (PI)

Despite attention being paid to psychological problems, causal factors are not dealt with. Access to doctors is not easy for prisoners. Most (ex-) prisoners reported poor medical service provision. In most cases doctors are not specialised in HIV/HEPC and drug treatment. All doctors need to have additional training for drug treatment but (ex-) prisoners often reported that they have no idea of the difficulties regarding drug addiction. Most professionals didn't know what happens in medical service because of data protection inside.

Portugal

According to professionals working inside prison, medical teams include general practitioners (GPs), psychiatrists, psychologists and nurses. The nurse team visits prison facilities every day (except during weekends and public holidays) while GPs visit twice a week. The prison also has a suicide prevention team permanently available inside the facilities.

One of the most common issues regarding medical care are the long waiting periods.

'After only a month of illness they called the doctor. I had a case that I went through a year with headaches and they gave me pills and more pills, until I refused because they were ruining my body. I wanted them to take me for exams. I had to go on hunger strike so they would take me to the hospital. Clinical services do not work very well there [in prison].' (EPR, M)

Medical services, whether inside or outside prison, are often subjected to a high load of bureaucratic and security issues, and there is a general lack of human resources. This was pointed out by both prisoners and professionals.

'I do not know if it's easy because I do not work inside prison, but here we sometimes feel requests are made within prison and it takes a few days to get here. But I think this has to do with prison internal issues and that is what they tell us. I do not know which bureaucracies and hierarchies exist there, because surely for security reasons they have protocols that surpass us and I do not know if the access is easy or difficult.' (PE)

From the perspective of prisoners, these problems lead to ineffective medical services.

'They are distanced from the needs of prisoners and they should be more on top of the matter. There were three doctors for more than two hundred men (...).' (EPR, M)

'When I make a request [for medication] I am waiting for two or three months, so I do not know if I can say that I have medical support.' (PR, M)

In order to tackle these limitations, some professionals working inside prison pointed out the need to hire more human resources to reinforce clinical services and the establishment of more protocols with specific services, namely private clinics, to increase access to a higher number of clinical specialities and to decrease waiting periods. The need to diminish bureaucratic processes was also pointed out.

5.1.3 HIV/ART/HCV

Belgium

In case someone requires specialised treatment, e.g. HCV or HIV treatment, prisoners are referred to one of the prisons with a medical centre. Smooth transitions are observed in cases where prisoners are transferred within the same prison, but if they need to be transferred to another prison, several obstacles were mentioned, e.g. the risk of losing their cell (mates). Some prisoners avoid asking for specialised help for this reason.

France

All the participants were tested for HIV/HCV and most of them were vaccinated against HBV during a previous incarceration. It appeared that screening tests were systematically offered at entry. Lower rates of screening were observed in large remand centres (compared with long sentence detention centres), and in centres where screening tests were not made directly after the patient's consent was given and needed a second visit to the medical unit.

HIV among the population of incarcerated people who used drugs was considered 'less of a problem than before' by professionals. From their experience, access to treatment improved and transmissions decreased in this population.

Regarding HCV, even though prevalence remained high in the professional's opinion, access to treatment and recovery rates were getting better. This improvement was largely attributed to the new direct antiviral therapy.

All in all, prescribing an HIV or HCV treatment in prison was not considered problematic for most professionals and users. However, greater concern was raised about the individual social context in which the treatment started and would continue, since its success depended greatly on a stable situation. In order to increase treatment adherence, professionals tended to associate the treatment with a post-incarceration housing solution like a residential treatment centre. Similarly, the initiation of HCV treatment could be delayed if the patient was going to be released in the few next weeks. On the other hand, professionals inside prison tried to establish a link with a treatment centre in the community, ensuring complete HCV care at this centre, from start to finish.

Prescription sheets for three months' worth of HIV treatment were sometimes handed to (ex-) prisoners when leaving prison in order to 'make the bridge' between the treatment set-up in prison and the one set up in the community. Apparently, this practice was not transposed to HCV treatment because of its extremely high cost. Additionally, after a mail was sent to the point of contact in the community, the medical file was handed over directly to the patient upon release, which meant there was no guarantee it would find its way to a medical doctor outside.

Another obstacle to continuity of care was observed: some people did not declare their HIV diagnosis and refused to be screened when entering prison in order to avoid stigmatisation from other prisoners.

Germany

In case someone needs specialised treatment, e.g. in the case of HCV or HIV, prisoners receive medication as they do on the outside. If they not in treatment at the time of detention, treatment is not ensured for short-sentence prisoners. Some (ex-) prisoners reported that HIV-positive prisoners receive additional food like fruit.

'I got my HIV medication. I got everything, extra food, what I wanted, all around.' (EPR, F)

'So this is planned in advance so that those treatments will be continued as soon as possible in detention. Respectively, depending on how long the stay in prison is, are not started in detention, but then a contact is made outside, where they can go promptly after the detention, and start with the treatment outside.' (PI)

Portugal

At entry, a needs assessment is performed by a medical team including GPs and psychologists. Personal and family history is assessed, blood and urine samples are collected, and additional diagnostic tests are performed within 15 days of arrest. Prisoners are also screened for HIV, HCV and HBV. Compliance with the vaccination plan is checked and if not up to date, the local health care centre is contacted for the acquisition of vaccines, which are then administered by health professionals inside prison. Regarding psychiatric and psychological care, the initial assessment is performed by a

re-education technician who evaluates the needs of prisoners and subsequently the type of intervention to follow, and whether or not a psychiatric consultation is required. During detention, the need for psychiatric and psychological care may be flagged by nurses, physicians, guards or other prisoners.

Commonly, general check-ups are performed upon prisoner request. Whenever the medical care available inside prison is insufficient or there is a need for specialised care and/or examinations, prisoners are referred to services with which the prison has formal protocols, namely public hospitals, health care centres, private clinics or drug-related treatment units, always escorted by and in the presence of prison guards. Medical appointments and treatments provided in private clinics must be financially supported by prisoners. For specific treatment, such as HCV or ART, prisoners are referred to an infection specialist outside prison. The medication intake is monitored by the nurse team since prisoners are not allowed to manage their own medication individually or to take it inside the cells. Medication is free of charge unless it is not prescribed by the GP. Aside from HCV and ART, the use of medication for sleep disorders (e.g. alprazolam, diazepam), mood stabilisers (e.g. mirtazapina) and other medical conditions was reported by some prisoners.

5.1.4 OST

Belgium

Opiate substitution treatment can either be started or continued in prison. When a prisoner indicates he is involved in OST treatment in the community, medical staff will – based on informed consent – contact the person's GP regarding dosage. Prisoners' accounts make it clear that prison doctors are usually not in favour of reducing substitution treatment. Not all doctors are willing to help someone reduce methadone doses, leading to situations where prisoners try to reduce it themselves (with the help of cell mates) or go cold turkey with the medication.

France

Opioid substitution therapy was reported to be largely available inside and outside prison. In prison, methadone was to be taken in front of a health professional and was mostly administered on a day-by-day basis, in the cell or in the medical unit. Buprenorphine, however, was given to the patient once or twice a week, so they could not find themselves with more than seven days' worth of treatment. In the community, access to free OST in the few identified centres was a substantial help for patients, even though the day-by-day delivery in the afternoon was seen as hardly compatible with work.

Whether it was from inside to outside or vice versa, continuation of OST was performed very smoothly when the patient was already known by prison or community staff. Also, both social and medical professionals stressed the 'relational' role of OST: seeing a patient regularly allowed them to build trust, especially outside where the person is more difficult to reach.

Professionals and (ex-) prisoners reported several elements linked to traffic control and misuse, which could act as a barrier to continuity of care regarding OST. First, the person asking for OST often had

to 'prove' they needed it, either by showing a previous prescription sheet or by taking a biological test. This practice was observed both outside and inside but proved to be really problematic inside, because the patient entering prison was often already lost to follow-up by community service (thus could not show a 'proof' of treatment). One prisoner recalled having a gap of one week in his therapy because of this procedure.

'When I came back into custody, I wanted to be on substitution treatment because I was a heroin addict. Since I didn't have any treatment outside, they didn't put me on treatment, not for another week. So, for a week, I stayed without treatment, they were taking blood samples to see if I really had used, to be able to put me on substitution treatment.' (EPR, M)

Second, some patients were forced to switch from their usual buprenorphine molecule to buprenorphine/naloxone (Suboxone®) because the latter was the only one available in detention, according to an institutional worker.

Another prisoner recalled being released without any kind of OST, since the prison guard did not allow him to go in the medical unit before leaving prison. As a result, he could not to take the prescription the medical staff had prepared for his release. In other cases, the lack of information given to the health staff regarding the release date was the cause of an unprepared release, and therefore without planned treatment:

'...I think there are a number of times they've been out [the prisoners] without the health unit being aware of it. In this case, he goes out with his little bundle without anything. Sometimes he has a little money enough for two days, sometimes he has two nights in a hotel that are paid for. But if the health unit wasn't aware, he doesn't always have a prescription, he doesn't always have an appointment. These ones, I think they're really messed up...' (PI)

Germany

Opiate substitution treatment can be continued in prison (with the exception of some federal states) in cases where prisoners have no additional drug use (tested with urine tests). In this case, prison doctors reduce dosage immediately and stop treatment after a few days. When a prisoner indicates they are involved in OST treatment in the community, then medical staff will – based on informed consent – contact the person's GP regarding dosage. OST is not guaranteed for the whole time inside, especially if urine testing is positive, and only one professional indicated that there is OST available with additional use on occasion. Some professionals mentioned that there a fixed number of OST places inside and they cannot offer it to more prisoners even if they might need it. Some (ex-) prisoners indicated that they had no free choice of substitution (methadone, Subutex®, etc.), even if they had problems with the usual medication, and that they would rather not take OST at all instead of medication they didn't like.

'That's a disaster. He's sometimes done something for me, then he said, "Yeah, we'll throw you out of the methadone programme. There is no therapy for you. I give you up".' (EPR, M)

'Yeah, well, there I just got substituted, so that's when I got a call from the doctor I was substituted for outside, so it's important that someone else takes over, so he does not say you're flying out with him out of the programme, and then you can keep it up.' (EPR, W)

And then, not in custody?

'Immediately cold turkey, nothing. (Location1 in BL1) gives nothing, (location2 in BL1) gives nothing. Only I have heard (Location3 in BL1) there is substitution, to reduce immediately. And in some prison, they continue I think, there is also there, some methadone or something. But in such prisons as (place in BL1) and (place2 in BL1) and what I know what. Other prisons, there is cold withdrawal.' (EPR, M)

'At that time I was substituted with Subutex® and then they switched to methadone but that was not for me. I always slept on methadone. After three weeks, I said I cannot do it anymore. I thought I would spend my life in bed, that will not work. Then I decided to get out of OST.' (EPR, M)

'Yes of course. What does of course mean, if you are in treatment outside, you will continue to substitute normally. But not everywhere of course.' (EPR, M)

'And when I got here, my urine test, of course, my urine test, was not clean yet. And the doctor had not been shaking for a long time and I was directly reduced to nothing (no more OST). I thought this broken my neck.' (PR, F)

'Often it is the case with the clients who were not substituted by us, whom we only knew before from other contexts, when they get arrested they do not get a substitute. Because they were not previously substituted and then you they are reduced to nothing in prison.' (PE)

'Of course, a daily methadone will be given. Of the 30 places, which are actually always occupied, so there is a short conversation with the medical staff, with the doctor instead. But that's not what you mean by psychosocial supportive care... I cannot say that. All I can say is that of course it's a medical decision. The doctor then looks at her patients. [...]. And maybe look at the one who comes and wants to be included in the programme now, or just to continue the programme started outside and then, yes, the doctor must make a decision. Whether she picks him up, suggests someone else to leave the programme, or if she then reduces OST to nothing and just wait until a place is vacant.' (PI)

Prisoners' accounts make it clear that prison doctors are usually in favour of reducing substitution treatment. Once they reduced the dosage the way back to more was very difficult or impossible.

'They always want to reduce, anyway. So if you start with that, I would not advise anyone to say that, yes. Because that's difficult to stop, yes. So what's gone is gone. And then it stays away.' (EPR, M)

'No, they (doctor inside) said two, two less (dosage). They want to get the people out of OST at all. No idea why, who have always been in treatment do not want to reduce, do not want to reduce anymore. But I had nine and there they said, "we reduce to seven, you do not need so much in here", they said.' (EPR, M)

Continuity of OST is not guaranteed in prison or after release, because of missing health insurance upon release. OST is available outside in all cases (via health insurance or self-payment). There is also no psychosocial supportive care alongside OST, as opposed to what is usual outside.

'Substituted before, then in custody no more. And then in custody again. Then I was outside, had no health insurance for two months, bought it illegal. And then stop again.' (EPR, M)

'They contact us as a continuing OST organisation because they were also substituted in prison. We often make admissions, if [no] house ban or debt to the (Catholic aid organisation), we take all, even on the same day, there are almost seamless in substitution. [If] they are not insured, then there are problems in most places with substitution [except for us], we are a big exception.' (PE)

'And psychosocial accompanying care does not take place so explicitly. [...] so there is a short conversation with the medical staff, with the doctor instead. But that's not what you mean by psychosocial supportive care.' (PI)

Portugal

OST is available in prison, both for prisoners that are already on treatment and for those who begin treatment inside prison. However, this transition is often slow and many prisoners experience long periods without any drug-related medication after arrest.

'I get into jail today and I'll be there two to three days without any medical care. After that I'm called to see the doctor, boss, etc. If the person is using, those two to three days will be very difficult. And it is only after three days that they give you some medication, whatsoever, because at that time they do not even have the medical file yet. Until the right medication arrives, a month goes by.' (PR, M)

5.1.5 Naloxone

Belgium

Naloxone is not provided in prison or upon release. Except for a small (discontinued) pilot study in Antwerp, knowledge about naloxone was limited among study participants. Only one prisoner had ever heard about it and most professionals are also not familiar with this opiate antidote.

France

Most of the professionals had already heard of naloxone nasal sprays, but only those working in specialised treatment centres had actually seen it and were trained to prescribe it. (The interviews were conducted at a time when authorisations for nasal sprays were still pending, therefore their use was done in the context of Temporary Authorisation of Use in the Community, but also in prisons – i.e. take-home at prison release).

All the professionals and users interviewed were favourably inclined towards the use of these nasal sprays.

Germany

Naloxone is not provided in German prisons or upon release. Except a small (discontinued) pilot study in one city, knowledge about naloxone was limited among study participants. Most prisoners had heard about it in the context of overdose and professionals were familiar to naloxone with only a few cases.

'Of course, there are condoms, there are no injection tools. Naloxone to the free, I say, there is no emergency treatment (naloxone) here on the stations. To whether the medical service got it, I do not know. I emphasise again data protection, medical stories, but our addiction counselling service also offers on all topics, I say supreme "addiction", which then also includes the harm reduction you just described, corresponding information and discussions.' (PI)

'I do not know, this does not exist here yet, but that in other states clients are being trained in custody with this naloxone and then also these naloxone starter kits or as it's been called, personally like it. Everything convinced me. I think it's great here, I'm not sure who's going to do it or who can, so I know it's controversial with naloxone that there are hardly any doctors who want to prescribe that and that then it is not clear if the clients pass that on and so.' (PE)

Portugal

Only one nurse reported the use and availability of naloxone inside prison, which is administered with the supervision of the nurse team. No other professionals working inside prison referred to the availability of naloxone.

5.1.6 Psychiatric care

Belgium

Despite attention for psychological problems, causal factors are not dealt with. Prisoners state that medical/psychiatric care is better on specific wards for drug users or for mentally ill offenders. On these wards, the focus is on care rather than security, and medical treatment is combined with psychological support. Several prisoners appreciate the support by the care teams for mentally ill offenders, as they follow up offenders' mental states and help them in case of psychological problems. Overall, there is little attention paid to psychiatric care and psychological support, and for individual assessment.

'Psychological support? No, nothing. Absolutely nothing, and I said it, I was still affected by my mum's death. I just had to take my medication I took outside. They knew already that I was taking medication. So, I just entered, they looked in my file and said: "OK, here are your pills". I received the same pills as before [last year in prison]. They did not even ask whether something had changed in the medical file whatsoever, no examination, nothing, nothing, nothing, (...)' (EPR, M)

France

With regard to the psychiatric needs assessment at entry to prison, it was reported by professionals that a routine examination was carried out for all new prisoners. Either all the newcomers were systematically seen by a psychologist (or a psychiatric nurse), or they were examined by a general practitioner who then referred them to a psychiatrist if necessary.

A problem of 'threshold' was raised: one professional felt that only the most serious psychiatric disorders were managed, leaving symptomatic disorders without psychiatric follow-up despite the presence of an addiction co-morbidity.

This statement was consistent with those made by other professionals: the challenge was not so much to ensure correct long-term follow-up, but really to initiate it, and to find the time and means to establish the necessary trust relationship for this type of follow-up. The time between the psychiatric screening examination and the first real individualised consultation was sometimes too long to achieve this goal.

During incarceration, the time between consultations varied greatly once the follow-up was initiated, from two weeks to three months in our sample. It was significantly longer in remand centres than in long sentence detention centres. On-demand consultations were available (requests were made by mail to the medical unit), but response times also varied greatly and were sometimes a reason to give up on psychiatric support.

At the time of release, a rupture was frequently observed because the relay with the local medical and psychological centres (i.e. the ambulatory sector of public psychiatry) was not successful. This was either because the upstream contact had been insufficient or because the waiting lists were too long. A lack of resources at these centres, which are often the main source of psychological support for this population, was pointed out by professionals.

An ex-prisoner brought up an inherent limit to the psychological support inside prison: since the prisoner is not in their usual environment, it can be difficult to help them face the everyday challenges they will have to face outside – it is difficult to ‘complete the work’:

‘I think that deep down inside, there is always this mourning. I think that, for this, it will take me some time to really accept it. I had two successive incarcerations after her death, so it’s not really a time when you can really do work on it, even if I talked about it in prison, even if I had a follow-up with the shrink at my request. But it wasn’t in everyday life, so it didn’t really allow me to meet other people, it didn’t allow me to get back together, so it’s sure that the work will take a little longer than if I had been free.’ (EPR, M)

Germany

All respondents reported existing psychiatric services in prison. It is possible for prisoners to see a psychiatrist if they need one. Normally, professionals inside refer prisoners to a psychiatrist in specific situations, but prisoners can also indicate the need for a psychiatrist. Respondents indicated that psychiatric care is rare, as there are too many prisoners who need medication and not enough staff available. This leads to short periods where psychiatric staff see the patients, e.g. once a month for 5–10 minutes.

‘We have a medical department, we have sex specialists, psychiatrists. It’s all in itself, the only problem is that, in my opinion, it’s too small. So we have too few people who can take care of the multitude of prisoners.’ (PI)

‘They can get in contact if they want to see a psychiatrist. Sometimes we report the prisoners to the psychiatrist, when we think it would be necessary for him to look at it. For special indications. But the psychiatrists are already doing well, now from my point of view of addiction counselling.’ (PI)

‘And usually this will be done through mediation of competencies, ranging from dealing with their crime and their life situation outside, to such practical things as debt counselling or mediation in external therapy, inclusion in drug treatment, either women with depression must be looked at. Then there must be the contact with the psychiatrist within the institution, there must be established and then one finds, of course as well a diagnosis and an indication for the medication.’ (PI)

‘Prisoners, I say, who come from outside, where are those who have been in psychological treatment, who, yes, now need antidepressants as an example. And that will continue to get from here, the drug. They will be presented to a psychiatrist in addition and then the whole thing will be discussed with the extent to which a medication is still required.’ (PI)

Portugal

Regarding psychiatric and psychological care, the initial assessment is performed by a re-education technician who evaluates the needs of prisoners and subsequently the type of intervention to follow and whether or not a psychiatric consultation is required. During detention, the need for psychiatric and psychological care may be flagged by nurses, physicians, guards or other prisoners.

5.1.7 Harm-reduction tools (needle exchange, clean equipment, bleach, etc.)

Belgium

All respondents agree that information regarding drug use and infectious diseases (e.g. leaflets) is available in prison, as well as condoms, but prisoners state they do not receive information proactively about drug use and harm-reduction measures. According to medical and social services staff in prisons, prisoners are actively informed about risks related to drug use. However, several prison workers state that there is no safe climate to discuss drug use, as psychosocial service staff have a duty to report, while medical services or care team workers are bound to professional secrecy and can discuss delicate issues with prisoners.

Syringes and bleach are not available in Belgian prisons and a taboo was observed regarding providing information on safe use or overdose prevention. Several professionals stated that prison staff have the wrong impression that providing needles and syringes would lead to increased use.

France

Regarding condoms, while their access was often not mentioned as problematic outside prison, condom distribution in prison, when available, consisted only of a box opened for self-service, on a desk inside the medical unit. Prisoners did not express concern about sexually-transmitted infections in the interviews, as they did not report any sexual activity. Ultimately, little discussion involved this subject, mainly because sexuality seemed to remain taboo in the prison setting.

Access to bleach was variable across prisons, and information about its purpose (to wash the cell or disinfect tools), its use and its dilution was extremely heterogeneous.

One inmate reported an informal syringe exchange programme currently set up in prison, where exchanges were performed inside the medical unit when the patient went there to receive OST.

It was, however, the only example of needle exchange reported. In our sample, people who used drugs did not express a current need for sterilised injecting tools, as none of them reported injection practices, and they all had the objective of drug cessation in sight. Professionals did not observe this type of harm-reduction measure inside prison first hand. Clean straws seemed more frequently available in prison but distribution was still sparse and inconsistent, according to professionals. Interestingly, one respondent observed that the equipment provided during incarceration could have proved valuable during their last post-release period, had he kept it on him.

Another respondent explained that he would not ask for harm-reduction equipment from the medical team because he was afraid his cell would be searched by the guard if he did, highlighting the need for more active distribution as well as general mistrust towards prison staff (medical or not).

Outside, information about access to sterilised needles in harm-reduction community centres seemed well known by users and health professionals: those who injected drugs outside knew quite well why and where to avail themselves of new syringes.

Ultimately, information on risk-reduction tools was inconsistent and highly dependent on the health care staff in place. The NGOs working in detention centres provided valuable support for the health care teams on site. Thus, in one prison, harm-reduction interventions were almost completely delegated to a community service which was authorised to enter prison every two weeks for a meeting/workshop with prisoners, and was able to distribute harm-reduction tools (but not syringes).

In other prisons, some prisoners found the lack of communication about the nature and aim of harm-reduction interventions regrettable, and wished it was better explained. For them, posters in corridors were not enough to inform prisoners, especially those who did not receive regular follow-up by the medical staff.

Germany

Harm-reduction measures and information about risk is provided to drug users outside. All respondents ((ex-)prisoners) had access to drug treatment centres, consumption rooms and/or clean tools. Upon entry into prison, prisoners get an appointment with the medical service (doctor) and are asked whether they received substitution medication before detention and/or if they are dependent on any drugs, in order to continue OST or starting a withdrawal with medication (starting OST is very unlikely). Most prisoners indicated that they know that methadone and/or Subutex® (maybe also Suboxone®) is available in prison. However, they stated that there is no specific prevention of drug use and associated risks in prison, nor do prisoners systematically receive information about harm reduction or other preventive measures (such as condoms, for example). Some prisoners received information about HIV/HEPC when they had HIV/HEPC-positive cellmates, and in some cases they went on a course or received an information letter about harm reduction (mostly tattooing, HIV, HEPC) at the beginning of their sentence. Some (ex-) prisoners and professionals mentioned that information is provided during drug counselling if needed. Nearly all respondents agree that there is no information regarding drug use and infectious diseases (e.g. leaflets) available in prison. Only in some cases was there information at the time of detention or in counselling. (Ex-) prisoners (men) indicated that they knew about condoms but also indicated that they knew this because of other prisoners, and in some cases the access is complicated or associated with questions from staff. Condoms are provided in every male prison, but in one they are provided just for long-term visits. (Ex-) prisoners and professionals state they do not receive/hand out information proactively about use and harm-reduction measures systematically. According to some social services staff in prisons, prisoners are actively informed about risks related to HIV/HEPC at the time of detention.

'So, in (long sentence execution) that is so, so, (name of prison) is like this, you get condoms either on long-term visit or you go to the medical service, there is a bowl, you can just grab some. Here it is, here it is like, when you go to the medical staff: "I would like to have condoms." Just so well accepted. "For what, why?" Then you first have to tell your half life story and are of course stupidly looked at and then you stand under permanent observation. Why did he need condoms? (Actual prison) is a strange prison.' (PR, M, focus group)

'So I heard there were condoms in here. We used to have a transsexual here who always gets condoms because he always offered himself for tobacco or whatever sexual acts. Yes, and there were condoms, but I have never heard of syringes.' (PR, M)

'I think they get it from the medical service. I think they can ask for condoms in the medical service.' (PI)

'I'm not really aware of that. Not in prison. So I can say that in the context of addiction drug counselling talks about risks. Just tattooing, injecting, intravenous use, syringe delivery, unprotected sexual practices and such things, that's already an issue. But that's not at detention. That's much later.' (PI)

'We have a colleague in the medical service who specialises in everything related to infection, infection prevention and so on. The addiction counselling service used to do that. In the meantime, we have included this colleague, who is also integrated, in this introductory course.' (PI)

Syringes or bleach are not available in German prisons and a taboo was observed regarding providing information on safe use or overdose prevention. Several professionals stated that they knew about needle exchange in prison a few years ago, but that this was not needed anymore, and some indicated that needle exchange could be helpful.

'I think it's good in principle that there are no syringes. For the simple reason that for me is always important to be open and honest, is always the best. And if I have prisoners here who are addicted, then we can go in open conversations, just of course also opioid user, get the people in OST, which is in my opinion, much, much more useful than handing out syringes.' (PI)

'We also had needle exchange here, because we had so many prisoners who consumed intravenously, so we had this syringe exchange programme. And at the moment, I'm very happy that there are only very few who actually use syringes. So at least I get the impression that over the past 15 years drug user behaviour has changed quite clearly, to smoking, snorting and swallowing.' (PI)

Portugal

The harm-reduction materials available for prisoners are mainly bleach and condoms. According to a nurse, condoms are rarely requested. Prisoners do not have access to sterilised material for security reasons, except for treatment purposes and when provided by health professionals. Greater investments in harm-reduction strategies inside prison and the creation of safe consumption sites were also referred to by prisoners and professionals.

'Prevention and harm-reduction programmes. As everyone knows, it becomes almost impossible to eliminate drugs inside prison. Therefore, we must invest in harm-reduction information, in order to protect the most important, that is, the health of prisoners.' (EPR, M)

'Properly monitored and controlled spaces could be created where some sterilised materials could be used to reduce the risks to which they are subject within the prison.' (PI).

Some nurses have also pointed to the need for more sterilised materials and other equipment inside prison.

5.2 Social support available for users inside and outside prison

5.2.1 Psychosocial support in general

Belgium

Connections with psychosocial support services in the community are usually discontinued upon prison entry. Whether support will be continued usually depends on the goodwill of individual caregivers or the explicit request of a prisoner. Prison staff are normally not contacted by psychosocial services regarding someone they have engaged with before entry. The psychosocial service in prison is mainly responsible for the social reintegration of prisoners, but it has a dual role: besides providing support, it needs to make a risk assessment regarding the prisoners' social reintegration, which usually takes a lot of time. Also, external services provide support in prison like judicial welfare work that helps with administrative issues, contacts with family, housing, etc. Mental health care services provide psychological support, and a specific referral service ('Tandem') is responsible for linking individuals with mental health and drug services to appropriate care and support after detention.

Most of these services are available in all prisons and operate based on the same procedure: if someone wants an appointment, then they have to write a letter or they need to be referred by another service. Prisoners should raise this question themselves. It often takes a long while before they can be seen by one of these external services, as they are usually overwhelmed by prisoners' requests and only have a limited number of staff members. The request often remains unanswered, leading to uncertainty about whether the prisoner will ever be invited, causing feelings of frustration and loss of motivation.

Continuity of care is also challenged after release. Prisoners often do not know which services to address, as they don't receive information about this in prison. They need to find this out themselves and whether they succeed usually depends on coincidence. Those who do know where to go were usually informed by fellow prisoners or the psychosocial service when working on their social reintegration plan. The threshold for contacting services after release is high, and ex-prisoners often have feelings of shame and find it difficult to tell their story to someone they don't know.

According to professionals and prisoners, the current offer of psychological support is not meeting the needs of prisoners. Since this is a vulnerable population, therapeutic support is often needed right from the start of detention. However, psychological support is only available to a limited extent, despite the efforts of the services concerned. Continuity of psychological support is hardly available after release, since ex-prisoners are no longer allowed to contact the psychosocial service once they have left prison. Judicial welfare work does provide services in the community, but ex-prisoners have to initiate the contact themselves. Other external services can be contacted, but no assertive connection is foreseen from inside prison. One respondent summarised some of the concrete challenges ex-prisoners encounter:

'One [ex-prisoner] said: "There is so many things that happen to you and I had to do it all alone". And, he really didn't have services that could support him directly (...). He had to go to the social welfare office, but he still had to get there. That was all arranged, but by the time it was operational (...). I think, the first week, that is really very heavy and I think we may not underestimate that. If they have a family or partner who can already do some shopping and things like that, so they don't have to do that themselves and only have to take care of their identity card and go the employment and social welfare office, then that is still fine. But, if they also have to take care of the household (...). I once went for a home visit and that person literally had one table and one chair. I could sit on the chair

and he was sitting on the windowsill. He had a mattress on the floor, and that was it. For the rest, he had nothing. And, yes of course, the start of the support...' (PI).

France

This topic was not mentioned in this sample.

Germany

Connections with psychological or social support services in the community are usually discontinued upon prison entry. Whether support will be continued usually depends on the goodwill of individual caregivers or the explicit request of a prisoner. Prison staff are normally not contacted by psychosocial services regarding someone they have engaged with before entry. The psychological service in prisons is mainly responsible for the social reintegration of prisoners and the first assessment at detention (suicide, poor mental health, etc.) Normally there is no access to long-term therapy for prisoners – only in individual cases. According to professionals and prisoners, the current offer of psychological support is not meeting the needs of prisoners. Since this is a vulnerable population, therapeutic support is often needed right from the start of detention. However, psychological support is only available to a limited extent.

'But there is usually no therapy here as they are known from therapies outside.' (PR, F)

'Psychologically, as I said, we have psychologists here. What measures can actually be continued in practice, I do not know. But the psychological care itself is ensured.' (PI)

'So in principle it is also to do psychotherapy or something like that. This will take place rather less. So there is such an institution psychologist, who also talks. But it's such a permanent treatment, so I'm not so well aware that it's happening.' (PI)

'We have a special group for four to five years for eating disorders with an external therapist.' (PI)

In all prisons there are psychotherapists who see the prisoners following detention and in case of suicidality or if they form part of a special station, such as 'social therapy'. There is no support like there is outside during OST, or support on a regular basis like therapy outside (only in individual cases).

'Well, here is a doctor in the house and in case of an emergency, you can go to the doctor but the soul is not really worked with, so there you are really on the track.' (PI)

'They are already being questioned in the access conversation by the ward service who picks them up, whether they have mental health problems, whether there were suicides, whether there are any current intentions. This is all specifically queried and then the psychological service is either informed directly or it is just given all-clear that everything is good. And the prisoner can always apply to the psychological service to talk to him. And if it is urgent, then he does that, as I said, via the station service and then the colleague is then informed directly.' (PI)

Social services exists in all cases, but the support they provide depends on the individual social worker. In any cases they provide prisoners with reintegration plans and initial counselling following detention. Social services in prison organise many things at the point of detention, like informing family or friends, securing rent (if the prisoner has a flat), and ensuring that all their belongings (such as ID card, clothing, personal belongings) come from the prisoner's last abode to prison. Moreover, they

check a lot of details with the prisoners, such as 'what do they need', 'what kind of support could be useful', 'what work could be useful inside', and other support inside.

'Socialisation of the prisoner. Special problems. Occupational situation, housing situation, social contacts. Small moment, definite, that is, the decisions that must be made fully. Accommodation. What will he do for work here. Is it suitable for action opening measures, yes or no? Yes, that's the big thing. What about possibly with a premature release. And of course the behaviour inside and the first impression of the prisoner are taken there. And relief and treatment measures. What do we consider necessary for the prisoner? What does the prisoner want to do himself? This will be included directly in this implementation plan.' (PI)

'They do a course, where the women are generally taught, where are they, what opportunities do they have, what is expected of them, what can they expect here from the execution, that is enlightenment and on the other hand just the same also in the one-to-one talks. This flows together into this treatment examination, as it is said, where basically the sentence is written together, how he thinks that the woman is, how she is ticking and a hypothesis, ideally a hypothesis, what is behind her delinquency. Because the work is supposed to lead to the fact that women just are not delinquent anymore when they are released. And this can just then, it also just includes the indication, so if you have formed a hypothesis, then of course also considered, what can help the woman that she will never become delinquent anymore.' (PI)

'After a list that we have, individual areas are checked. What's up? What else needs to be done? How is this incorporated in the execution process and plan? Of course that depends on it, is someone only in here for two months, or is someone in here for six months? This is important because for people in (large city net to prison) – who have to go to prison from six months onwards, an implementation plan must be drawn up, for people below six months, a so-called short allocation. And for people under two months, there is an individual approach of colleagues.' (PI)

Gaining access to social services after the first counselling session is difficult. Prisoners have to write a request to see a social worker. In some cases the social worker never shows up again (for short-term prisoners). Professionals and (ex-) prisoners mentioned that social workers are overworked inside because of too many prisoners for one social worker. Some (ex-) prisoners indicated that they felt they weren't taken seriously by their social worker or that they couldn't trust them. In some cases (ex-) prisoners had good support from social service inside.

'I do not know. They might say, OK, there's somebody from the Relief Aid somehow blah, blah, blah, you can write down that they're in custody or something. But otherwise, they are actually working against you. I do not know, they can ask a lot of people, so many can tell them somehow. You cannot call this social work anyhow.' (EPR, M)

'Yes, there are social workers, but when I wrote a request that I wanted to talk to a social worker, no one came and then I left it because my imprisonment was so short. Were only 30 days and there was no need. But ... I cannot say more about that.' (EPR, M)

'I've always done penalties and social workers who come in early to fill out the forms and so and then you have to do it yourself if you have a concern. Always write concerns and they will pick you up.' (EPR, F)

'Yeah, everything from (social worker) who used to work here. Little woman, who supported me honestly, telephoned everywhere and I have had everything in three weeks already.' (EPR, M)

In most prisons there is access to external social services, but this is not guaranteed for all prisoners. Most services like ex-prisoners' aid, volunteers, counselling for women and other types of counselling are available in all prisons and operate based on the same procedure: if someone wants an appointment, then they have to write a request or need to be referred by social service. It often takes a

long time before they can be seen by one of these external services, as they are usually overwhelmed by prisoners' requests and only have a limited number of staff members.

'There in detention, for example, there was at that time in (big city other BL) a law enforcement helm. Those are – that was sort of such a club and then they got in touch with some people in prison to visit them in prison and just to go through the detention maybe. And that's what I did back then. At that time I had a full-time assistant and they cared very, very lovingly for me.' (PR, M)

Portugal

Although the majority of professionals indicated the existence of several types of social support available inside prison (namely psychosocial support, reintegration services, religious services, re-education support, training and education, basic needs support and legal support), all (ex-) prisoners, with the exception of one, who made reference to the available social support reported not having access to any type of social support inside prison. This is somewhat contradictory to what prisoners described throughout the interviews and suggests that prisoners may not perceive some measures and activities as social support.

Though the importance of continuity of care and support is undeniable, there seems to be a lack of adequate support after release. According to some professionals, the whole intermediate structure between prison and community is absent.

Prisoners on conditional release, i.e. in the period just before the end of their sentence, are supervised by the social reintegration team of the area where they are going to live, and they take a series of measures that they must comply with. However, this supervision is far from an adequate response. Ex-prisoners are required to make regular visits to the DGRSP (generally with a frequency of three months at the beginning and then annually until the end of the conditional release period). Other than that, supervised ex-prisoners receive no relevant support.

'After release, prisoners are on their own because there is no support. Entities that provide these services simply do not work.' (PR, M);

'I think that with time, people are forgotten after release.' (PR, M).

For prisoners leaving at the end of their sentence, no supervision is provided. Available support after release differs from prison to prison and in accordance with available services in the residence area. Lack of support services regarding work and housing are the main complaints. Prisoners claim that with all the difficulties with job-seeking, relapse and recurrence are very likely, since alternatives to ensure subsistence are virtually non-existent. There are some local institutions they can appeal to, but ex-prisoners are often not properly informed of their rights and opportunities. Due to difficulties in reaching these institutions, many of them eventually give up. Prisoners and ex-prisoners also believe that institutions and professionals have a severe lack of concern for them and the existing responses are not efficient or tailored to their needs:

'There is no real concern regarding basic situations such as housing or food. Even in relation to social support these are very slow and are in no way an efficient support for the first months in freedom.' (EPR, M).

Aside from clinical services provided by inside professionals (such as pharmacological and psychological support), prisoners may also receive psychological support from external institutions, namely drug treatment units and medical consultations in hospitals/health care centres for drug-related problems. The procedure varies from prison to prison: in some cases outside professionals visit prison facilities, while in other cases prisoners are escorted to external services for medical care. This follow-up is usually made with a frequency of every month, or possibly every three to four months, according to each individual assessment. Outside professionals have pointed to some difficulties that hinder the

therapeutic process, namely those related to their access to prison facilities and the transportation of prisoners.

'The prison has rules... we do not go there, they bring prisoners here and often at the day of the appointment they do not come because there is no staff to bring them to the consultation, and it ends up being a break in the follow-up, for reasons that many times surpass both parties.' (PE)

'There are patients who may have a biweekly or monthly follow-up... it should be weekly, but for one to come every week other would get no treatment. Maybe... I do not know if it would be a good idea... to deliver a response [drug treatment service] within prison. With the technician there, more than one patient could be seen.' (PE)

Prisoners with alcoholic problems may also be followed in alcohol units and attend alcohol support groups outside prison.

Both internal and external professionals displayed a satisfactory appreciation of outside support, although some mentioned that the communication between prison and services should be improved and professionals from both parties should have regular staff meetings for improved collaboration. One nurse working inside a prison pointed out that '(...) there is no regular follow-up of prisoners [outside] and medication is prescribed without being asked for the opinion of professionals who deal with the prisoner daily. Often, medication is prescribed without proper evaluation', (PI) as well as the need to 'improve provided care' at these institutions. Another professional argued that alcohol programmes should also be increased in terms of hours and in number.

Regarding the perception of prisoners receiving available psychological support during detention, some declared a complete absence of support.

'There is little [support]. It's a bit like they do not care. Technicians... only when they remember to call them [outside support]. Otherwise prisoners have to be the ones trying to get to them. It was my case, when I entered I was using cocaine, I tried to look for support inside prison and I could not [find it].' (EPR, M)

'I did not have any psychological support except the one I had from APDES. Now at the institutional level, I have never had.' (PR, M).

On the other hand, some have presented a positive overview:

'Psychological support is quite accessible. I resort to it every time I feel down and anxious.' (PR, M)

'Sometimes people complain [prisoners] and we do not have much to complain about. People call us and we sometimes do not care. Psychologists... I do not know very well to characterise... but I think they do the best with the tools they have within the system.' (PR, M).

One prisoner has suggested that there should be increased support from drug treatment units and the implementation of a therapy group. According to some professionals, the interventions performed are not as effective as they could be, due to the lack of human resources and the excessive workload of the technicians involved.

5.2.2 Housing

Belgium

When prisoners are released, they need to provide an address where they can stay after release. However, respondents state that this address is often not controlled. Consequently, many respondents are released without knowing where they will actually go. Finding a house when still in prison is not easy, as the release date is often not known. Also, they need sufficient financial resources to pay the house rent as well as a warranty. Ideally, a prisoner can go to family or (clean) friends upon release. Support for finding housing is limited, but they can address the judicial welfare service, which can help to find a place in a shelter for a period.

France

Housing support was seen by prisoners and professionals as the cornerstone of social support. Housing was therefore the priority support to be provided and the primary concern of social services, both outside and inside.

In prison and before release, housing support consisted of completing an application form with the prisoner and arranging permissions to visit the foreseen accommodation facilities, when possible. If the person already owned accommodation (which was quite rare in our sample), the objective was obviously to keep it, mainly by requesting the maintenance of financial support for housing provided by the French social security agency, for a maximum of one year.

Participants described several types of support available to prison leavers with addictive disorders, knowing that not all of them are national systems. These methods of support are described below, in descending order of available places:

- Hotel nights could be financed (for a maximum of three months). This assistance was accompanied by specialised social medical support.
- Stays of three months in a 'residential therapeutic centre' could be organised (for a maximum of one year). Here the person had a private room but nevertheless lived in a community in a rather well-defined environment (rules of life and follow-up to be respected) with close medical and social follow-up. This type of accommodation could constitute a sentence arrangement with the justice department.
- A person with a certain level of autonomy (e.g. having a source of income) while needing medical support could be offered a 'therapeutic apartment'. This type of support allows more independence while maintaining social and medical follow-up.
- In a more isolated instance, a professional mentioned support specifically designed for people with hepatitis C associated with their addictive disorder to ensure complete treatment.

Housing support was faced with several limitations. According to professionals and (ex-) prisoners, there was an important lack of places available and human resources to manage them. In particular, professionals pointed out the lack of places in 'low-threshold' facilities. For prisoners with short sentences (six months or less), it was highlighted that the social services in prison 'didn't have the time

to launch anything regarding housing support'. The national centralised system designed to assign places in residential centres (SIAO) was also criticised. The opacity surrounding the progress of the request made the job of local social workers all the more difficult, as they would have to wait for information for several months and would often find out at the last moment (i.e. at the time of release) if the request was accepted or not.

Germany

Many respondents are released without knowing where they will actually go. Finding accommodation when in prison is not easy (and finding your own flat is impossible), as the release date is often not known and housing is in short supply in German cities. In all interviews, housing was one of the most important but hardest issue to resolve after release. Ideally, a prisoner can go to family or (clean) friends upon release. But this happens only in a few cases. Mostly prisoners can go to therapy, have to go back to old friends (sometimes bad contacts with female perpetrators), shelter homes or low-threshold drug treatment centres, which are associated with drug use. In some cases organisations provide emergency beds for ex-prisoners. Access to inpatient drug treatment (except transitional centres) is very complicated because of difficult financing rules.

'If I come out of here, where should I go? I'm going to Central Station, back from Central Station, where should I go. I will come back here. That is, this situation, this is called, I do not know how to say in German. I only have to deal with drug people. But I cannot get out and only when I go away, my own apartment and then automatically comes slowly, slowly. You change your life. But you are here. Even if you have money, you have no money.' (EPR, M)

'Like now, for example, really secured accommodation or something.'

B: 'Yes that is, as I said, the most important thing I think. I think that is what everyone wants in here. That's the biggest problem.' (PR, M)

'Emergency accommodation for drug users. It's good that they exist, but that's not something that helps anyone.' (PE)

'Is impossible! So it is impossible anyway, because the job centre pays only after the release but you have to looking for an apartment long time before and is always rented for the 1st and that is not paid for the 1st, but only on the day of release.' (PE)

'Well of course we are very fortunate that there are often family, where they can go to. They can then look for a new apartment from outside in peace. Sometimes we are lucky that we actually get a flat, but that's really rare.' (PI)

In case prisoners have their own flat outside, the rent will get paid by social welfare for up to 12 months (six months is usual).

Portugal

When asked about housing support for prisoners, all professionals inside prison described the living conditions and facilities in the prison. Professionals reported that prisoners lived in shared accommodation, where they have access to one bed, daily meals and shared bathrooms. Even though professionals noted that there were basic living conditions, all assumed that prison facilities needed refurbishments, mainly to change the shared accommodations for individual rooms and the improvement of hygiene conditions.

'Prisoners complain a lot about the lack of hot water for bathing, poor or low-quality food, moisture on the walls, in some cases of unwanted insects or rodents, lack of maintenance and degradation of spaces.' (PI).

Finally, one professional made some suggestions in this regard, in terms of using the resources available for the improvement of the facilities.

'To take advantage of training of masonry and coating to improve the living conditions of cells. Implement fines for prisoners who degrade accommodation for no reason.' (PI)

5.2.3 Work and education

Belgium

Prisoners have the possibility to train or work in prison. However, the number of slots is limited and according to the respondents, they often have to wait for two or three months before they can start work or training. Some prisoners choose to follow training during detention rather than doing a prison job. However, payment is very low in that case. Consequently, prisoners without financial support from outside prison choose work, as they can't manage (financially) otherwise. Respondents further state that several training courses are not useful for finding a job in the community.

Prisoners with long sentences (more than three years) are eligible for conditional release, in cases where they have a job or are in training. Since finding a job in the community cannot be taken for granted, several prisoners choose training as this encompasses the possibility of being released earlier. Respondents state that prison staff do not monitor whether they complete the training. When looking for a job, prisoners are confronted with the stigma of being an (ex-) prisoner. Since employers often ask for a clean record, prisoners have to lie about their background or need good connections to find a job.

France

Access to formation during incarceration was theoretically possible, even though places seemed to be very limited. Requirements for being enrolled in these formations were not clear, and one participant reported having her access to a hairdressing diploma denied by the prison administration because 'priority was given to the youngest'.

In prison, work support consisted of skills assessments, CV- and motivation letter-writing workshops, and arranging leave to see a counsellor at the national employment agency outside prison. Work support was mainly provided by social workers in prison and NGOs. In a large detention centre, the national employment agency would regularly send a counsellor inside prison for group or individual advice sessions. Some (ex)-prisoners mentioned the lack of information regarding the support available, and felt they only knew about it through NGOs outside prison or through other prisoners after several periods of incarceration.

As for housing support, sentences of less than six months were too short to launch a reintegration plan. Furthermore, the search for a job after release would often come after housing and medical

support as priorities, which meant that work support was only conceivable for long sentences. On that same note, work support was obstructed by uncertainty regarding the date of release.

Once released from prison, support was often provided by social workers from NGOs. They would help the patient to provide the documentation required by the employment agency, or directly guide them towards a potential employer. It has been stressed that there was a clear 'threshold' effect for access to the employment agency in practice: only those who had accommodation, training and a treated addictive disorder were likely to benefit from support from the employment agency. This led some professionals to state that governmental work support was unsuitable for a population of (ex-) prisoners with illicit drug use history.

Some participants explained their need to be accompanied for some job interviews: they felt the employer would trust them only if a social worker was there to 'validate' their goodwill and assure them that there would not be any problems.

'With regards to job search, if you go on your own, if you're not accompanied, it'll never work. They know who they're dealing with. Someone has to be there to reassure them: "No, he has changed", "no, the gentleman can do it". We need support because even I would have difficulty making these people understand that I have changed. If there is a colleague who comes up and says: "He can do it, I know it, he can do it", they believe it more easily than if I explain it to them.' (PR, M)

Germany

Prisoners have the possibility to train in some prisons. However, the number of places is limited. Training is not always available, especially if the sentence is only short. One professional indicated that the training can take place in modules which makes it easier to start, even if someone is in prison for a short time. In one case training was accepted outside as well. Professionals reported that some training courses are not needs-oriented. Some respondents also reported that the waiting time for training is long, so it's not guaranteed that prisoners can join the training.

'There you have offers so pseudo-Dinger so no idea um so six-month training for building cleaners or any such stuff, because you will only be taken, if you have a longer time yes. Not so in just a year, I've never been accepted anywhere, if I'd written it like that. Since you can do anything in the locksmith you can do such a course and building cleaner.' (EPR, M)

'Well, now in the case, short-term penalties, most of the time it would not be in my prison. There are just the usual punishment times too short. Modular education takes place. In the field of colour technology, painters, painters. And also in the field of wood technology. There are such three-month modules, which can then sometimes even then rank. There are three modules. Then over nine months then virtually a basic education takes place, that takes place. But in my estimation, the demands would be much higher than what is offered. Although I hear from reports, then you offer a secondary school, then it is too short. Then they report too few and so on. But that, I think, would be man-. So the people who have a need to do an apprenticeship or catch up or even do language courses to do more – there are language courses, but I think that could be a lot more.' (PI)

School was possible in individual cases.

'There is a lot of work from laundry to kitchen to school, sewing, office buying to single tradeswoman.' (EPR, F)

'We also support, for example, if they want to study. We now have one who studies. It is supported. He has to have a teacher by his side who supports him. We already had that. Well, it's not the first one.' (PI)

Prisoners have to work in prison (except for prisoners on remand, on a pension or if incapacitated). So in most cases prisoners had work inside and were able to earn money. If they had no work they could get pocket money. All respondents indicated that there are various opportunities to work inside.

'And otherwise, the prisoners are given the opportunity to work in business enterprises and self-employment, in various areas. We have a joinery, metalworking or just work therapy. There is also a bakery and a kitchen... And there are, as I said, the business enterprises, where they can pursue packaging work. Exactly.' (PI)

Most (ex-) prisoners are incapacitated for work for the so-called 'first labour market', but could still work inside. Some professionals indicate that work inside is different to work outside. One professional reported that some ex-prisoners were very good at their job inside but couldn't handle the same job outside. In most cases ex-prisoners were in work measures outside and nearly all respondents mentioned that work is very important for daily structure.

'Our measures or our offer is a daily structuring measure. People who are in substitution, as a rule, these are our participants, who have quite a lot of day off, the procurement crime often falls away, so the day has much more hours available, as in the time of consumption. That's where we start and offer different work projects, we have different jobs and they can be employed. From small hours, just a little, a small unit in the house clean up to large orders, which are handled. The craftsmen over there build furniture, in the laundry we offer a laundry service for the residents of the house, but also externally. Within these work projects, people can find employment from one to six/seven hours a day.' (PE)

Portugal

Prisoners have the possibility to work during detention and are encouraged to do so. There are different job positions, some of them through protocols with small and medium-sized enterprises or inside prison, such as cleaning services. In addition, prisoners may attend professional training courses provided by the Centre for Vocational Training for the Justice Sector. Although this possibility was mentioned, it was also recognised by some professionals that this type of support is defective, mainly because the number of job positions are limited, the income is very low, and not all prisoners have the right and the possibility to work or participate in professional training.

'There are some jobs but they can only cover a small portion of the prison population giving preference to less problematic prisoners. (...) most problematic prisoners [should be included] in these systems, thus taking up their time and also as a way of giving them rehabilitation opportunities.' (PI)

In this regard, half of the prisoners interviewed were working, while the other half did not have access to this type of support.

In light of this context, professionals described prisoners' financial situation as uncertain, since there is no regular income or support available for all prisoners. They characterised this support as sporadic and in small amounts or even non-existent. Prisoners have limited means to acquire financial support and for most the main one is often through their social network, namely family and friends. Nonetheless, there is also the possibility for some prisoners to be occasionally supported by institutions and services of social security and by national embassies, in the case of foreign prisoners. Professionals have also provided some suggestions for improved work conditions and financial support during detention, the main one being the possibility of paid work and training for all prisoners. In order to implement these measures, professionals suggested higher investments within these areas

of support, the provision of technical workshops, the improvement of inter-institutional communication through periodic meetings and case discussions, and the establishment of protocols with private and public enterprises and educational institutions.

The majority of professionals and (ex-) prisoners displayed an unsatisfactory view of work support upon release. Prisoners stated that despite their registration with the Institute for Employment and Vocational Training (IEFP), no specific measures were taken in order to support them in job-seeking. In addition to this lack of support, some social determinants hinder their process of finding a job, such as the absence of qualifications, stereotypes and stigma.

'I went to several places to ask for a job and nothing. I went to the IEFP and they told me to go to an institution that was asking for staff. Stupidly, I said that I was an ex-prisoner so they did not give me the job. I suffered the label of being ex-prisoner.' (PR, M)

'There is great difficulty in finding a job because of their status as ex-prisoners, or because of the shortage or lack of qualifications and training.' (PI)

Most prisoners mentioned that they are attending or have already participated in training or school classes in the past. School attendance is perceived as a possibility for the majority of prisoners and is recognised as a positive element inside prison and a useful moment that provides an escape from being restricted to cells.

'I always studied inside the PE (...) I'm in higher education now. (...) Now I have another perspective, that's why I'm taking a university degree, the other time I just had high school degree.' (PR, M)

'The time I find most useful is school. School is a very useful moment for me, it is where I get some knowledge, where I'm with people from outside... and also training inside always bring people from outside. These are my moments of escape.' (PR, M).

However, one professional believes that there are some unequal opportunities regarding education in the prison context.

'Women seem to be in large disadvantage compared to men, especially regarding training opportunities in the period of incarceration.' (PI)

Additionally, some issues were raised by some prisoners, such as the impossibility of attendance for foreign prisoners who do not have Portuguese nationality, and the feeling of constraint by being in class all day.

'I was in school but by the third year... being closed inside a classroom... it's hard. The first two years, as it is new, it is less hard, but afterwards it's hard.' (PR, M).

Some prisoners indicated their participation in training and awareness-raising activities inside prison in different areas, namely painting, the construction industry, and health and drug use, among others.

5.2.4 Finances and administration

Belgium

Prisoners and staff describe life in prison as expensive. Although they have no costs in prison, they need to pay for phone calls, letters, daily products (e.g. cigarettes, snacks) and drugs. Without a wage, allowance or financial support from family or friends or a prison job, it is very difficult to manage

financially. Support with financial issues in prison is largely absent, which is a serious threat during the immediate period after release when no job or money is forthcoming. Furthermore, it not easy to arrange administrative issues when still in prison. Prisoners often have issues regarding their identity card or health insurance – things that can only be arranged after release.

'OK, you have done something wrong, you are punished (...). But you are punished twice: you are deprived of your freedom, but if you are released you are also robbed of society since you don't find a place in society, nowhere. I had to live for a month without an income, without anything. Do I have to steal or what do I have to do? Now, I only got an appointment at the social welfare office. That is for my money, the first time at the welfare office. Only now. And I still have to receive my identity card, which is suspended now.' (EPR, M).

France

Prisoners have the possibility to work inside prison, but places are limited and it is not compatible with a short sentence. The money earned during incarceration is almost never sufficient to fulfil basic needs for more than a month after release.

Upon release, participants benefited from two types of financial support: 'Waiting temporary welfare' (380 euros/month) for a maximum of one year, accessible only after the first release from prison. If they are not eligible for this help, they can ask for the 'Revenu de solidarité active' (RSA, a French form of in-work welfare benefit), which is the same for all citizens. The period of time before having access to this latter benefit was described as 'quick' (less than a month) when the person already had identity documents and had prepared the application during incarceration, which was rare. It was reported to take more than three months when these conditions were not met.

Professionals and patients agreed that it was extremely difficult to complete the procedures for welfare access without close monitoring by a social worker.

Germany

Even if prisoners have no costs (if they work) in prison, they need to pay for phone calls, television, letters, daily products (e.g. cigarettes, snacks) and drugs. Without a wage, allowance or financial support from family or friends or a prison job, it is very difficult to manage financially, even if there is an option for a small amount of pocket money for prisoners who have no job inside where it is not their fault. If they have work, they pay into their accounts. They have three accounts inside, one for daily use, one to pay debts, and one for the time after release, known as the bridging allowance. They receive this money upon release to finance the first days after coming out of prison.

'If I am, for example, the accommodation cost me 2017 189 euros and 55 cents a month. Breakfast costs 50 euros a month, lunch 93 euros a month and dinner 93 euros a month, so you have times so sums. But as I said, when I work, I do not have to pay. However, if I am not in work (on my own fault), I have to pay.' (PI)

'Well, from my family, yes. From my grandma. The last time my father sent me 50 euros so I can do go shopping and this time my grandma.' (EPR, F)

Prison and services outside often provide debt counselling for prisoners. In some cases this can also take place or start inside.

'So they can go here, if they tell us what they have for debt, for example, to debt counselling. We also have internally as an offer. That is also, I have to say, very well used

by us. So I think there is no measure that is as well filled as debt counselling. Instalments are agreed. In some cases, insolvency proceedings are also initiated. So we'll take care of it when the prisoner is open for us.' (PI)

It is not easy to arrange administrative issues when still in prison. Prisoners often have issues regarding their identity card or health insurance, all things that can only be arranged after release. Ex-prisoners can receive unemployment benefit and other social welfare after release, but their bridging allowance is counted as social welfare, which is in some cases hard to understand for (ex-) prisoners.

'So it is now the walk to the job centre or social services, if no release money is there. This is a great burden ... the same day to the job centre and that start and there was a situation, I do not know, there, the colleague, I think, spent four hours with the client at the job centre. It was completely self-contained and there you can imagine that the client will eventually say, no longer bother.' (PE)

Portugal

Prisoners have the possibility to work while inside prison. However, due to the limited number of positions and low income, professionals described prisoners' financial situations as uncertain, since there is no regular income or support available for all prisoners. They characterised this support as sporadic and in small amounts, or even non-existent. Prisoners have limited means to acquire financial support, and for most the main route is often through their social network, namely family and friends. Nonetheless, there is also the possibility for some prisoners to be occasionally supported by social security institutions and services, and by national embassies, in the case of foreign prisoners.

5.2.5 Drug-related treatment

Belgium

Specific support for drug users in Belgian prisons is limited. Respondents state that if a prisoner wants to do something about their addiction, then they have to take care of it themselves. Many prisoners do not know how or where to go for help. Continuity of drug treatment is dependent on the goodwill of support workers in the community, but it is rare. To be admitted to one of the drug projects or drug-free wings, prisoners have to pass a thorough assessment. Not all prisoners are eligible for specific drug treatment in prison. Prisoners as well as staff working on the drug-free wing are very positive about the support on this ward.

Continuity of care after release is largely lacking and little effort is made to provide continuity of care. Unless a prisoner was involved in a drug project in prison or engaged with the linking service 'Tandem', they state they do not receive information about help and support in the community. Prisoners have to look for this information themselves when they want (residential) drug treatment after release. Several respondents state it is not easy to start up treatment while still in prison, as some services only arrange intake assessments once someone is released or when permission is granted to leave prison (provisionally). Waiting lists are another challenge when contacting drug services.

France

In most prisons, harm-reduction community services and support groups like Narcotics Anonymous are authorised to operate regularly. Workshops are organised once or twice a month, but information regarding the existence, nature and aim of this support was insufficiently transmitted to the target population, according to the (ex-) prisoners. Peer support including ex-prisoners were also lacking, according to professionals. Therapeutic activities such as sophrology or theatre were sometimes available but always limited to once or twice a month, which was also considered insufficient by (ex-) prisoners.

Germany

Specific support for drug users in German prisons is limited. Nearly all prisons are provided with drug counselling (mostly through an external social worker). Respondents stated that if they wanted to do something about their addiction, then they would have to take care of it themselves because of long waiting lists for drug counselling inside (sometimes up to six months). In some cases, drug counselling provides groups like 'relapse prevention'. Mostly drug counsellors inside organise formal interventions like therapy applications and cost absorption. If the drug counsellor is an intern, they are not seen as trustworthy to prisoners, because of the fear of consequences if they speak about their drug use. Continuity of drug treatment is dependent on the goodwill of support workers in the community, but it is rare. There are some projects inside like Alcoholics/Narcotics Anonymous. To be admitted onto one of the drug treatments, prisoners have to write a request and wait for a free space. All prisoners are eligible for specific drug treatment in prison.

'Well, then, so they are being cared for by psychosocial treatment as normal but not while detention. I meant that with bad cooperation, so we have no contact. As a rule, we also hear nothing from the people, well we are not take care of it.' (PE)

'So drug counselling there was six months, so a list, I was never there because that's only if you need any applications for therapy, if you want to get out and I've always done penalties and social workers who come in early to fill in the forms and so on and then you have to do it yourself if you have a concern, Always write requests and they will pick you up.' (EPR, F)

'We have our addiction adviser here, this is Mr X and he has to sort out 4000 women somehow and that's why he does not always have much time for us and if he has time then he really has an ear for us... then he also asks why you did that, which has made one, whether it is currently not so good. That helps women more. He is so busy here, so we need more support. Then we would also feel better understood and better understood here.' (PR, F)

'When they hear, there will come someone who dealing with drug addiction that they are pretty fast. And then talk about everything with one and also have a good trustworthiness.' (PR, F)

'So, to practice situations, to practice situations in relaxation, to create things, to trust things and to make a statement : "Oh man, that works without drugs." Fall asleep without drugs, relax without drugs. Very difficult topic for our women to find relaxation without substance.' (PI)

'So two colleagues are doing addiction counselling here. Full-time, 40 hours a week, is basically a daily contact for all prisoners with addiction problems. We do therapy mediation, we mediate, as I said, provide cost commitments, clarify the whole legal on the courts or even on the prosecutors. Accompany people who go into other facilities.' (PI)

Continuity of care after release is widely provided and easy to access in low-threshold drug treatment. Prisoners receive information about help and support in the community, and in most cases they already had social support outside and would go back to this after release. Mostly prisoners have to look for information on their own when they want (residential) drug treatment after release. Several respondents stated that it is not easy to start up treatment while still in prison, as most services only arrange intake assessments once someone is released and they have to call them every week to tell that they are still interested. As telephone calls are very expensive and social workers do usually not provide calls that often, it is hard for prisoners to stay in contact with treatment centres. Waiting lists are another challenge when contacting drug services.

'We have no obligation that the people who come to us and work with us are drug-free or anything. So that's a low-threshold offer.' (PE)

'Yes, here from A. (social worker in low-threshold drug treatment centre) so that was useful, very useful for me.' (EPR, F)

'After the release, that is, where I was released, I am directly back in the (emergency dormitory/drug facility) and have reported myself, just for the reason that I am in OST and get methadone and have no apartment and therefore immediately registered here they gave me place to sleep.' (EPR, M)

Portugal

Aside from clinical services provided by inside professionals (pharmacological and psychological support), prisoners may also receive psychological support from external institutions, namely drug treatment units and medical consultations in hospitals/health care centres for drug-related problems. The procedure varies from prison to prison: in some cases outside professionals visit prison facilities, while in other cases prisoners are escorted to outside services for medical care. This follow-up is usually made with a monthly frequency or every three to four months, according to each individual assessment. Outside professionals have pointed to some difficulties that hinder the therapeutic process, namely those related to their access to prison facilities and the transportation of prisoners.

'The prison has rules... we do not go there, they bring prisoners here and often at the day of the appointment they do not come because there is no staff to bring them to the consultation, and it ends up being a break in the follow-up, for reasons that many times surpass both parties.' (PE)

'There are patients who may have a biweekly or monthly follow-up... it should be weekly, but for one to come every week other would get no treatment. Maybe... I do not know if it would be a good idea... to deliver a response [drug treatment service] within prison. With the technician there, more than one patient could be seen.' (PE)

Prisoners with alcohol problems may also be treated in alcohol units and attend alcohol support groups outside prison.

Both inside and outside professionals displayed a satisfactory appreciation of outside support, although some mentioned that the communication between prison and other services should be improved and professionals from both parties should have regular staff meetings for improved collaboration. One nurse working inside prison pointed out *'(...)there is no regular follow-up of prisoners [outside] and medication is prescribed without being asked for the opinion of professionals who deal daily with the prisoner. Often, medication is prescribed without proper evaluation.'* (PI) and

the need to 'improve provided care' at these institutions. Another professional argued that alcohol programmes should also be increased in hours and in number.

Regarding the perception of prisoners receiving the available psychological support during detention, some declared a complete absence of support.

'There is little [support]. It's a bit like they do not care. Technicians... only when they remember to call them [outside support]. Otherwise prisoners have to be the ones trying to get to them. It was my case, when I entered I was using cocaine, I tried to look for support inside prison and I could not [find it].' (EPR, M)

'I did not have any psychological support except the one I had from APDES. Now at the institutional level, I never have had.' (PR, M).

On the other hand, some have presented a positive overview.

'Psychological support is quite accessible. I resort to it every time I feel down and anxious.' (PR, M)

'Sometimes people complain [prisoners] and we do not have much to complain about. People call us and we sometimes do not care. Psychologists... I do not know very well to characterise... but I think they do the best with the tools they have within the system.' (PR, M)

One prisoner has suggested that there should be increased support from drug treatment units and the implementation of therapy group. According to some professionals, the interventions performed are not as effective as they could be, due to the lack of human resources and the excessive workload of the technicians involved.

Regarding continuity of care after release, prisoners on conditional release who are receiving OST and/or other therapeutic measures during detention are referred by the DGRSP for the next consultation outside prison. Prisoners leaving at the end of their sentence must manage their clinical process on their own. According to most professionals, medical support for drug users is generally good and sufficient, but prisoners and ex-prisoners that commented seem to have a different opinion. For some, the available support is not very accessible and is too focused on medication:

'It is easier to get drugs than medication.' (PR, M);

'I don't know. If we were treated differently, it would be good. To them is like to take one drug away and give us another that is legal. I was taking 75mg and getting really high. Drug treatment services should work differently. I do not recommend the experience I had.' (PR, M).

Some professionals report that prisoners are often unaware of which services to go to or do not have the required financial conditions to continue treatment without monetary support.

5.2.6 Leisure time and relationships

Belgium

Ex-prisoners state that having daily activities (e.g. work, fitness sessions, walk) is of utmost importance in prison. Several activities are offered in prison, but prisoners need to be open to it and take the initiative themselves, otherwise they stay in their cell until the day has passed by. Prisoners

on the drug-free wing are obliged to work, do sports, follow a training course, etc. They agree this helps them to build up a daily structure, as otherwise they would do nothing or use drugs. Leisure activities after release are not dealt with when in prison.

Opportunities to maintain relationships in prison are limited. Prisoners can make a free phone call upon entry, but then phone calls are payable and limited to specific time slots. They can also write letters or receive visitors, although not from drug users or ex-prisoners. 'Undisturbed visits' are allowed if prisoners can prove they have had a partner for at least six months. According to the respondents, some prisons arrange child visits or children's afternoons in order to promote prisoners' contact with their own children. Besides these options, prisoners are not stimulated to reinforce the bonds with their family. The family (or broader social) network is not contacted, either at entry or during detention, due to lack of prison staff. Professionals state that it is unclear who is taking care of family issues, but in practice little is done to promote these bonds.

France

According to the prisoners in our sample, access to activities and sports equipment in prison was very limited, even though its benefits for mental and physical health was often stressed by prisoners. Therapeutic activities such as sophrology or theatre were sometimes available but always limited to once or twice a month, which was also considered insufficient by (ex-) prisoners.

Contact with friends and family was generally in the visiting room (once a week at most), telephone (rarely with the public phone set up by the prison administration) or by mail. According to prisoners and professionals, building relationships was hardly achievable while in prison. However, the participants in our sample reported having limited contact with their network partly because that was what they wanted, or because they did not have any close relatives to talk to while in prison.

Germany

Nearly all respondents indicated that there are many options regarding leisure time in prison. These included a lot of sports groups, but also choir, art groups and group activities. In one case prisoners have the opportunity to go on excursions outside and also to look after animals. Some professionals reported that the leisure groups are not needs-based in all cases. Sometimes prisoners are not using the groups. According to professionals and (ex-) prisoners, activities are not guaranteed all the time because of staff shortages or security reasons. As a result, several activities are offered in prison, but prisoners need to be open to them and take the initiative themselves, otherwise they stay in their cell all day. Leisure activities after release are not dealt with when in prison.

'You have more of a day structure (inside). If you are outside, you have to create it yourself.' (EPR, M)

'So prisoners, who may also be actively involved in sports here in prison, there is the possibility that the outside maybe even a football club ties with or something. But that is quite optional and at the request of the prisoner. So when he comes up to us and says he wants to do something and would like to organise it from here somehow, then we take care of it as well, but we do not do it on our own initiative.' (PR, F)

'So that starts with crafting stuff, puzzles and so very little stuff that we... Some start here to crochet or knit or somehow or something to do so, so. Or to paint, we often have totally creative women here, of course we also support that. With sports it is such a thing, we

have always offered to use our sports yard, that is what some women do. We have a gym with sports equipment, some women use it, we have had all kinds of classes in between, from yoga to hip hop.' (PI)

In all cases visits were possible. Only visits from ex-prisoners or drug users are not permitted in some cases. In all prisons, prisoners have the possibility to receive long-term visitors in a private room, but there is a difference between men and women prisons as sex is permitted in male prisons but not in women's (this was not mentioned).

'My social environment that I have, how should I say, accordingly also the friends and that is bad in prison. They cannot visit you, because when a visit should take place a request is made, they check everything and if you have a criminal record, you will not get a visit ticket. Anyway, and if you're married, it's not possible! There are the very clear lines, except letters and phone calls, there's nothing there.' (EPR, F)

Daily contact is only ensured by letters or phone calls, but calls are very expensive inside. Access to contact/calls with friends and family through a social worker inside is very hard. In some cases respondents mentioned that they have seven minutes of 'call time' a month.

'There is a telephone system where you need credit for which you have to pay. If there is no money, then I sometimes see that social service calls were then granted. That one can then make contact, outside, to relatives, partners. And then, of course, visits are possible.' (PI)

'But he charges my Telio (calling card) from outside. Because that's also very expensive and you really get that in here. Either you have to vary, or you just cannot afford it. Telio on, or we write, we call every day.' (PR, F)

Most respondents indicated that there are various family groups inside like father-child days or family days. In one case a prison has a special rule to ensure family contact.

'There is the father-child group here. There is a long-term visit, but you have to first privileges. Over Y, Z, three hours, once a month. And you have house X two times three hours a month. The father-child group is, I believe, once a week. And if – if the corresponding officials are there.' (PR, M)

In summary, contact with a person's social network is possible, but active support is rare. The family (or broader social) network is not contacted, neither at entry (only if needed) nor during detention by prison staff. Professionals state that it is unclear who is taking care of family issues or the family members outside, but in practice little is done to promote these bonds. (Ex-) prisoners indicated that it would be helpful if members outside had the opportunity to receive support as well.

'Once have the opportunity to visit. To make telephone calls, to contact us by post. So, we social workers try to make contact there. Especially in the detention it is so that often at the beginning not allowed to make phone calls. It's really time to get in contact with the family. To keep up to date that her son, husband, or otherwise is doing well. Exactly, then you have the opportunity, even at some point to get long-term visit. What we have here is a fathers' group.' (PI)

Portugal

Most leisure activities are provided through protocols and institutional communication with the community and local institutions that are allowed to enter the prison in order to develop different projects and activities. Nonetheless, prison services also promote some activities. In this regard, many examples were provided, such as sport activities, handball and football tournaments, crafts, theatre and music workshops. The majority of professionals mentioned that more and improved

communication with outside organisations should be developed, since community institutions are the main providers of leisure support and the existing support is not sufficient. Besides, the improvement or even construction of sports halls in prison settings is mentioned as a need.

'Some prisoners complain about the lack of gymnasium in some prisons, so I think that this situation could be standardised in order to avoid discrepancies between prisons, which leads to discomfort among prisoners.' (PI)

Finally, due to the reduced number of leisure activities and limited vacancies, not all prisoners have access to these activities, which is seen as bad practice by some professionals.

'Authorisation of participation of a larger number of prisoners [in leisure activities], not always choosing the same (with apparently more appropriate behaviour).' (PI)

5.2.7 Other types of support

Respondents mentioned that other types of support, beside specific services, are very important.

Prison wardens are identified as a potential source of support, although not all wardens. Some seem to be unmotivated and/or have conflicts with prisoners, while others take the time to talk and try to motivate prisoners when they are not doing well. Being approached in a human and friendly way is regarded as very important and it appears that such a personal approach is provided in small prisons or on small-scale wards (BE).

Contact with family and friends in the community is also important. Support from friends and family is deemed important, not only during but also after detention, particularly in terms of emotional and financial support. Some respondents stated that without them, it would be very difficult and often they develop a closer bond during detention. Support occurs both outside and inside the prison context, through visits, phone calls and letters (BE, DE, FR, PT).

'Emotional support is the most important. Monetary also. Yes, the emotional is the most important and monetary is also important, we always need hygiene products, that piece of clothing that they send, a letter is also important, the friendly words...' (PR, M, PT)

'The best support is the emotional support. Financially here we tend to want what we cannot have. They only think about money and do not think about the aspects that are most important as human beings, for example, pick up the phone and someone asks you "how are you?" or "how was your day?"' (PR, M, PT)

'Emotionally they give me strength, as well as financially. It is very important; if they did not support me maybe I would go depressed, it is always important to have the support of the family.' (PR, M, PT).

'If you come out and, well in my case, I have my husband. But that is now, toi, toi, toi, but something would happen to him now, I stand before nothing.' (PR, F, DE)

'My husband always comes here, to visit and so on. Always bring me draw money and all that. Costs everything. 120 euro phone money every month on it. Because he only has a cell phone and that costs of course.' (PR, F, DE)

'I have many, luckily I have a family outside.' (PR, M, DE)

Regarding social network support outside the prison context, professionals emphasised the influence of family support and reported that the social network is an important factor of support (BE, DE, PT).

'Some relationships that they had before they were deprived of liberty no longer exist when they are released, often being abandoned by the family, compromising their emotional condition. Others return to toxic family relationships and repeat offenders.' (PI, PT)

'Family and social support should be more structured, promoting greater contact with its social-family network in order to strengthen these ties, since these will be their greatest support after their release.' (PI, PT).

Professionals also reported that relationship support of prisoners with their social network outside prison is provided by social reinsertion and re-education professionals or community organisations, through psychosocial support and the possibility of visits, conjugal visits and phone calls. In some cases (ex-) prisoners mentioned that their lawyers were helpful regarding problems inside. Some also mentioned that pastoral help and other help from external professionals is helpful and a good source of support inside (DE, PT).

'Through the SAEP [Serviços de Apoio à Execução de Penas - Support Services for the Execution of Sentences] that promote the contacts with the outside and have an important role in the acquisition of information for the authorisation of visits. There is also a regulation that allows for intimate visits in order to promote the strengthening of relationships between couples. Some voluntary institutions often bridge the prisoner's social and family contacts. In the case of the EPG, which has a project of reinsertion, through APDES, where a psychosocial support office has been set up, which one of the many objectives is to promote socio-family relations.' (PI, PT)

'I also have a lawyer when it comes to applications to the prosecutor.' (PR, M, DE)

Regarding relationships between prisoners inside prison, the majority of respondents described them as good and positive or having a neutral view on them, but they also mentioned that other prisoners are usually not friends. In some cases peer projects were also mentioned as helpful inside (DE, PT).

'I have my colleagues inside; I would not say friends, but colleagues.' (PR, M, PT)

'Well, we have groups, the prisoners (peer project), working on various smaller projects.' (PI, DE)

5.3 Specific preparations for release

Belgium

Preparations for release are minimal, in particular with short-term prisoners (< 3 years) who don't have to develop a reintegration plan. Prisoners with longer sentences need to prepare a reintegration plan in collaboration with psychosocial services and may be granted a permit to leave the prison for specific purposes (e.g. an intake assessment), after extensive screening. Prisoners state that they need to take the initiative regarding the reintegration plan, as this is not taken up proactively by the psychosocial services.

According to professionals, preparations for release need to be concrete and operational, in order to realise smooth transitions. Linking with services during detention is recommended to build up a relationship of trust and to increase the likelihood that ex-prisoners are retained in community services. Attention to various life domains is required, including financial, relational, medical, employment and psychological aspects. Ideally, this support should be available in prison from the

start of the sentence and needs to be continued in the community after release. However, such support is not available and preparations for release really depend on the initiative of the individual, particularly when one is serving a short sentence.

Respondents state that prisoners are often unaware of which services can be contacted upon release and they are not informed about drug-related risks when released. However, overdose prevention before release is very important, given the increased risk of overdose after leaving prison. Some respondents stated that this issue is addressed occasionally, and that prisoners' unrealistic expectations regarding remaining abstinent after release are not addressed. Some prisoners are literally released without anything. In the best case, ex-prisoners can rely on family, a care giver or another acquaintance. Individuals' own networks, on which they should be able to rely, are not involved systematically, although they can be important to avoid recidivism and support reintegration in society. Psychological support during detention is minimal, while emotional readiness is as important as practical readiness, since prisoners often leave prison with fear for and stress about confrontation in the outside world. Those prisoners who stayed on a specific ward or followed a specific programme (e.g. a drugs project) are better prepared.

In addition, medical support for release is far from optimal. In principle, prisoners receive medication for the first few days after release, but not all (ex-) prisoners share this experience. As a consequence, they are left without medication (if they have no income), they have to go to a GP or community service, or they try to obtain medication on the black market.

Respondents stated that the preparation of the reintegration plan is only started a few weeks before the date of conditional release. This is often due to issues of prioritisation for complex and urgent cases for the psychosocial service, leaving limited time for preparing for release in the early stages. Several professionals suggested that it would be ideal to start preparations for release at least six months before release.

'Are there any challenges you can think of? In fact, everything. (...) Everything is almost ready, but nothing changes while still in prison. Everything depends on whether the prisoner can arrange things when he is released, whether he has the resources to do that and arrange all those things. Let's say, if we have to do that as resourceful persons that is already difficult. Not to say when it concerns someone with limited administrative skills, with an addiction problem that can easily worsen after release, or who was still using in prison, of course. All these things, in combination with the feeling: "I am released". That is a day to party, isn't it, or at least an emotionally important moment.' (PI).

France

Overall, in prison, there was no official structured programme specifically aimed at preparing for release. Probation and rehabilitation services were overwhelmed and their work was more and more focused on the judicial process.

Reinsertion planning for prisoners with a history of illicit drug use was mainly carried out by a social worker from the medical unit inside prison (if the position existed) or by NGOs. As previously described, social preparation by the prison health staff was largely focused on liaison with the housing and treatment centres. The range of support provided by NGOs in the community was broader but their actions were limited before release, due to difficult direct access to prisoners.

It was also observed that even minimal preparation for release was almost impossible to achieve for sentences shorter than six months.

Medical preparation, when possible, consisted of establishing contact with NGOs in the community, and giving the patient a few days' worth of treatment and a prescription sheet listing all the medication on the day of their release.

There was no specific preparation for overdose in prison, except general warnings given by the medical staff and, rarely, more targeted ones given by harm-reduction services intervening in prison. Most of the time, however, the patient had to actively seek out information about overdose prevention (either by joining the support group or asking the medical staff). Therefore, overdose prevention was far from systematic.

Germany

Continuity of care is a challenge after release. Prisoners often do not know which services to address, as they didn't receive information about this in prison if they didn't ask for it actively. If they did, they received a lot of information, in some cases way too much, and information about services which didn't apply to their case. Those who do know where to go were usually informed by fellow prisoners, social services when working on their social reintegration plan, external social services, or they had their own experiences with releases, a social worker outside or other ways (such as family, lawyer, etc.). The threshold to contact services after release is low; in most cases they went directly to low-threshold drug treatment centres to make sure their OST and housing was organised, or to ex-prisoners' support to receive information or help. (Ex-) prisoners reported very good experiences with social services outside.

In general, prison releases are organised in different ways. Social service inside prison coordinate the different possibilities, if needed.

1. Release management (probationary services)

Release management is only available for prisoners who leave before ending their sentence on probation. Release manager offer help to organise everything for release, especially housing, finances and relationships.

2. Release management (external services)

External release management is not ensured in every federal state and is also only available to prisoners who leave at the end of their sentence. This service is provided for prisoners with special needs, such as those with no housing, no family, etc. It is not guaranteed, as there is only one or two social workers who provide this service. Support starts six months before and ends six months after release, so (ex-) prisoners have a person of trust inside and outside prison.

3. Therapy instead of punishment (drug counselling/social work)

German law provides the possibility to leave prison earlier for drug treatment therapy. Therefore, prisoners need to make a lot of applications to different services. As they cannot do it on their own, they have to contact drug counselling inside. Even if the law enables

early release from prison, the whole process can take more than six months, due to long waiting lists for drug counselling and long decision processes for services.

4. Social work (prison)

Social workers inside are responsible for implementing prison system planning, so they need to know and decide on what measures inside are necessary and what kind of support might be needed upon release. According to (ex-) prisoners, some professional social workers inside have a lack of knowledge regarding release and special needs and are also not available, as they are overworked anyway. If they do hand out information, it is only general information and often not useful and sometimes even wrong for drug users.

For all outcomes, the following problems were mentioned by respondents:

The rarity of settlement opening measures for people who use drugs, which, according to the respondents, is very important for improving life outside and for organising different needs like ID cards, housing, work ,etc.

- Knowledge and self-initiative are needed for getting help. It is only if prisoners know how and where they have to ask that they receive information and help. Systematic help and information are not provided in any prison.

Respondents also mentioned some good examples for useful support for release:

- Bridging allowance to finance life after release, even if this is also associated with challenges upon release for drug users to spend this money on drugs.
- Part-municipal organisations inside to inform prisoners about their services.
- Help from networks outside, such as ex-prisoner support, drug aid services and other organisations.

All professionals indicated that they do not exactly know (because of data security) what kind of services/support the medical services provide. They reported that prisoners receive OST and other medication on the day of release and also medication for the first week (except OST). The possibility to receive OST after release was mentioned in one case where prisoners can come to prison (every day) in the first week to receive OST.

Respondents also reported that drug users receive OST before release even if they didn't during imprisonment.

Overdose preparation is not provided in prison. In some prisons, prisoners receive information upon release or could go to relapse groups inside, which are organised by social services or drug counselling. Even if prisoners receive little information, talking about drug use after release seems to be difficult as prison staff are abstinence-oriented and prisoners do not trust them regarding issues about drugs. Professionals mentioned that they speak about overdose after release if they think it is needed, but there is no systematic preparation regarding to overdose.

Specific reintegration plans were not mentioned. Prisoners mostly undergo prison system planning, which comprises different points and measures such as temporary release, planning of work and

leisure time, and special support or preparation. The preparation of a checklist for release was only mentioned in one prison.

Portugal

The social reintegration process starts at entry, with the development of individual readjustment plans. This plan is developed by a reinsertion and re-education professional in collaboration with the prisoner through a number of interviews. After the prisoner's validation, the plan is sent to the supervisory court for approval. Psychosocial professionals working inside prison are responsible for promoting literacy and improving the education of prisoners, encouraging responsibility and, upon release, promoting communication with specialised services. On release, an individual integration plan is also developed by the social reinsertion team, which establishes formal contacts with local community institutions to ensure support after release and that follows a similar procedure to the readjustment plan.

These plans, however, are often only theoretical or difficult to implement and are, therefore, disregarded in practice. Ex-prisoners who leave on conditional release are supervised by a reinsertion professional from the DGRSP, who refers them to local community organisations, drug treatment units, social services and the IEPF. The number of established protocols is, however, insufficient and the release term is sometimes issued on the day of release, which completely hinders the release preparation process. Prisoners leaving at the end of their sentence are expected to seek out these services on their own. According to professionals working inside prison, prisoners are informed of existing services in community as a preparation measure for release. However, from the perspective of some professionals working outside prison, this is a rather random process, where prisoners do not have equal access to this information.

'It is variable. There are some [prisoners] who do [know about the services] and there are others who do not.' (PE).

This was also pointed as one of the main barriers in the process of transition to living in the community. Prisoners are often not aware of which services are available for their specific needs, demonstrating a complete lack of preparation for release. A nurse has also pointed that prisoners are not aware of existing medical services because there is no pre-release consultation.

In order to ensure financial support upon release, prisoners have the possibility to initiate the request for social reintegration income (SRI) during detention. However, neither prisoners nor professionals mentioned how this process takes place nor how many prisoners actually do have access to SRI before release. Professionals and prisoners agree that, even when available, this income is insufficient to ensure reintegration and the process to access this support is usually very slow.

Regarding medical care, upon release, medication is usually prescribed for the following week, but for prisoners experiencing severe economic issues it can be prescribed for up to one month, including OST, ART or VHC treatment. Prisoners are also informed of the date of their next medical appointment and their clinical file is sent to their local GP, although this appears to not always be the case. After that, (ex-) prisoners are expected to provide for and manage their own medication and clinical process. Available services are those provided by the national health service and drug

treatment units, *'like for any other citizen'*. There is no specific health insurance or health subsystem for ex-prisoners after release.

Formal procedures aside, according to the perspective of (ex-) prisoners, there seems to be a complete lack of social reintegration measures after release.

'There is no real intervention plan for ex-offenders, especially in the first few weeks or months. Much has to be done in this area; otherwise we will continue to have high levels of recurrence.' (PR, M)

Existing support is not really accessible or the liaison between prison and services does not really exist. Twelve out of fifteen (ex-) prisoners expressed a very negative opinion regarding support services after release and described a situation of being *'on your own'*. Most services do not have a concrete and coherent response for prisoners upon release. A psychologist working inside prison highlighted that *'some aspects are ensured through social reinsertion but in a very limited way'* (PI). The continuity of social support is often mainly ensured by the social network of prisoners, namely family and friends.

Suggestions to improve preparation:

- Increase training on administrative procedures (e.g. how to open a bank account, where to go to get a citizen's card, how to use an ATM card, how to ask for support, how to fill in certain documents, what rights do they have regarding the health system, etc.);
- Greater contact and sharing of information between internal and external professionals;
- Prior preparation of their social and family situation;
- Increased psychosocial support;
- Behaviour monitoring to outline action plans;
- Activities to promote adequate and adjusted interpersonal relationships;
- Creation of temporary therapeutic communities where prisoners could be integrated during detention, in order to facilitate transition to the community.

Ten out of fifteen (ex-) prisoners reported having been provided with information on overdose prevention through training and awareness-raising activities during detention, either by nurses and other health professionals, peers and peer education training courses, namely by those provided by APDES. However, for most professionals, prisoners are not prepared to deal with overdose situations. Regarding naloxone, the general perception among professionals is that it would be an asset within the prison context as it could avoid situations that could *'endanger users'*, but its introduction within the prison context would be very complicated in terms of safety. One professional has suggested that prisoners should be trained so that one could be responsible for naloxone in each prison ward and administer it if necessary.

5.4 Challenges on release

5.4.1 (Ex-) prisoners' points of view

Individual level

(Ex-) prisoners make it clear that it is difficult, especially during the first days and weeks, to get back into 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 was, 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 few days outside is very hard according to the respondents, and some have the feeling that they have to learn how to behave when in contact with other people in society again.

'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 from ex-prisoners, like administrative organisation, contact with people in society and managing life outside prison. In this regard, respondents indicated a lack of internal motivation in order to approach services and engage in activities, or that they were struggling to accept support.

'It's complicated, the number one 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 like drug use, friends who use drugs or criminality. Returning to former social networks, when mainly comprised of people working in drug trafficking and drug dealing, is mostly named as 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)

In addition, the social network could negatively impact the release experience in a different manner. Issues such as the negative emotional experience towards family or friends who are not met at release, fear of stigmatisation from the social network and a lack of a social network are reported as negative experiences upon release. The absence or attitude of some close relatives can lead to a strong sense of 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 the 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).

The interviews show that the main fear of participants is a relapse after release, because of the difficulties and challenges related to the first 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 a drug aid system, 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 period after release. Especially getting into health insurance and getting OST legally after release. Finally, respondents mention mental harm from prison and 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 lose their flat during imprisonment and do not know where to go after release. Respondents who had no housing before reported not to have a better situation after release. Most of the time, participants did not have any permanent 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 streets. 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. And finally, a few participants were given the opportunity to reside in a 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 made them drop their guard regarding their dependence on drugs, especially following the first release. A participant tried to explain this phenomenon and underline his need for support associated with housing, in order for the solution not be counterproductive:

'[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 learned 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 the daily structure it provides, and the opportunity to perform a task in the community. Mostly respondents reported a lack of support regarding measures that help with the situation on 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 often mentioned by interviewees, especially with 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 the right knowledge about administrative organisations. They often started these procedures from zero: with no fixed address, no bank account and no proof of ID. Therefore, it turned a usually laborious task into a seemingly impossible one, and brought disappointment or frustration, which often leads to drug use after release.

Respondents also mention 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 get once out of prison. They experienced a brutal and difficult transition from quite accessible, regular and well-defined support inside to more volatile and sporadic provision outside. It is as if care inside was somehow 'passively' received, and health care outside prison requires much more motivation, implication and active search. A treatment gap observed with opioid substitution illustrates this problem: in prison they are called into the medical unit to be given their treatment daily, a strict routine is installed; once they are released they need to find a way to obtain OST without health insurance, and sometimes without a 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 the support in the prison and that 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)

5.4.2 Professionals' point of view

Individual level

Professionals state that a reliable social network is a personal challenge, restoring bonds with family and (clean) friends, as well as building up new relationships and networks. Individuals may be afraid of returning to their family or living on their own and returning to fellow drug users, which represents an increased risk of recidivism (DE).

Staying away from drugs is another personal challenge, in particular when one needs to adapt (again) to stress and pressure in society. Professionals have also noticed the need for some prisoners to have a few days of intense partying and/or drug use right after release. They explained this by the forced drug cessation in prison, insisting on the fact that the initiation of treatment in prison is sometimes due to circumstances (drug inaccessibility) rather than a mature decision of prisoners to cure themselves. They also noted that some patients come back spontaneously to the planned treatment centre after these few days of 'disappearance' (BE, DE, FR).

Professionals indicate that ex-prisoners outside still behave like prisoners inside, which is not useful during application for social welfare and other administrative stuff. Being a 'good prisoner' doesn't work outside (DE).

Regarding the state of mind of prisoners after release, some professionals observed two elements that were less visible in the interviews with (ex-) prisoners and that can help explain a difficult continuity of care among these patients (FR):

- The belief that they will not stay out of prison for long, because they never did in the past and it has always been round trips from inside to out in their adult lives.
- They are not used to asserting their rights (their life outside and inside prison was often ruled by 'the law of the strongest'), and as a result it might lead them to giving up claiming the support they are entitled to.

Structural level

The main challenge upon release is 'surviving', meaning returning to reality and being confronted with diverse stimuli. Ex-prisoners are confronted with challenges in a wide range of life domains and need to deal with multiple stigmas ('drug user', 'ex-prisoner', etc.) They come from a very structured and 'safe' environment (prison) back into an unstructured 'dangerous' world. Almost all professionals also

described the brutal transition between the close monitoring inside and the disorientation outside, and talked about its negative impact on empowerment. In prison they are used to having someone 'who thinks for them', 'telling them where to go and what to do' at every moment. This means all the initiatives required upon release regarding housing, money and treatment are all the more difficult to access. They need to 'recondition' themselves (BE, DE, FR).

'Inside there is a certain supply and there is a certain supply outside and in between they fall into a black hole. They often do not come from inside the help system out there.' (PE, DE)

'It is beginning to run from the overstimulation of being no longer used to running for long stretches, to the point that the behaviours that are required are also completely different. So if you behave in the office as a good prisoner, then you get nothing at all, but there is simply, just a bit of assertiveness required and stamina, above all, and wait until the door is unlocked, as it once was used in prison and get used to it, that does not get you anywhere.' (PE, DE)

'The women always have a lot of plans, but I mean, it's just that they come out and mostly drive right back, consume, and then either the money is gone directly or they cannot do the administrative part [...] I find it totally unfavourable when women are released on Fridays, so we have that often, that then suddenly they are released sooner and I have on Fridays, for example, street work. We sometimes find that we meet clients and they say, yes, I've just got out of prison, then somehow Friday is early afternoon and then they say, yes, we do not have any substitution and you think so, "what should we do now about that?"' (PE, DE)

According to the respondents, there are some top priority topics to consider upon release in all countries.

- Housing was named by nearly all respondents. Professionals stated that housing in bigger cities, but also in the suburbs, is very difficult to find. There is not enough housing specifically for ex-prisoners and also no chance for a private flat after release.
- The employment situation is bad as jobs are limited and ex-prisoners often face several difficulties. Observing the (probation) regulations is another challenge: ex-prisoners are expected to build up a new life and take responsibility regarding various life domains. The most commonly highlighted negative element by prisoners was the lack of support regarding the labour market.
- Professionals acknowledged the administration of transport, handling of documents, institutional accessibility and the return to problematic previous contexts as challenges upon release. It should also be noted that professionals also mentioned the difficulty of reintegration in society, either as a result of their ex-prisoner status or because of their re-adaptation to life in society after a period of reclusion, such as work and family environment. Prisoners need to find resources, they cannot go to some specific places (linked to drug use/criminal behaviour), they need to make arrangements with a probation officer and/or treatment services, and so on. These difficulties become more salient and adverse for ex-prisoners that do not have any social or financial support from formal institutions and have therefore no means of subsistence. This view is in agreement with the

experience of prisoners, which indicated that the main obstacles experienced were those regarding housing, employment and financial situation.

Further, the delicate balance in the choice of treatment centre has been mentioned in terms of its effect on post-release experiences: when the patient already knows the location and the health team, the trusting relationship is easier to build, but the chance of an encounter with an old acquaintance who might trigger a temptation to use again is higher (FR).

In addition, psychological and drug-related support in prison was mentioned, particularly when related to the fact that a patient might gain confidence about his/her addiction management in prison, thinking they are over it, but without realising that 'the work on themselves has been done without the difficulties and temptations of the real world'. As a result, they tend to let their guard down and relapse as soon as they return to their usual environment (FR).

Professionals pointed out some other challenges, such as:

- The day of release is not known in all cases or release on Fridays (meaning that application for social welfare is not possible) (BE, DE)
- Ex-prisoners do not know how to apply for social welfare benefits (DE)
- Ex-prisoners have poor knowledge of daily structure regarding leisure time (DE)
- Compliance of (ex-) prisoners is different inside prison to outside, so working with them outside is more complicated (missing appointments, etc.) (DE).

In Germany and France, health care was one of the major topics, as making applications is complicated and it takes a lot of time right after release (see also 5.1.1).

5.5 Cooperation

5.5.1 Cooperation between prisons and external services

Belgium

Respondents describe the prison/judicial context and treatment services as two separate worlds, with different visions and objectives: the former is based on punishment and suspicion, while the latter is about care, support and trust. Professional secrecy protects and hinders communication between prison and community workers. Judicial actors have different tasks from caregivers, and treatment is subordinate to justice in prison. This is illustrated at different levels: security measures affect support in prison (e.g. no treatment contact at time of calls), and caregivers need to walk a thin line when talking to judicial servants. Prison services and external services providing support in prison often work separately, based on their specific expertise, but without coordination or attunement of these services. A coordinated approach or an overview of all the stakeholders involved is often difficult. However, the quality of collaboration between services is often dependent on individuals.

Structural consultations between prison and external services are not organised, except in some specific projects. Most contacts are 'ad hoc' and concern prisoners' reintegration plans. One of the

challenges mentioned concerns different views between prisoners and the prison psychosocial service, in which external services are put in a difficult position as they act on behalf of the client. Communication between prison and community services is limited to administrative and practical information (e.g. whether someone has turned up for an appointment, missed a drug control session, etc.), but given the professional secrecy, no information regarding the treatment (trajectory) is passed from community workers to judicial/prison services.

Collaboration between internal and external services may also be challenged when arranging (drug) treatment after detention. According to the respondents, some services only take intake appointments once released and/or once administrative requirements have been fulfilled (e.g. health insurance). Other residential (e.g. (psychiatric) hospitals) or outpatient services (e.g. community mental health centres) are not eager to support ex-prisoners. Once a prisoner is released, collaboration and communication between prison and community services ceases. Continuity of care and exchange of information is limited, resulting in community services starting all over again, regardless of any previous actions that were taken. This is also the case regarding medical information and treatment. Probation officers working for community justice agencies state that there is no systematic contact with prison psychosocial services upon release. Suggestions for improvements by professionals include physical meetings between prison staff and community workers, and better information/knowledge about treatment and support services in the community.

France

Obtaining information about a patient's OST or medical follow-up seemed systematically feasible (if the community service was identified). However, it appeared more difficult for outside professionals to obtain information from inside than the other way around. Moreover, some professionals working in the community reported that information obtained from prison often remained 'strictly factual'. Finally, professionals agreed that it was hard to build a real working relationship, mainly because of the 'hermetic separation between the two settings', and the lack of meetings 'in person'.

The lack of communication observed between the court registry and professionals in the community was particularly relevant for continuity of care. In the following instance, the unanticipated change in the date of release led to a complete collapse in the social and medical preparation for this patient:

'It happened to us less than a month ago. The prison administration realised at the last moment that they were about to release him one day too late. As a result, they took the person out a day earlier, but no one knew about it, neither the medical nor the probation and rehabilitation counsellor. It's the clerk's office that does its own thing and says, "The gentleman is going out now". And then the gentleman is going out now, except that we were waiting for him one day later. And then the educator who had coordinated all this, who had taken care of the application, there was nothing he could do either. He tried to call the guy [ex-prisoner]. The guy, besides, he was out and the medical staff don't know. So no one prepares a treatment for him on the way out. The guy is left without treatment, with quite heavy stuff [health condition] that you can't just part with overnight without decompensating. Of course, the guy disappeared into thin air. [...] the guy was missing, impossible to get his hands on him. It's several months of work [gone up in the air], just because the prison administration has decided it like this.' (PE)

Germany

Respondents describe the cooperation between inside and outside as difficult. Both sides reported that they have no contact person on the other side. This is illustrated at different levels: security measures affect support in prison (e.g. no treatment contacts), as all social workers from outside need to submit any evidence of a criminal record and organisation to go inside is complicated. Prison services and external services providing support in prison often work separately, based on their specific expertise, but without coordination or attunement of these services, only in a few cases do they meet to plan treatment for prisoners. A coordinated approach or an overview of all stakeholders involved is often difficult. However, the quality of the collaboration between services is often dependent on individuals, and there are some good examples.

The interviews showed that professionals inside don't know what professionals outside do and vice versa. In some cases all professionals conduct a round table meeting on a regular bases (twice a year). Professionals outside reported that professionals inside are hard to reach and they don't know what is really important for release.

In most cases, professionals inside reported collaboration with social services outside, such as job centres, OST centres, debt counselling and so on, while professionals outside reported that prison staff are not open for collaboration.

In individual cases there is regular cooperation between services outside and social service inside, but mostly if there is a special contract. Good cooperation is also seen and reported by external staff who work inside and professionals outside, and/or other external staff.

'Usually a difficult collaboration with the colleagues in the prison. Because even if we explain this over and over again, we cannot avoid this administration and unfortunately it is that this was very difficult to understand. That was often rated that they do not come to the prison, that's way too much for them. [...] Partially very difficult, so very difficult, because I often feel like they just do not want to understand that and I mean, we all come from a profession.' (PE)

'The social service and so we work with them but they don't work not with us. Anyway, not the rule, there are a few who would call times or give you an info you need or something. [...] Depending on the person. So there are some, there you are just in contact and if you have to speak to them you just take the phone.' (PE)

'Identity card, as we are also very closely in contact with the office. It comes here too. That prepares that. We have a camera and a printer for the photos.' (PI)

'Exactly. So, the successful cooperation is with the former employment office, job centre and the probation service, because we meet here regularly, so, and the networking is more intense. [...] As I said, the employment office, job centre, the probation service, so the general judicial social service these are the pension insurance, health insurance, offenders, treatment facilities.' (PI)

'Would be a slightly better networking. Direct contacts, perhaps also contacts who are more frequent in the prison.' (PI)

'My job as release coordinator and my committee work is in various working groups outside the institution. These are working groups that have found their own way, yes, for example, like the addiction workgroup; drugs and AIDS, where people from the city, the region, from different disciplines, freelancers, charities, church leaders, all working in the field, meet monthly and discuss topics.' (PI)

Portugal

Professionals that work inside prison named several partners with whom prison services work in collaboration, namely social reintegration teams, social security, courts, local municipalities, the health ministry, the education ministry, IEPF, voluntary associations, health institutions, private and public institutions, social institutions, academic institutions, the Catholic Church and other religions and public libraries. Although some cooperation challenges were presented, both professionals working inside and outside prison characterised cooperation and professional relationships as adequate, positive and successful, without any major difficulties. Most challenges to cooperation presented by professionals working within the prison context are cross-cutting to the work of different institutional collaborations: limitations in external services due to the uncertainty of permanence of prisoners in prison; security issues and transport of prisoners; entry of external staff to prison due to security issues; restricted schedules of prisoners that are sometimes incompatible with service hours, and lack of understanding of prison context norms. However, one professional made a distinction between areas of activity: *'Academic and voluntary institutions are very interested in participating and collaborating in the prison context, having a greater sensitivity to these contexts. Health institutions, either because of lack of time or because of the devaluation of the environment, are not so available for the collaborations.'* (Participant no. 21, 37 years old, female, inside professional). For their part, professionals working outside the prison context presented other challenges in cooperating with prison services, such as lack of privacy in individual visits since *'doors must be half open'*, which hinders prisoners' trust and, as a consequence, the service's quality; and some limitations due to lack of resources in the prison context, namely for prisoners' transportation with ideal regularity.

In order to protect prisoners, confidentiality is taken very seriously and external services do not have any access to prisoners' information without their permission. Professionals reported that external services only have access to strictly necessary information in order to provide a quality service for prisoners. In this sense, they provided some specific cases where information is shared, sometimes by prisoners themselves: overall data for the DGRSP and individual data to criminal police agencies when required; health services only have access to clinical files; drug treatment units only have access to drug-related information.

5.5.2 Cooperation inside prison

Belgium

According to respondents, inside prison an area of tension is observed between security and support staff, with support staff indicating that they have to compete against the predominant security approach. For example, security staff outnumber support staff and the former sometimes doubt the necessity of talks with prisoners. On the other hand, some wardens mention the hierarchical organisation of services in prison and that they often don't receive information. For example, they are not informed about specific disorders (e.g. autism spectrum disorders or ADHD), which can be important information for addressing prisoners. Professionals state that communication between

prison staff is often better in smaller prisons. Collaboration is also better when all prison services are concentrated on one wing and when staff turnover is limited. Some professionals indicate that the 'professional secrecy' is often used as an argument to not communicate or collaborate. Suggestions to improve communication between prison services include regular meetings between medical and psychosocial services in prison, a more open and constructive attitude between prison staff and services, information about each other's tasks and obligations, adequate communication with warders, and so on.

France

Circulation of information was less fluid and was an obstacle to good continuity of care in some instances reported by (ex-) prisoners and professionals. Two major blockages were identified.

The first was a lack of communication and coordination between probation-rehabilitation services and the court registry on one hand, and the health staff on the other, illustrating a clear division between health and justice professionals inside prison.

'I would have liked us to have access to the court clerk's office, but there is not too much of a liaison because the clerk's office is a fairly important institution. He [the court clerk] is a person who holds a lot of power in a prison, but you don't have access to it.'

Is this a problem for the continuity of care, for example?

Yes, it is.

To get the information for release dates, that kind of thing?

Yes, and then even, as soon as a document is missing, it should normally be requested from the court clerk's office. Something stupid, but when a person goes out, they get a release document. Without this document, administratively, they can't do anything because it proves that they didn't escape. The only person from whom you can ask for the release document, if the person has ever lost it, is the court clerk's office. Usually, a homeless person who gets out of prison loses everything or has his stuff stolen. Not being able to ask a court clerk for that is stupid, and it's like a person without an identity card, you can't do anything.' (PE)

A second frequent blockage was identified inside by the health staff, between the somatic unit and the psychiatry unit. Professionals reported a 'historic separation' between the two units, in addition to a physical one, while both of them were involved in the management of addictive disorder. This sub-optimal collaboration was not systematic but could hinder the medical care of the patient in some prison settings.

A professional inside prison regretted the lack of cross-cutting meetings in prison: between the somatic and psychiatry teams, and between the health and justice departments, even though a lot of the staff asked for such regular meetings.

Germany

According to respondents, cooperation inside is good, especially between social workers, but a structured exchange of information between disciplines (such as social workers, wardens, psychologists) is not guaranteed. Professionals reported that there is a web-based platform (BASIS-Web) in all prisons where professionals from every discipline can write actual information, but they also reported that this is not used by all. Poor cooperation inside was reported between:

- Social workers and medical staff
- Psychological services and drug counselling staff

In both cases, the professionals indicated data security, even inside, as a huge barrier.

Suggestions for improving communication between prison services included regular meetings between medical and psychosocial services in prison, a more open and constructive attitude between prison staff and officers from other services, sharing of information about each other's tasks and obligations, increased use of BASIS-Web, and so on.

'So here we are meshing like gears. And have a good network. So the specialist services that are responsible for my area and my station here, that works hand in hand.' [...] 'I: OK good. So now some questions about overdoses. How are prisoners prepared for a possible overdose? B: That's not my area. I really cannot comment on that.' [...] 'So in some cases the communication is really blocked. That's where I run after my information.' [...] 'We have a programme, that is, BASIS-Web, where we can enter a lot of information. Unfortunately, this is often not used as it could be used.' (PI)

'I do not know if our addiction doctor is the point of contact, or the head of medicine. I do not know that. But there is a contact person here. I just do not know who it is.' (PI)

'But there is no demand. So, informal talks are already taking place. So on the stations, so in the everyday life of the prison, since we had already contact with staff. And then it turns into specialised questions. But that's nothing, nothing formal. Well, that's not structured and that's not planned, it's more random and interest-based then.' (PI)

Portugal

Since cooperation is seen as essential and effective, all services within prisons cooperate, as assured by professionals working inside prison. However, one psychologist claims that *'all services have the opportunity to collaborate with each other, but this does not always happen. Often services with individualistic approaches share little information. This depends on the prison and service'* (PI). Although professional relationships are generally adequate and beneficial, some challenges regarding interpersonal relationships, conflict management, communication channels, lack of sensitivity for the issues handled, services dehumanisation and lack of information are felt. One professional specifically stated that *'sometimes there are difficulties in communication and understanding between surveillance services and health and social services'* (PI).

Another challenge mentioned by professionals regarding the collaboration between services was the bounding of professional secrecy and confidentiality, since leaks of information sometimes occur. In this regard, professionals indicated some strategies that are implemented in order to guarantee confidentiality, namely restriction of data for the majority of prison staff (e.g. medical files can only be accessed by authorised health professionals), individual sessions with prisoners, individual databases of personal information that can be managed by prisoners, confidentiality training for professionals, professionalism in all actions and best practice compliance. The confidentiality issue is a day-to-day challenge, where one professional stated they are *'always being careful to know what can be transmitted for the benefit of the prisoner, without ever putting him in risky situations. This line is very tenuous. In some situations, in order to protect the prisoner from some situations, we have to expose him to others...'* (PI).

5.5.3 Cooperation in the community

Respondents reported good collaboration between all services outside. In some cases they meet on a regular basis or meet for 'treatment plan conferences', where they discuss individual cases. Respondents also indicated that they know a contact person in different social welfare organisations, but also state that cooperation is not easy all the time. In some cases, respondents indicate data security as a barrier for good cooperation.

'We present the clients in a help plan conference. Then we get the consent to the admission and that takes place every fourteen days, there meet all carriers/organisations, who offer assisted living for people with addiction.' [...] 'Our doctor, with whom we cooperate, is still a social worker who is involved and there are also discussions in this regard.' (PE, DE)

'We also know the people from the offices, that you can ask, can the please keep the apartment and I think that is also usually then.' [...] *'So we also sometimes have dropouts that we either know or the facilities then call us in the street work and say, here's someone who's coming out of therapy.'* (PE)

6 Conclusion and recommendations

6.1.1 Barriers of continuity of care

Respondents, including professionals inside and outside and (ex-) prisoners, mentioned the following specific barriers to continuity of care.

Administrative procedures

Health insurance: Procedures for achieving effective coverage are difficult to initiate before release, and once in the community, it implies showing a valid identity card and having a registered address (the latter is sometimes provided by NGOs and homeless shelters). Access to health insurance that ex-prisoners are entitled to is not systematic and takes three months on average to sort out (DE, FR).

Source of income: The period of time before having access to welfare was estimated to be 'less than a month', when the person already had identity documents and had prepared the application during incarceration, which was very rare. It was reported to take more than three months when these conditions were not met (FR).

Identity documents: Although essential to initiating health coverage or welfare benefit procedures, it was reported that more often than not, prisoners were released without a valid ID (DE, FR).

Bureaucracy regarding financial rules: Bureaucracy is the most reported barrier for continuity of care. Respondents reported many difficulties related to rules inside and outside. The main barrier with bureaucracy was that prisoners lose their claim for any social welfare benefits inside, so they can't apply for that while they are in prison. This needs to be done on the day of release and authorisation takes between two and four weeks, which leads to gaps in continuity (DE, FR, PT).

Circulation of information

Health/justice communication: A lack of communication and coordination was reported between probation/rehabilitation services and the court registry on the one hand, and the prison health care staff (medical and social) on the other (BE, DE, FR, PT).

Date of release: Almost all professionals in our sample mentioned the extreme difficulties they faced in dealing with sudden changes in release dates. The almost unpredictable release date hinders continuity of care after release, as smooth transitions should be based on clear arrangements regarding the above-mentioned issues. Also, the judicial trajectory needs to be adjusted to the treatment trajectory, as the policy level is now stimulating quick release, but unless there are good arrangements for reintegration and between prison staff and service providers, this may work counterproductively. For example, prisoners are released days before they can be admitted to a treatment centre, or inversely, one may have a job, but then the sentence is prolonged, which is frustrating for all partners involved in the process (BE, DE, FR, PT). In addition, releases on Fridays are mentioned as problematic, as it is not possible to apply for social welfare or reception of OST if it is not well organised (DE).

Professional secrecy: Some professionals stated they deplore over-zealousness regarding professional secrecy. Some information concerning continuity of care is kept confidentially without purpose, because professionals, both in the justice and health department, do not understand what is allowed to be shared and what is not well enough (FR).

Communication and cooperation: Cooperation inside and outside is reported as a barrier for continuity of care regarding a smooth transition from prison to life in the community. In this context, knowledge of professionals inside was also pointed out as a barrier, as they don't see the specific problems for ex-prisoners after release. Lack of communication between prison and community services, as well as between mutual prison services, is an important problem. The situation was problematic, and especially challenging, in remand centres, where the anticipation of early releases, sentence remissions and parole would often come up unannounced to the health staff (BE, DE, FR, PT).

Support inside prison

Manpower: The number of support staff and caregivers in prison is too low in relation to the demand, leading to overly long waiting lists and times. If care and treatment is provided, quality is often poor and not intensive due to lack of time, staff and training. Preparations for reintegration after release are limited, but should include housing, employment, training, and financial and psychological support (BE, DE, FR).

Insufficient preparation before release: There was no official structured programme specifically aimed at preparing for release (medical and social preparation, overdose prevention except in France, where the provision of naloxone spray before release for take-home is possible but only partially implemented). Probation and rehabilitation services were overwhelmed and their work was more and more focused on the judicial process (BE; DE, FR, PT).

Control and punishment: Prisons are primarily oriented towards control and punishment, while care and support are subordinate to these objectives. Caregivers mention that this is often frustrating when trying to support prisoners, but prisoners are also not motivated for taking responsibility in this way. As a consequence, wardens focus on control and are not trained to deal with individuals' support needs; neither are they informed about prisoners' specific needs (BE, DE).

Treatment and support: The treatments and services on offer differ from prison to prison. The offer for prisoners serving long sentences is the largest, but short-term prisoners have similar needs and also need to be prepared for reintegration. Treatment options in prison are really limited, particularly abstinence-oriented drug treatment services, and are mostly not individualised (BE, DE).

OST: In prison and after release OST is not ensured. This barrier leads to relapse into drug use, physical health problems and infectious diseases, and in the worst cases to overdose after release. In cases where OST is ensured, there is no specific psychosocial support (regarding OST) provided to prisoners like there is outside prison (DE). A person asking for OST had to 'prove' they need it, which could lead to a gap in the treatment, especially at the time of entrance to prison (since the patient had often been lost to follow-up at this time) (FR).

Therapy instead of punishment: Uncertainty about the release date hinders continuity of care after release, as smooth transitions should be based on clear arrangements regarding the above-mentioned issues. Also, the judicial trajectory needs to be adjusted to the treatment trajectory, as the policy level is stimulating quick release like therapy instead of detention (section 35 of the BtmG), but this is not possible in the first month inside because a lot of application forms and authorisations are needed and there are long waiting lists for drug counselling (DE).

Support outside:

Housing: According to professionals and (ex-) prisoners, there is an important lack of places available and human resources to manage them. In particular, professionals pointed out the lack of places in low-threshold facilities. For prisoners with short sentences (six months or less), it was highlighted that social services staff in prison 'didn't have the time to launch anything regarding housing support'. For example, some prisoners lose their accommodation while in prison and have no opportunities to rent a flat on the day of release or before. Shelters and low-threshold drug treatment centres that provide housing are often associated with active drug use (FR, DE).

Stigmatisation: According to the professionals in our sample, the population released from prison is considered a 'difficult audience' on several levels by some support services. These community services are not necessarily familiar with all the difficulties associated with prisons (i.e. release dates which can be modified until the last moment, difficult access to health services, and so on). This population is sometimes also associated with dangerousness, and for all these reasons some services seem to refuse access (FR).

Individual level

Lost to follow-up: As described in the 'experiences of release' chapter above, some people need to 'lash out' with drugs immediately after release. This can lead to a definitive loss of follow-up for some,

or for a return to care after a few days for others. A quick return to criminal activities right after release, and to re-incarceration, was also reported as an obstacle to continuity of care.

Language: Some professionals reported having trouble dealing with some populations due to language barriers. They added that translators were hard to find in these situations.

Other barriers

- Specific restrictions/privileges for going out during a prison sentence are rare for drug users, so it is often not possible to get used to the outside world or to have the possibility to organise administrative issues before release (DE)

6.1.2 Promising practices

Professionals reported different promising practices for overcoming some barriers regarding continuity of care. The practices described in this section are rare and are only available in some prisons, or are bound to individual professionals.

Administrative practices

Active procedures linking the inside with the outside: Some professionals indicate individual solutions regarding contact between professionals inside and outside prison to overcome the gap at the time of release.

- Making up a clear reintegration plan in cooperation with professionals inside and outside prisons.
- Facilitating access in prisons for NGOs and, in accordance with health staff, officially delegating part of the support to harm-reduction services existing in the community.
- Activating welfare support before release, in order for this support to be up and running during the first week after release.

Medical throughcare: Some professionals mentioned good practices regarding medical throughcare, especially OST.

- For each patient, defining the community services that will be involved in the OST follow-up, as soon as the prison staff initiate OST.
- In accordance with the patient, systematically notifying the pharmacy in the community that it should expect a visit and confirm the need for OST delivery.
- Systematically issuing an official document listing the treatment needed and hand it out to the patient just before release or at the clerk's office (as prisoners may refuse to have a clear identification of treatment in their cell).
- Allowing the prison's pharmacy to provide a few days of treatment upon release.
- Developing free OST delivery facilities outside prison (NGO treatment centres, harm-reduction centres, etc.)
- Drug treatment services that provide OST even without health insurance.

Information and support:

- Making throughcare possible for prisoners in some prisons via the provision of case management, which gives support six months before and after release.
- Providing a release checklist in prison which guarantees all (administrative) preparations until release, such as ID card, OST, health insurance and so on.
- Just before release, handing out a leaflet to the prisoner that presents an overview of local support services.
- Cooperation between prison and community services to provide an ID card inside prison. There is also a prison which cooperates with professionals from external municipal services who come into the prison to prepare prisoners with the support they need like an ID card, information for applications (e.g. for a bank account), and so on.
- Providing access to health insurance directly after release through cooperation with the health insurance fund, municipal services and prison (important in Germany).
- Providing support with health insurance coverage by the national health service inside and outside prison so there is no delay to gaining access freely to usual treatments in Portugal.
- Employing case workers who work 50% in prison and 50% outside prison. They mentioned a good overview of both sides and skills to fill the gap between prison and reality on the outside as the main advantages.

Support inside and outside prison

Drug-related support:

- Peer support, including working with ex-prisoners who have managed to recover from their substance use disorder.
- Drug treatment courts before incarceration prevent drug offenders from ending up in prison and help orient them to treatment instead of incarceration.
- Successes often depend on coincidences and individual support workers who are willing to do something extra, such as accompanying someone to an intake assessment in a residential drug treatment centre, or conversely, community workers who come into prison to do an intake assessment.

A programme promoted by the Institute of Employment and Vocational Training (IEFP), called Vida-Emprego (Life-Employment;URL) was dropped by the Portuguese government in 2017. During the therapeutic process of drug users, professionals managed and prepared them for professional integration and established formal contacts with employers. Throughout the process, a team of GPs, psychologists and social workers provided medical and social support to participants while monitoring their progress. After twenty years of implementation, the success rates reached 80%, meaning 80% of the individuals involved were hired by contacted employers. At present, no similar response is available.

- Employment offices, functioning as a response from the IEFP, based in drug treatment units, facilitating cooperation between both technical areas and in proximity to users.

Support in general:

- Activities, work and training for prisoners to minimise the likelihood of recidivism.
- Projects promoted by the General Directorate of Reintegration and Prisons Portugal (DGRSP) for the integration of young people and ex-prisoners into the labour market, which included training and therapeutic support. A team of psychologists and social workers provided social therapy sessions for participants who would then develop internships in selected companies.
- Developing psychological support, based on the improvement of self-esteem.
- Training of prison staff for managing prisoners, including those with specific needs.
- Volunteers or caregivers who help to bridge the gap between prison and the community, as they can often support prisoners to arrange things which they can't do on their own.
- Establishing a relationship of trust between caregivers and patients before release from prison, including:
 - Authorising one day of leave to visit treatment centres.
 - Before release, systematically arranging a first telephone call or in-person meeting with the services that will support the individual in the community.
 - Upon release, proposing an escort from the prison door to the treatment centre in the community, when relevant.
 - Allowing follow-up by the same professionals before and after release from prison: designate a referral addiction treatment centre for each prison. Create functions specifically designed to play the role of liaison between residential treatment centres and detention. Hire a professional that can work both inside and outside prison, and can consequently ensure continuity of care more easily.
- Projects to involve family members like father-child days, providing a focus on contact with the family and social network, the possibility of longer visits, and the promotion of relationships outside.

Good preparation for release: an example (France)

(Interview with a professional inside)

A medical doctor working inside prison described the social support and reintegration plans provided by the staff she worked with. However, she insisted that this detention centre was clearly a 'special situation' and had 'enormous means' at its disposal, compared to others.

Reintegration plan

[This prison] is a special situation! It is equipped with enormous resources.

Is there a reintegration plan that is made before release? Planning with the prisoner where they will go, what their resources are, what are the professional perspectives, where they will have to go if there is treatment available?

Yes, it's done. We don't call it like that, but it's more or less the same. [...] In the ideal situation, when we can do it, we have the release date, so we know how much time we have left to prepare for the release. We start preparing it a year before, six months before, three months before, it's settled: does

the guy need a cure, an aftercare, where is he going? Often, there are multidisciplinary consultations with the downstream sector team, so we try to do our best to do so. Either we're the ones who move outside, or we call the community health professionals to come and meet the guy [the patient]. It's always done with the guy. In any case, we insist that he be part of it, otherwise it won't work. So it is a consultation between the social worker who comes to tell us: "in terms of housing, this is where we are, in terms of resources, it is there, this what we still needs to address, etc." And we, as the medical support, we say: "we have contacted this or this addiction treatment centre, this or this ambulatory psychiatric support...", and often appointments are made. So, when you are released, you have three days of treatment (in case of trouble), you have your appointment with the community psychological support on a given day, at a given time, then you go to the addiction treatment centre on a given day, at a given time... This is the ideal situation and when it works, it works well.

Social and medical preparation

Throughout the [patient's journey during incarceration] there are several supports. First of all, there is the ambulatory support in prison where we do all-day long special addiction-oriented sessions. The level 1 session will be everything that is product knowledge and the level 2 session will be everything that is knowledge of downstream support services. So there are real support sessions. These sessions last three weeks, we have partnerships and we bring in people from outside to present their support service in the prison[...]. This is for those who are eligible in quotation marks, who are motivated enough to follow this thing.

Otherwise, this support is done as part of the addiction and OST follow-up, where there is systematically, in the time of guidance, information on all the support services that exist, if only for guys who move from one region to another. For those from [the region where the prison is located in], it's easy because the social worker knows the thing quite well. And when they move to another region, there is at least one search for information on all the support services that exist and it is shared with the patient in custody. We say: "where you are going, there is this and that, you will be able to go there", or "the structure we have thought of for you, it's more like that". This is done as part of the consultations. [...]

Normally a guy who leaves, before he goes to the clerk's office for the exit, we inform the prison that he must go to medical unit. That's how it works[...] It's not so much a visit, it goes like this: I go to the medical unit, I get out of my building, I take my package, I take my treatment. He has a small bag, we give him the doctor's discharge letter in person, we tell him: "don't forget, the appointment is at this time". If it is a guy who really needs support, there is the educator who is there, who accompanies him to the clerk's office, he says: "I will call the support service to find out if you have been there", since now we are no longer allowed to accompany him outside the prison. Although sometimes, there can be a relay of professionals since there are partnerships, with guys who work on downstream support services, who come to prison to pick up the guy and bring him in. That's his journey.

[...] For example, if he is offered an aftercare in a treatment centre, can he go there and visit it before release?

Yes, this is done almost systematically, if only in the case of pre-admissions. There are rarely admissions without the team seeing the guy. Often, the downstream support service, the residential treatment centre, there will always be a meeting with the team, or they will get on the phone and the phone call will be mediated. After that, it depends on the judge in charge of enforcing sentences. But often it goes well enough that there is a permission to leave, as part of the visit of the support service. But it can be done to meet a public psychiatric ambulatory team. As part of the release authorisation, there is an accompanying person. In this case that's easy because we can go there with him. What is more difficult is when its sentence is officially over: he is no longer under the responsibility of the health unit he is supposed to go to the community support service on his own.

Good Preparation for release: an example (Germany)

Preparation for release (Interview with a professional inside)

I: How do you regulate release regarding of substitution and health insurance?

B: (...) I am in my capacity as dismissal coordinator, so I also do a lot of committee work outside the prison to represent the institute, also to bring in the interests of the institution on these committees corresponding results. (...) That's a difference, many always forget and think prisoners are health insurance, (...) They are, but they do not have health insurance on the day of their release. And there we found a way, with the job centre region (big city next to JVA) and in the end unfortunately only with the AOK, where we said, after a structured procedure, thus the tasks became binding and clear agreed that a patient who receive substitution who is insured with the AOK in (state of the JVA) can apply for benefits six weeks before his release, regardless of the local jurisdiction, regardless of the entitlement to benefits. He can make this application and is also processed ready for decision. That is, during the last six weeks of decision-ready processing, the job centre makes the message to the health insurance, the health insurance knows, aha, it's all safe. The job centre has handled this accordingly and we send, for example, the medical treatment certificate and if they already have it, photo, etc., even the health insurance card is possible to the job centre. And that means that on the day of discharge the detainee gets the whole package when he goes there. He gets the treatment certificate, possibly even his new health insurance card, he gets paid performance and I stress, regardless of the local jurisdiction. And he can still on the same day, or the next day, on the same he could go to the doctor and the doctor can treat him and settle. That's very, very important. That did not exist before and that is unique in Germany. (...)

(...) We also managed to win the institute, an institute outpatient clinic, which guarantees the psychosocial counselling (PSC). Well, we've done that already, well under the difficult conditions.

(...) If job centres or option communities are willing to get involved, then it's possible. That one uses the last weeks of imprisonment to get decision-ready decisions on the discharge side on the official side. As far as benefits are concerned, health insurance coverage all. With us there are still so special features that, the additional need for the ticket to the substitution doctor, that's all safe with us. Unfortunately only for members of the AOK.

6.1.3 Suggestions for overcoming barriers

Professionals made different suggestions, particularly related to the need for a smooth and 'warm' transfer from prison back into the community, including concrete arrangements regarding housing, health care, drug treatment and work/training, but also regarding medical and psychosocial needs. By doing so, links with services and service providers can already be established before release. All life domains need to be considered and prisoners should be stimulated to take responsibility in this respect. Support services in prison need to be organised in a more personalised way to address prisoners' individual needs (e.g. psychological support, administrative help, valuable training, OST), while the context and social networks of prisoners should also be involved in this process.

Communication and consultations between service providers are of utmost importance in providing coordinated and continuous care. The concept of a 'case manager' was often mentioned by respondents, as an individual case worker who is a client's advocate and contact person (person of trust) from the start of detention (or even before) until release (and beyond) (Rapp et al., 2014). Besides a professional case manager, a buddy system could also work in which a volunteer or professional supports a prisoner at difficult moments and facilitates their social reintegration. Some professionals also refer to 'detention houses', which are small-scale units providing individualised support, for promoting continuity of care and a smooth transition back into society.

Beside suggestions regarding the need for support as mentioned before, structural suggestions to overcome barriers in- and outside prison were made by professionals.

The suggestions for improvements and to overcome barriers are summed up below.

Suggestions inside and outside prison

Staff: Regarding staff inside prisons, professionals suggested the implementation of more jobs for social workers and medical staff to guarantee better individual support. Also, the implementation of training and information for professionals inside about the special needs of prisoners who use drugs was suggested.

Evaluation: Improving support for prisoners regarding preparation for release, education inside prison, leisure time, drug use and the organisation of administrative issues to make it more effective and suitable for prisoners.

Communication: Improving communication between professionals of different professions (social work, medical care, drug treatment), by using existing platforms and information pathways. This is particularly important regarding support/needs for release, such as lists that inform others 'who does what and when and for whom'.

Improving networks of support for a coordinated response and improved referral process, including social security services, employment and vocational training institutions, health care centres, local community associations and municipalities.

Open doors: To guarantee good communication and cooperation between professionals in- and outside, prisons need to improve access to prison for external professionals.

Taking measures to open the doors for prisoners to give them a chance to improve their lives outside should be possible more often and on a structural basis.

Suggestions for support

Relationships: Implementation of family visits, possibility of longer visits and access to telephone cards (also for free) to establish contact with social networks outside on a regular basis.

Implementation of free telephone cards or regular access to telephones to stay in contact with social workers and community services outside to improve circumstances after release.

Release support: Creation of special support like a full mobile team that can move from one prison site to another, which offers support and continuous monitoring inside and outside, or individual professionals who are responsible for the organisation of the release (case/release management).

Creation of a temporary social security card, proving health coverage and recording the care received by the individual (like any social security card). The card would remain valid for about three months after release and would allow the gap between two health coverages to be bridged.

Activation of welfare support before release, in order for this support to be up and running during the first week after release.

Creation of a card allowing the free use of public transportation for a month after release to guarantee access to transport for visiting treatment centres and social services.

Creation of multidisciplinary teams to provide valid responses for follow-up at release and to improve communication/boundaries between different types of support.

Integration of prisoners after release into psychotherapeutic programmes or transition homes in order to guide them throughout the integration process and prevent relapse by avoiding old routines and social contexts.

Drug treatment: Implementation of a harm-reduction/prevention service for each prisoner regarding possible risks and suggestions to cope with drug use and the risk of overdose in prison and upon release.

Implementation of harm-reduction measures inside prison, such as needle exchange programmes, access to OST for all prisoners (drug users) during and after imprisonment, and the provision of naloxone upon release for all drug users to minimise risks regarding drug use.

Offering special treatments for drug users inside prison, which could be offered by external professionals, to guarantee support inside and outside prison.

Offering access to essential medical and psychosocial treatments (OST, HIV, HCV, ...) directly after release.

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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, etc.):

 - 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, etc.):

- 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, is it 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, etc.):
-
-

Access to care and health insurance *INSIDE PRISON*

3. In your country, is organisation of care 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 misuse 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 on 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? ☐ yes ☐ no
 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, 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 excluded subpopulations?

- 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, 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 free treatment from a pharmacy just after prison release? ☐ 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, do prisoners 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 a 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. Medication 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. Please 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	Yes
			If certain conditions	

			(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 case-by-case agreement	Yes

Health insurance and access to care INSIDE PRISON

	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	
• 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, but 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 referred to the sanitary drug team if there is 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 pays 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	
○ Some limitations?	No	No	No	
	Some states do not provide OST	No		

Health insurance and access to care INSIDE PRISON (continue)

	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 pays 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	
<hr/>				
• 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
	Only in prison hospitals	Yes	Yes, except for prisoners awaiting sentence, at least in Wallonia	Yes
○ Principle of equivalence respected?			Yes, except for prisoners awaiting	
• Take-home naloxone available?	No			

○ Principle of equivalence respected?		Yes	sentence	Yes
			No	
• Psychosocial interventions available?	No		Yes	
○ Principle of equivalence respected?	Yes	Yes		No
		Yes	Yes, but not in all prisons	Yes
	Yes		No	Yes
		No, staff often not available		
	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?				
○ Any delay?				
	Yes		No, as before incarceration	Yes
	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 resource 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 getting 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 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 alternative access to cost-free treatment?	Yes	For OST and naloxone, in specialised centres For ART and anti-HCV treatments, in hospitals	Public Centre for Social Welfare can vouch for the client and provide a social card	National health services except in case of waiting lists
• In practice, are there barriers at prison release?				
○ To getting a certificate allowing health insurance	Yes	Yes	No	No certificate
○ To getting a medical prescription				
○ To getting the treatment for few days	Yes	Yes	Depends on the area, in Wallonia, not often but yes in Flanders	No
○ To informing sanitary unit of the date of release	Only in some prisons (OST)	Yes (except for ART)	Yes, for OST given in a limited number of prisons in Wallonia (naloxone, not available)	No (except naloxone)
○ To getting contact details of professionals in the community			No	
○ To being in contact with professionals in the community before release	No	Yes		No
			No	
	Yes	No	Yes	No

	Yes			No
		Yes		
<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 the pills for few days? 	Prisoner themselves Medical unit Medical unit	Prison registry service Medical unit Given to registry service for day of release (except ART)	Prison director (proof of detention) Medical unit Medical unit	NA Medical unit Medical unit (eight days to one month)
<ul style="list-style-type: none"> Are some professionals or NGOs responsible for continuity of care? <ul style="list-style-type: none"> Funding? 	Yes, for some prisoners in some federal states Ministry of Justice	Yes, one dedicated social worker in every prison since 2010 Ministry of Health	No	No

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 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):
 - How long have you been released from prison now?
 - How many incarcerations have you had?
 - Do you know the total amount of incarcerations you've had, expressed in months?
- Prison journey:
 - 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.
 - 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:
 - What did your housing situation look like before your last period of imprisonment? (*Where did you live? Was it a stable housing situation?*)
 - What does your current housing situation look like?
- Occupation and leisure time:
 - How did you spend your days before you were in prison? (*employment, volunteer work, activities, etc.*)
 - How do you spend your days now?
- Relationships:
 - 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?*
 - Who supported you before you went to prison? And during your imprisonment?
 - How did you keep in touch during incarceration?
 - What kind of support did you get? What did this mean to you?
 - What about that support now? Is it continuing?

- **Health**
 - 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?
 - Are you vaccinated against hepatitis B?
 - 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 now, about the manner of use (*inhalation, snorting, ...*), possible time of cessation of drug use, etc.
- **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 the NPS*)?
 - in ways of using drugs (*injecting, snorting, ...*)?
 - Have you ever used equipment to use drugs in prison?
 - If yes, what (*straw, 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 ones 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 up 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 up 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):**
 - How long have you been released from prison now?
 - How many incarcerations have you had?
 - Do you know the total amount of incarcerations you've had, expressed in months?
- **Prison journey:**
 - 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.
 - 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:**
 - What did your housing situation look like before your last period of imprisonment? (*Where did you live? Was it a stable housing situation, ...?*)
 - What does your current housing situation look like?
- **Occupation and leisure time:**
 - How did you spend your days before you were in prison? (*employment, voluntary work, activities, etc.*)
 - How do you spend your days now?
- **Relationships:**
 - 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?*
 - Who supported you before you went into prison? And during your imprisonment?
 - How did you keep in touch during incarceration?
 - What kind of support did you get? What did this mean to you?
 - What about that support now? Is it continuing?

- **Health**
 - 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?
 - Are you vaccinated against hepatitis B?
 - 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 the NPS*)?
 - in 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?
 - 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 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 with care services before prison, during imprisonment and after release.

- **In general**
 - 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?
 - Do you know if an individual integration plan was ever made?
 - Who did it?
 - Were you involved in it?
 - What did it include?
- **Medical support**
 - Before you entered prison, did you get any medical support in the community?
 - If yes, what and what for?
 - 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?
 - Do you receive any medical support now?
 - Did you have opioid substitution therapy before you entered prison?
 - If yes, what medication and since when?
 - 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*)
 - Are you still on OST?
 - Did you take any other treatments/meds before you entered prison? (*ART, mental health e.g. benzos*)
 - If yes, what medication and since when?

- 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*)
- Are you still taking ... (name of other treatment)?
- 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**
 - Before you entered prison, did you get support from any social service 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 kind 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 into 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 in 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 up 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 up relationships (partners, friends, family members)
 - Avoiding criminal activities
 - If no, what made it hard?
 - How (else) did you prepare yourself, what helped you?
 - What role did your family/partner/other important people play in your release?
 - How could you have been better prepared?
- **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?
- **Experience with community services**
 - 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...*).
 - 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?
 - 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**
 - According to you, what factors help with reintegration? What helped you?
 - What are the obstacles to reintegration?
 - 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 the focus on your release)?
 - Which elements are helpful
 - What could be improved?
 - 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:
 - the changes in drugs when in prison?
 - 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?
 - Does it happen in prison?
 - How?
- Are harm-reduction tools (OST, syringes...) available?
 - 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?*
 - Did this happen in the community (when? just after release?) or in prison?
 - 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?
 - 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/....
 - Is it useful?
 - What else is needed?
- Can you tell me something about the continuity of care:
 - When entering prison?
 - During imprisonment?
 - (Just) after being released?
- Have you received information/advice on harm reduction when entering in prison or at other times during your incarceration (condoms, bleach availability/syringes/sniff tools, naloxone, etc.)?
 - If yes, which one?

Optional questions:

- Would you be in favour of the implementation of prison needle and syringe programmes (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 to the first week)?
 - 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?
 - 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?

Questionnaire for individual interviews with professionals outside prison

e.g. for social workers, psychologists, housing officers working outside prison with (ex-) prisoners

I. Demographic data

- Gender?
- What is your age?
- What kind of support is your organisation offering to (ex-) prisoners?
- What is your function?
- How long have you been working in this function? (*Aim: what is their experience?*)

II. Throughcare (in general)

- Prisoners are entitled to receive the same care inside prison as anyone outside prison. This means there should be continuity of care, not only when entering prison and during imprisonment but also on release. Can you describe to me in your own words what throughcare/continuity of care is? (*Aim: what do they know about throughcare?*)
- According to you, what elements are important in throughcare? Why? (*Aim: what is their knowledge about the importance of throughcare/continuity of care?*)
- In general, what do you think are the main barriers in continuity of care?
 - Do you have any suggestions or have you seen any good examples of how to overcome them?
 - What do you think already works well?
- Do you think there is enough variety in the availability of (support) services to provide effective throughcare? What kind of support is lacking?

III. Collaboration with prison

- What does your organisation think about working with prisoners/hospitalised prisoners?
 - Is it easy to be included?
 - Are there subgroups that are excluded?
- Do you work together with prison staff?
 - If yes, who with?
 - How would you describe the relationship with prison staff?
 - How does the collaboration go:
 - What works well?
 - What barriers are experienced?
 - How can the collaboration with prison be improved?
- How is the continuity of care arranged in practice?
 - How does the referral to your organisation go: (*first let them speak freely, specify when necessary with the questions below*)
 - Is there any contact with professionals working inside the prison (when the prisoner enters/before the prisoner got released)?
 - If yes, at what time (e.g. how after entry, how long before release)?
 - If yes, is the prisoner involved in the contact?
 - If no, how does the (ex-) prisoner reach your organisation?

- Does the prisoner have the opportunity to visit or call your organisation before release?
- If a prisoner already receives some kind of support/treatment from your organisation before imprisonment, how is the continuation of support arranged during imprisonment?
 - What works well?
 - What are the difficulties?
 - How could it be improved?
- If the prisoner receives some kind of support/treatment from your organisation during imprisonment, how is the continuation of support arranged after release?
 - What works well?
 - What are the challenges?
 - How could it be improved?
- Is data about the prisoner shared with your organisation (during imprisonment/after release)?
- Have you experienced some administrative obstacles when working together with the prison?

IV. Release

- What are the challenges on release, especially on the immediate release period?
- How are prisoners prepared for this? (*health care, housing, finances, finding a job/meaningful activity, alcohol/drug treatment, relationships, criminal activities*) (some parts may already have been answered in previous questions)
- Do you have the feeling prisoners get easy access to information about the community services available to them following release?
 - If no, what are barriers according to you?
 - How do you ensure prisoners know about your organisation?
- What else is needed to increase the likelihood of social rehabilitation and integration for prisoners?
- How can community services play a role in it?
- How is the transfer/escorting of the prisoner to your organisation arranged?
 - What already works well?
 - What could be improved?

V. Overdose

- What do you think of the preparation of prisoners in terms of overdosing?
- Does your organisation play a role in the preparation of prisoners in terms of overdosing?
- What would you suggest to improve overdose prevention?
- What do you think about naloxone?

VI. Overall concluding question

- What would the perfect throughcare service for prisoners look like?
- How can better continuity of care be ensured?
 - Which conditions are important for good continuity of care?
 - Which elements should be retained?
 - How can services be improved, with a focus on release and continuity of care?

Questionnaire for individual interviews with professionals inside prison

*e.g. for prison officers, social workers, health care staff, psychologists, educators,...
working inside prison*

I. Demographic data

- Gender? Age?
- What is your role?
- How long have you been working in prison now? And in this role? (*Aim: what experience do they have?*)

II. Throughcare (in general)

- Prisoners are entitled to receive the same care inside prison as anyone outside prison. This means there should be continuity of care, not only when entering prison and during imprisonment but also on release. Can you describe to me in your own words what throughcare/continuity of care is? (*Aim: what do they know about throughcare?*)
- According to you, what elements are important in throughcare? Why? (*Aim: what is their knowledge about the importance of throughcare/continuity of care?*)
- In general, what do you think the main barriers in continuity of care are?
 - Do you have any suggestions or have you seen any good examples of how to overcome them?
 - What do you think already works well?
- What do you think about the monitoring of prisoners once they are released?
- Are throughcare services evaluated inside this prison?
 - If yes, how?
 - If no, why not?

III. Entry in prison

- First, I will ask you a few questions about what is done according to some aspects of care when prisoners enter prison. Can you tell me what is done on entry with regard to:

Medical care:

- Are prisoners screened/tested for HIV/HVC/HBV?
- Do prisoners receive any vaccinations?
- Are some treatments for chronic hepatitis C initiated in this prison?
- Is OST initiated in this prison?
- Is ARV initiated in this prison?
- Are there other meds prisoners can receive on entry?

Psychiatric treatment and psychological care:

- How is a prisoner's mental health evaluated?
- What is done when it's clear the prisoner needs psychiatric or psychological care?

Administration

- Is a needs assessment done?
- What does this include?
- If prisoners have already received some kind of support/treatment in the community (this can be medical, psychological,...), is there any transition arranged in prison?
 - If yes, which services from the community are continued in prison and how?
 - Are there other services that are not continued in prison?
 - If yes, which ones?
 - Why is there a discontinuation?
- Do prisoners get advice on harm reduction when entering prison (or at other times during their incarceration)? (condoms, bleach availability/syringes/sniff tools, naloxone, etc.)
 - If yes, about which?
- Do prisoners have access to tools/clean equipment?
 - If no, why not?
 - What is your opinion about it?

IV. Support in prison

- I am now going to ask you some questions about the support available for prisoners concerning different life areas. In general, for each life area we want to know:
 - 1) What kind of support is available in prison
 - 2) What already works well
 - 3) What is lacking in this support or could be improved
 - 4) If there are any suggestions for improvement
- Topics:
 - Health care
 - 1) What sanitary services are available in prison? Does this include specialised consultations on addiction medicine/HIV/hepatitis?
 - 2) What works well?
 - 3) What is lacking in this support or could be improved?
 - 4) Do you have any suggestions for improvement?
 - Alcohol and/or drug use
 - 1) What kind of support is available in prison with regard to alcohol and drug use?
 - 2) What are the good elements?
 - 3) What is lacking in this support or could be improved?
 - 4) Do you have any suggestions for improvement?
 - Housing
 - 1) What kind of support is available in prison with regard to housing?
 - 2) What are the good elements?
 - 3) What is lacking in this support or could be improved?
 - 4) Do you have any suggestions for improvement?
 - Finances
 - 1) How are prisoners financially supported?

- 2) What are the good elements?
 - 3) What is lacking in this support or could be improved?
 - 4) Do you have any suggestions for improvement?
- **Meaningful activities/jobs**
 - 1) How are prisoners supported regarding finding a job/ having meaningful activities?
 - 2) What is good about it?
 - 3) What is lacking or could be improved?
 - 4) Do you have any suggestions for improvement?
 - **Leisure time**
 - 1) How are prisoners supported regarding their leisure time?
 - 2) What is good about it?
 - 3) What is lacking or could be improved?
 - 4) Do you have any suggestions for improvement?
 - **Relationships (partner, children, family, friends)**
 - 1) How are prisoners supported regarding keeping/developing relationships?
How are partners and family members involved in the support of the prisoner?
 - 2) What is good about it?
 - 3) What is lacking or could be improved?
 - 4) Do you have any suggestions for improvement?
 - **Recidivism**
 - 1) Is there any kind of specific support available for prisoners that supports them in avoiding criminality in the future?
 - 2) What is good about it?
 - 3) What is lacking or could be improved?
 - 4) Do you have any suggestions for improvement?
- a. Are there any other support services for prisoners?
 - b. Which kind of support is still lacking?
 - c. How does the prison deal with specific support for specific subgroups?
 - d. Can you tell me something about access to the services?
What about frequency?
 - e. Does this prison work with peer support in prison?
What's your opinion about it?
 - f. Is there support to the family (outside prison)?

V. Release

- What are the challenges for prisoners on release, especially in the immediate release period?
- How does prison prepare them for this? (*health care, housing, finances, finding a job/meaningful activity, alcohol/drug treatment, relationships, criminal activities*) (*some aspects may already have been answered in previous questions*)
- Is an individual reintegration plan made?
 - When does this happen? (*at the beginning-middle-end?*)
 - To what extent is the opinion of the prisoner taken into account in this plan?
- Do prisoners easily get access to information about the community services that are available to them following release?

- If yes, how?
- If no, what are the barriers?
- What else is needed to increase the likelihood of social rehabilitation and integration for prisoners?
 - How can prison play a role in it?
- I'm now going to ask you some questions about the continuation of treatment after release. For specific topics, we want to know:
 - 1) How continuity is ensured
 - 2) What already works well
 - 3) What could be improved
 - 4) If there are any suggestions for improvement
- Can you tell me something about the continuation of:
 - medical treatment
 - 1) How is the continuity of OST/ARV/Hep C and other meds ensured?
Do prisoners receive OST or ARV treatment for a few days before release (from the prison medical unit)?
 - 2) What already works well?
 - 3) What could be improved?
 - 4) Do you have any suggestions for improvement?
 - Social services
(e.g. drug treatment, psychotherapy, housing services, job services,...)
 - 1) How is the continuity ensured?
 - 2) What already works well?
 - 3) What could be improved?
 - 4) Do you have any suggestions for improvement?
- How are administrative issues arranged (health insurance, other documents,...)?
 - What could be improved?
- How is the transfer of the prisoner arranged?
 - Does this work well?
 - What could be improved?
 - Is family involved in the release of the prisoner?

VI. Overdose

- How are prisoners prepared with regard to overdose?
- What would you suggest to improve overdose prevention?
- What do you think about naloxone?

VII. Staff training

- Do you have the feeling that you have had enough education/training to handle the specific (health) needs of prisoners?
- Are there any workshops/educational sessions,.... organised to support staff with their knowledge and training (to handle the problems of prisoners, to emphasise the problems prisoners are confronted with on re-entry, about throughcare,...)?

VIII. Collaboration (between prison staff/with other services outside prison)

To ensure a good continuity of care, collaboration is essential. Now I will ask you a few questions about collaboration, either between prison staff or with other services outside prison.

- Inside prison
 - With which services do you regularly have to work closely together?
 - How would you describe your relationship with them?
 - What are challenges in the collaboration between the different disciplines inside prison (with a focus on throughcare)?
 - How do you try to overcome those barriers?
- Outside prison
 - With which partners do you have to work closely together?
 - How would you describe your relationship with them?
 - What collaborations with partners are successful and what makes them go so well?
 - What are the barriers that are experienced in the collaboration with staff outside prison (with a focus on throughcare)?
 - How do you try to overcome them?
 - How does the transition from care services in prison to the community work?
 - Which aftercare services are involved?
 - How does referral to these services work?
 - Is there any contact with professionals in the community before release?
 - If yes, is the prisoner involved in the contact?
 - How long before release?
 - Do prisoners benefit from leave to visit professionals in the community before release? Or is there any phone contact?
 - What are the good elements?
 - What could be done better?
 - How is the transfer/escort of offenders to community services arranged?
 - Do other services have access to data on prisoners?
 - Is there a transfer/exchange of data during imprisonment or after release?

IX. Overall concluding question

- What would the perfect throughcare service for prisoners look like?
- How could a better continuity of care be ensured?
 - Which conditions are important for good continuity of care?
 - Which elements should be retained?
- How can services be improved, with a focus on release and continuity of care?