Healthy and Unhealthy Drug and HIV Policies: Harm reduction in England and Italy

Introduction

There are many drug-addicted prisoners both in English and Italian prisons. The Prison Service houses the groups that, probably, are most vunerable to HIV and Hepatitis. The two countries have adopted different approaches to the management of drug addiction.

In England, there have been some worrying signs that the government, in response to drug addiction both in and out of prison, is moving away from a harm-reduction strategy to one of crime control. For example, In 1997–98, 75% of £1.4 billion committed to tackling drug misuse in the UK was spent on law enforcement activity by police, customs, probation and the courts. This compares to just13% spent on treatment and rehabilitation programmes and 12% on education and prevention (Royal College of Psychiatrists, 2000).

There are more than 500 drug-treatment agencies in the community in England and Wales, over half of which are in the voluntary sector. They include needle exchange schemes intended to reduce the transmission of blood-borne diseases such as HIV and hepatitis.

There have been difficulties translating the experience of operating a harm reduction/public health approach to HIV prevention and communicable disease control into the prison system. In the UK women in prison are 13 times more likely to be living with HIV than women in the general population, and men in prison are 4 times more likely to be infected. There is also increasing concern about the prevalence of hepatitis C within the prison system.

It needs to be remembered that, in Italy and England, successful anti-HIV measures, such as safer sex messages, condom distribution and needle exchanges, have been incorporated into the general population politically and socially. However, the prison service has been slow, at least at a political level, to incorporate harm-reduction measures known to have been successful in the community.

Since the mid 1980's in England, needle exchange has been considered an important strand in the strategy to prevent the spreads of HIV, and other blood borne diseases, among those who inject drugs. A harm-reduction approach in the community has operated which recognises the realities of people's lifestyles while, at the same time, seeks to reduce the associated harm of drug injecting. This harm-reduction policy has contributed in large measure to the relatively low prevalence of HIV in England and Wales.

However, harm reduction measures in the prison system have been more difficult to implement. There have always been concerns about prison rules, and the potential to be perceived as condoning or encouraging 'illegal' activity. There are concerns, too, that measures associated with harm reduction present risks to prisoners and staff, for example, the use of condoms to conceal drugs, the use of needles as weapons.

However, there have been some 'moves' to take forward the principles of harm reduction within the prison system, most notably the 'Disinfecting Pilot Project' in 1998 in England and Wales and the continuing treatment of drug addicts by SERT in prison in Italy.

The move to make standards and measures 'equivalent' to those in the community, raise (or re-enforce the need to consider) the question about how far 'equivalence' of harm reduction can be taken within the prison setting.

Further, it could be argued in England, that the various strands of the drugs strategy currently being implemented within the prison system, is actually serving to undermine work to develop and promote harm reduction and health promotion measures within individual prisons.

Having briefly set the scene about harm-reduction, I would like to consider the following four key areas:

- Drug control strategies
- Prevention and harm reduction
- Blood borne diseases
- Through care

1. Drug control strategies

There has been a change in British drug's policy since 1977, when drug policy had a relatively healthy focus with attention being placed on health issues and a tolerant attitude to drug issues resulting in public health success (that is, reduction of risk behaviours). British drug policy has changed following moral panics, which have 'demonised' the drug user coupled with the rhetoric of a 'war on drugs' and the politicisation of drug use.

It is important to look at what is happening nationally and how this then has informed harm-reduction policy in prisons.

Until 1995, the policy on drug misusing prisoners was essentially determined by the guidance manual *Caring for Drug User**s***. The manual was published in 1991 and was primarily concerned with the welfare of the individual drug misuser. A focus on throughcare practices and the development of a multi-disciplinary

approach in the treatment and control of drug misuse were central features of the guidance manual. According to the Advisory Committee on the Misuse of Drugs, ‘a substantial improvement in the quality of services to drug misusers occurred in prisons where the guidance was implemented’.
In 1995, the manual was superseded by the publication of a prison Service Policy and Strategy Document, *Drug Misuse in Prison*. The new prison service strategy proposes the development of local prison strategies which embody policy aimed at reducing the supply of drugs, reducing the demand for drugs in the prison and rehabilitating drug misusers. There should also be measures to reduce the potential for damage to the health of prisoners, staff and the wider community, arising from the misuse of drugs.

The shift between the 1991 manual and the 1995 strategy is marked by the new emphasis on punitive supply controls. *Drug Misuse in Prison,* emphasises that ‘the prison service will not tolerate the presence and use of illicit drugs in its establishments’ and mandatory drug testing remains the centrepiece of this punitive supply-focused strategy.

In Italy a document written by the Department of prison administration in 1992, *Intramural Treatment of Drug Addicted Prisoners and Community Based Measures in Lieu of Imprisonment*, clearly indicates the awareness of the Italian Prison Administration to the need for a preventative strategy to tackle the spread of HIV and AIDS within prison and for more health education. At this time the Italian Prison Department does not officially recognise that risk behaviour does occur within prisons.

Mandatory drug testing

In England, under the mandatory drug testing programme (MDT), 10% of each prison population is to be randomly tested each month.

Most significant are the punitive costs of MDT and the whole security approach to drugs in prison. Prior to the introduction of MDT, far fewer prisoners were sanctioned for drug offences in prison. In 1994, for example, there were just 2,450 such offences recorded by prisons. By 1996, that figure had escalated to 22,423. According to Home Office funded research on MDT in prisons ‘there is little doubt that many prisoners will spend longer in custody, at a significant cost to the prison Service’.

In 1997, 159,000 additional days were served by prisoners because of MDT. Based on a minimum annual cost of £20,000 per prisoner per place it is estimated that the extra prisoner days in custody will cost the taxpayer an additional £7 million annually.

A concern voiced by prisoners, prison workers and some medical and drugs researchers is the potential that MDT has for shifting some prisoners' choice of drug from cannabis to opiates, some of which will be injected, because of the relative lengths of time these drugs remain detectable in the blood stream (MacDonald, M, 1997, Mandatory drug Testing in Prisons, UCE Press).

There is no mandatory drug testing of prisoners in Italy.

Methadone in Prisons

In England at the current time, prison doctors in England, have discretion about prescribing methadone for detox withdrawal. However, there are plans to make methadone more consistently available because of the increase in the number of suicides in prison by addicts. Currently prisoners are prescribed methadone for between one week and ten days, with the norm being five days of reducing dosage only.

The audits in England showed that few of the sample prisons had clinical detoxification procedures or protocols available. While some doctors in some of the English prisons do prescribe in response to withdrawal, there is little consistency in their practices.

In Italy if prisoners have a drug addiction on entry to the prison then blood and urine samples are taken to calculate the correct dosage of methadone. The local SERT is then contacted and they oversee the continuing treatment. If a prisoner comes from another area, the local SERT will contact the SERT in the area where the prisoner comes from and continue the treatment suggested by them. This situation is not the same for migrant prisoners who do not normally have contact with SERT before their imprisonment. The dosage of methadone, and how long it is prescribed for, is decided by SERT. If a prisoner is suffering with withdrawal symptoms, they can detoxify following a therapeutic protocol with SERT within the prison.

As a rule, the medical staff do not commence methadone treatment in the prison to addicts not already known to SERT. The exceptions are for pregnant women, where prisoners are HIV-positive, have heart disease or suffer from psychiatric illnesses. In these circumstances, the doctor can decide to provide methadone to a prisoner.

The methadone treatment that is available depends on individual prisons. In one of my sample prisons there are some prisoners receiving both methadone maintenance and reduction programmes that are controlled by SERT. It is, therefore, possible for a prisoner to be on a methadone programme for the whole of their sentence. The more common approach is that addicts, who are

known to SERT in the community, can continue the methadone treatment prescribed but only a decreasing dose.

In one area, the SERT had a history of using methadone maintenance treatment programmes and argued that a break in continuity of treatment could cause risks to a prisoner. Therefore, an agreement was made with the prison to allow the use of methadone but this protocol has only been in existence since 1994. The prison changed the protocol with SERT in 1998 and now only allows a reduction-methadone programme. The prison staff believe that while a drug-addict is in prison this is the prisoner's chance to stop using drugs. In theory, the prison is a drug-free situation but, in reality, it is acknowledged that this is not always the case.

The prison medical staff provide medical help to control the symptoms of withdrawal. One doctor argued that, outside the prison, withdrawal symptoms are very hard to deal with but in prisons they are not so hard and go more quickly. In another prison, the main prevention strategy is to use drugs for detoxification and then locating prisoners in a drug-free section as a way to stop them using drugs again.

The audits in Veneto region showed that there is a good protocol in place with the local SERT with drug-addicted prisoners in most of the sample prisons that provide methadone programmes and there is detoxification programmes available to prisoners.

What we can learn from the audits in both countries to improve practice in the use of methadone are that:

- a detoxification and maintenance protocol should be developed, which meets the needs of migrant prisoners in Italian prisons;
- a wide range of methadone programmes should be available to prisoners both in Italy and in England.
- detoxification protocols should be developed and reviewed at each prison (particularly in the English sample prisons).

A multi-disciplinary approach

A multi-disciplinary approach in the treatment and control of drug misuse is a central feature of both English and Italian drug strategy in prison. In England the professional groups who normally make up the membership of the multi-disciplinary teams are the prison governor, probation officer, doctor, MDT co-ordinator, Board of Visitors, community agency, chaplain, psychologist, security officer and discipline staff.

The audits in England showed that most sample prisons had multi-disciplinary drug teams with most of the recommended membership. Most prisons in the English sample had a written drug strategy operated via a multi-disciplinary team. Most prisons made available a written strategy. However, few prisons run meetings on a regularly scheduled basis and many took no minutes of meetings for future reference. Few prisons have established procedures for reviewing their strategies and for ensuring consultation on strategies is wide reaching. Few prisons have a timed implementation plan.

All the prisons visited in the Veneto Region said that they operated a drug strategy within the prison using a multi-disciplinary approach. The professionals groups who made up the multi-disciplinary teams differed within the sample prisons. The professional groups who were usually involved were the director, the vice-director (not always involved in all the prisons), the psychologists, medical staff, the educators and a representative from the Local SERT (not present in all the multi-disciplinary teams).

What the audits in the Veneto region showed was that none of the teams included a representative from the volunteers who were working with drug addicts in the prison nor were there any representatives from the prisoners. Most of the volunteers who were interviewed said that they would find it helpful to be involved in the multi-disciplinary group responsible for the formation of the strategy. On the whole, only the senior member from each professional group were involved in the multi-disciplinary drugs team and this could account for the lack of knowledge about the strategy from other staff in the prisons.
Most prisons have a drugs and alcohol protocol established with the local SERT. Most of the prisons had a well-established link with the SERT.

To improve multi-disciplinary practice, the audits of prisons in Italy and England suggest that:

- there should be a written drugs strategy, specific to the prison, made available to all staff;
- supply, demand and harm reduction should be incorporated in to the prison's drugs and alcohol strategy;
- the strategy should be reviewed and evaluated more formally involving a wider group of prison staff;
- membership of the multi-disciplinary team might be extended to include representative from the volunteers working within the prison;
- the multi- disciplinary team should have planned regular meetings (rather than on an *ad hoc* basis);
- consideration should be given to staff training to improve liaison and working practices between the different professional groups involved in drug and alcohol addiction.

2. Prevention and Harm Reduction

Education and information

In England, prisons should provide awareness packs for prisoners at the time of induction that contain prevention and harm-reduction materials. Each prison should have a harm-reduction strategy formulated by the communicable diseases team. There should also be available a range of courses run by trained staff in the area of drugs and alcohol. The general philosophy is to use group work involving interactive techniques.

What the audits have shown is that nearly all the English sample prisons ran some form of education or group work programmes for drug-addicted prisoners that utilise interactive techniques. However, few of the prisons had a comprehensive range of programmes. Staff training and experience in running these programmes varied across the sample prisons. There was some good practice in some prisons. For example, in one prison there were specific programmes that targeted individual prisoners according to need including a course for drug suppliers and a course for cannabis users.

Awareness packs are usually provided for sentenced prisoners but not always for remand prisoners. Some of the sample prisons do not have a communicable diseases team that meets regularly. Access to prevention education materials of any sort is very limited and information is often given at inappropriate times, for example, on induction.

Further, the lessons learned in the community concerning HIV prevention, namely that approaches need to be varyingly applied to be culturally specific to different communities, has not, in the main, been taken up in prisons. Different approaches for men and women, for young people, approaches which reflect racial or religious cultural difference all need to be considered. However, resources and, sometimes, expertise and experience usually conspire to make any approach universal; as though staff were dealing with a homogeneous community.

In Italy the stress is on individual prisoners and their treatment needs. There is no consistent programme of information given to all prisoners about drugs and HIV, information is given to some prisoners, at the time of induction, on an individual basis. Leaflets containing harm-reduction information are available and may be given at the time of induction.

What the audits have shown is that the stress on treatment for individual addicts, which operates in most prisons, works often to the detriment of harm-reduction

and prevention strategies and tends to focus attention on known opiate users and ignores the rest of the prison population. In most prisons, it was evident that a range of staff provided useful information to prisoners about prevention and harm reduction. However, this was done in an *ad hoc* way to individual prisoners, who either asked for information or who were known to be involved in risk behaviours (for example, intravenous drug users) before coming into prison.

As there are no written strategies or specific programmes for harm reduction, professionals working in the prison are constrained in any attempt to inform prisoners about prevention and harm reduction in a consistent, planned way. One member of the staff from one of the sample prisons argued that courses could be provided about prevention and harm reduction for prisoners but the individual approach provided by the medical staff is considered to be more effective.

The educators in other prisons have tried to organise courses about drugs but often there are problems with the availability of guards to escort prisoners to attend such courses. The Attenuated Custody prison in Venice offers a range of programmes that involve group work. There is a strong emphasis on group work within this prison. The psychologist, the SERT and the educators are involved in the group work. It is not always possible for the educators to provide courses due to the shortage of educators. This shortage results in the existing educators having to prioritise their work. In addition, in some prisons, there is a strong belief among the majority of professionals that an individual approach with prisoners is more effective than small-group work.

There were some courses running for drug-addicted or alcoholic prisoners in some of the prisons. For example, there was one structured course for alcoholics, which has been attended by 56 prisoners during the course of the past year. Twelve of the medical staff of the prison were trained to run this course. There were also two projects for drug- addicted prisoners; an art project involving the painting of murals (as mentioned above) and a theatre project at one of the other prisons.with some prisons having none at all. In one prison, there were no programmes specifically for alcohol or drug addiction. The Director of this prison argued that the biggest problem in providing services for drug and alcohol addiction is that the budget is too small to allow the development of specific programmes. The prison is very far from Rome and decisions and budgets coming from Rome may not actually meet the needs of the prison.

It was argued, by some staff, that the policy suggested by DAP does not address the reality of overcrowding in prison. It is not possible, for example, to provide separate sections for drug addicts, sporting activities and courses. Another problem, highlighted by some staff, was that although there is some money available for programmes for drug addicts, such as training courses and specific cultural activities, it is impossible to provide programmes for prisoners

who are only in the prison for a short period of time. Some staff thought that there is very little offered to drug addicts by way of treatment, information or courses and that much more needs to be done in this respect. Prisoners spend a lot of their time doing nothing constructive while in the prison.

In some prisons, the workers who come from SERT are used to provide information, concerning prevention, to prisoners with whom they are working. They give information to the prisoners about the risks of the HIV/AIDS virus at the first meeting. The prisoners are also given leaflets about prevention in some prisons. All the sample prisons have many prisoners who come from other countries and the majority of professionals are aware that the available leaflets need to be translated into other languages.

To improve education and information for prisoners, the audits of prisons in Italy and England suggest that:

- there should be a prevention and harm-reduction strategy formulated and implemented, which addresses the incidence of risk behaviours occurring in the prisons;
- there should be a written prevention and harm-reduction strategy;
- courses, which address prevention and harm reduction, should be supported;
- information needs to be provided in a consistent way (for example, in the form of a leaflet) to all prisoners about risk behaviour while in prison (tattooing, sexual contact and drug use involving needles);
- information and leaflets should be provided in a variety of languages;
- consideration should be given to the development of interactive induction packages that include basic-drug misuse awareness.

Condoms

In England Dr. Rosemary Wool (August 1995) then Director of Health Care in HM Prison Service, wrote to all prison doctors to 'encourage prison doctors to prescribe condoms and lubricants, when in their clinical judgement there is a known risk of HIV infection as a result of HIV risk sexual behaviour'. Dr. Wool cautioned that a failure to make condoms and lubricant available might constitute a breach of the physicians' duty of care.

The guidance, provided through the 'Dear Doctor' letter of 1995, goes some way to at least tacitly accepting that sexual activity does take place within prison establishments. However, the continued lack of a formal instruction leaves the interpretation open about implementation.

In late 1996, the BMA Foundation for AIDS surveyed the availability of condoms in prisons as well as prison physicians' awareness of, and adherence to, the advice given in Dr. Wool's letter. The survey found 'significant obstacles to

condom accessibility' in many establishments, for reasons ranging from 'fear of condoning homosexuality' to the view that condoms were still considered to be illegal 'contraband'. In one establishment, there was a requirement that 'subsequent issues [of condoms] would depend on return of used condoms'. Ex-prisoners have also told the NAPF of delays of over six months between an application for a condom and receiving one.

In July 1998, in response to a Parliamentary Question from Helen Jones, Ms Joyce Quinn, then Minister responsible for prisons, stated:

> Prison doctors are able to prescribe condoms to individual prisoners on application, where, in their clinical judgement, there is a known risk of HIV infection. We have no present plans to make condoms more freely available to prisoners either as part of the pilot project for the reintroduction of disinfecting tablets or generally.

There continues to be ambiguity and ambivalence about the provision of condoms in prisons. Such ambiguity means that condoms are not easily accessible, particularly for men who would not identify as 'practising homosexuals'. Furthermore, prison governors may be fearful of the implications of allowing condoms to be provided even through health care department in their establishments.

What the audits in England have shown is that condoms are available within very few prisons although it is possible for individual doctors or prison Governors to provide them.

In Italy, it is not prison policy to supply condoms to prisoners.

What the audits in Italy have shown is that staff from the Italian sample prisons differed in their opinions about whether to provide condoms as part of a prevention strategy. Some staff think that condoms are not necessary for prisoners because there are single cells or cells only for two people in the prison. Although some members of staff did acknowledged that sexual contact between prisoners occurred, they preferred to ignore the situation because they were against the introduction of condoms. Other members of staff said that there was no need to provide condoms in prison, as there was no sex within prison.

Other staff thought that condoms should be provided to prisoners for prevention and harm-reduction reasons. Although prisoners do not ask for condoms, staff are aware that there is sexual activity in the prison. Prisoners find it difficult to talk about sex but some prisoners have asked to be tested for HIV after being in prison for three or four years. When asked why they want the test they have indicated that they have been involved in risk behaviour. In this situation, the doctors will give the prisoner the HIV test.

On the whole, the doctors interviewed were of the view that condoms should be provided if requested by prisoners. However, Italian law prohibits this as prisons are classified as public spaces so the introduction of condoms was seen as a problem which DAP had to solve before prisons could start to consider the introduction of condoms.

To improve the situation in relation to condoms, the audits of prisons in Italy and England suggest that:

- that harm reduction and prevention needs to be reprioritised with a close examination of how each prison responds to risks associated with injecting drug use and penetrative sex both in the prison and while on leave from the prison (permesso);
- prisons regionally should be pressing for, in Italian prisons, permission to supply condoms. Clarity about existing provision to supply condoms should be sought in English prisons.

Safer injecting practice

In England the Home Office Advisory Committee (July 1995) recommended that disinfectant tablets be made available for prisoners with which to clean injecting equipment. The recommendation was accepted by the Government in Autumn 1995. After an initial decision to issue tablets in 1996, they were almost immediately withdrawn for further testing for health and safety reasons. The London School of Hygiene and Tropical Medicine's *Disinfecting Tablets Pilot Projetc* (1998) recommends that disinfectant tablets should be introduced to all prisons and should be presented as a public health issue and not as relating to discipline and order. The prison strategy should reflect and be harmonious with community approaches. Currently cleansing tablets are available in some prisons. In England, there are no needle exchanges available inside prisons.

The audits in England showed that the tablets were not available in any of the prisons but that there was evidence that information on cleaning injection equipment was available to prisoners in most establishments.

Although, in Italy some needles and syringes have been found in some of the sample prisons and there has been evidence of overdoses in prison, there are no decontaminates inside any of the sample prisons nor is there any information provided about cleaning injecting equipment. There are no needle exchanges available within Italian prisons.

The audits showed that, some staff thought that needle exchanges were a good thing, in theory. However, in practice, they were of the view that the best harm-reduction within the prison is the methadone programmes.

To encourage safer injecting practice, the audits of prisons in Italy and England suggest that:

- the existence of risk behaviour, which is occurring in all of the sample prisons, indicates the need for consistent and effective prevention and harm-reduction strategies in each of the prisons;
- clarification about the issue of decontaminants be sought in the English prisons from the Prison Service. As a first step all the sample prisons should make available information about cleaning injection equipment;
- the issue of providing needle exchanges in prison be explored.

3. Blood-Borne Infections

HIV and AIDS

In England, there are no national guidelines for the treatment of prisoners with HIV and AIDS. The Prison Service argues that there is no need for national guidelines because all prisoners are entitled to the same health care as any other member of the community. Primary care services are provided by the medical officer of health within the prisons, secondary care by local NHS providers. However, there is a world of difference between the theory and the practice. Many prisons have not established links with healthcare specialists in this field. Many are even denying that there are any prisoners with HIV infection. Each prison should have a policy regarding treatment for HIV prisoners.

It has been noted (NAPF, 2001) that prisoners, on transfer, may have their drugs withdrawn, subject to re-prescription by medical practitioners in the new establishment. In one case, there was a delay of two weeks before the prisoner saw the new medical officer during which time their drugs were not available. In another situation, it was reported that drugs were withdrawn as part of a punishment given by an individual officer. Ex-prisoners note that if they disclose their HIV status, particularly about HIV prevention measures, it is likely that they will be moved to another prison. Continuing institutional and individual prejudice contributes to creating disincentives to HIV-positive prisoners to participate in peer education and other health-promotion programmes.

Whilst such cases may be the exception, they are a cause for concern, and possibly a breach of the Human Rights Act.

The English audits showed that in sharp contrast to the experience of Italian Prisons, where prisoners have the same access to treatment as provided in the community, the majority of the English sample prisons had no policy regarding treatment of HIV-positive prisoners.

In Italy, the same treatment that is available in the community is provided for prisoners who are HIV positive. Individual treatment programmes are managed by the infectivologist. The Ministry of Justice pays for the contract with the infectivologist and for the cost of combination therapy. The cost of providing combination therapy is very high and the number of prisoners who are HIV-positive is also high and this raises questions about the continuing financial support for this treatment.

The Italian audits showed that in all the sample prisons it was possible for HIV-positive prisoners to have the same treatment opportunities as is provided by the Health Service in the community. In each of the prisons, there were prisoners who were receiving combination therapy. In some of the prisons, there were some problems with compliance with the therapy regime. For example, in one prison there was not always a nurse available to give the prisoners their pills at the correct time. It was not possible within any of the sample prisons for prisoners to keep their medication with them.

A key issue that needs to be considered is whether it is possible for prisoners to be given the opportunity, while in prison, to take responsibility for taking their therapy. As the life style of many drug addicts is chaotic, it is an important part of combination therapy that prisoners receiving it learn to manage their own therapy to encourage continuing compliance with their treatment after release from prison. Compliance was not seen as a problem in one of the prisons where ten prisoners were receiving combination therapy and only three were experiencing some problems with compliance.

Another problem that was mentioned in one prison about compliance with the therapy was that other prisoners soon realise that an individual is positive when they are seen to be taking so many drugs. The lack of confidentiality has caused some prisoners to refuse combination therapy.

Officially, only the doctor is aware of who is HIV-positive but, in reality, this is not the case. It was possible, in some of the prisons, for prison officers to find out who is HIV-positive when, for example, a prisoner requests to see the infectivologist. Prison officers working in the infirmary may also pass on information about HIV-infected prisoners and sometimes prisoners will disclose their own HIV status. The breach in confidentiality can result in prejudice against the prisoner, both from other prisoners and from staff. Indeed some members of staff felt that there were some ‘problems’ between prisoners directed against those who had AIDS.

The majority of professionals working with drug-addicted prisoners considered that they had not had sufficient training about HIV/AIDS and drugs. There was a strong commitment, among the staff interviewed to attend more courses. They wanted to update their knowledge of HIV/AIDS and drugs and to develop other

areas, such as, multi-disciplinary teamwork, working with female drug addicts and drug use in migrant communities.

Some members of staff were of the view that they did not understand the different cultures of migrants and needed to link with experts who know about these different cultures. This lack of knowledge was thought to hinder treatment relationships. Due to the high number of non-European prisoners in the prison, it was suggested that a course, that looked at the issues raised about motivation and drug use in migrant communities would be very helpful.

To improve practice around HIV and AIDS, the audits of prisons in Italy and England suggest that:

- practices be implemented that guarantee prisoner confidentiality;
- practices be implemented that ensure prisoners are able to access their treatment at correct times;
- strategies be considered that will enable prisoners to take responsibility for their own therapy to help compliance after release from prison;
- each English sample prison should consider their response to HIV-positive prisoners. That the resource issues raised by offering combination therapy are discussed with Local Health authorities;
- the precise training needs of the prison staff should be evaluateed to take into account the changing nature of the prison population**;**
- there should be a 'refresher' course to update the HIV/AIDS training provided in the past.

Hepatitis

In England, there should be a policy in each prison that covers blood-borne infections. The English audits showed that about half the English sample prisons had a policy on blood-borne infections.Staff working within the prison should have access to vaccinations against hepatitis and Hepatitis B vaccinations should be available to all prisoners following medical assessment.

The audits showed that the opportunity to have the Hepatitis B vaccinations for staff or prisoners was lacking in most of the prisons.

At the current time there did not appear to be a policy about treatment for Hepatitis C in any of the sample prisons in England.

In Italy, there are campaigns to encourage staff to have the Hepatitis B vaccination. Prisoners, in most of the sample prisons, were also provided with the vaccination on request after suitable tests.

The Italian audits showed that in all but one of the sample prisons the prison police are encouraged to have the Hepatitis B vaccination, usually via specially

run campaigns. The uptake of the opportunity to have the vaccination was as high as 66% in one of the prisons and, at the other extreme, only one or two staff availed themselves of the vaccination in another of the prisons.

Prison guards at one prison raised concern about the risk of contacting TB within the prison. In one prison, Hepatitis C was considered to be a problem. At the current time there did not seem to be a policy about treatment for Hepatitis C in any of the sample prisons.

The policy of offering the Hepatitis B vaccination to prisoners differed in the sample prisons. In one prison, all drug-addicted prisoners are offered the vaccination at the time of initial medical assessments. Ideally, the course of vaccinations should be finished while prisoners are still in the prison. In one prison, the doctor has links with some services in the community, where the course of injections could be finished if the prisoner is released. In another of the prisons, the medical staff said that they would vaccinate prisoners for Hepatitis B if requested. However, they do not advertise the availability of the vaccination to prisoners in any proactive way.. In one prison, all prisoners were told about the possibility of having the vaccination not just those known to be drug addicts. Some of the medical staff interviewed considered that they needed to better inform prisoners that the vaccination is available.

There are some problems about who should pay for the blood assessments before the vaccination. Prisoners, who are not ill, have to pay for the assessments in one of the prisons. This causes problems for migrant prisoners in that prison as the are not able to pay for the blood assessments. However, in one of the other prisons there is a policy to give the migrant prisoners the money for the assessments from the prison budget.

To improve practice around hepatitis, the audits of prisons in Italy and England suggest that:

- all prisoners should be informed about the possibility of having the Hepatitis B vaccination not just drug-addicted prisoners;
- the extent of Hepatitis C amongst the prison population should be monitored and the treatment requirements for Hepatitis C should be evaluated;
- there should be an education campaign for both prisoners and prison staff which focuses on Hepatitis C.

4. Throughcare and links with the community

In England there should be sentence planning for prisoners in all prisons which include assessment for follow up treatment after release. This involves referrals being made to outside agencies and this should be available to all prisoners prior to their release. Each prison should have systems in place with which to monitor *CARAT* (Counselling Assessment Referral Advice Throughcare) throughcare arrangements.

The treatment component of the MDT strategy is being met by the introduction of the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) strategy that was introduced in 1999. The CARAT initiative is a multi-agency approach to tackling drug abuse in prison and it also has the aim to co-ordinate support for prisoners after release. The stated aims of the CARAT service is to:

- identify drug misusers as soon as possible;
- provide ongoing support and advice throughout their time in prison;
- work in conjunction with agencies inside and outside the prison to ensure prisoners are properly assessed and directed to the most appropriate intervention to tackle their problem;
- link the various departments and agencies that deal with prisoners in order to provide continuity between treatment in prison and that available on release.

It would appear that the CARAT initiative has several limlitations. First, it does not address lifestyle issues, opting for abstinence alone rather than a combination of harm reduction and abstinence measures. Second, it appears that CARAT contracts have not been designed to—take account of issues relating to communicable disease control and management. Third, it does not ensure that workers are HIV and Hepatitis aware/ or educated. Fourth, CARAT contracts do not take account of the learning from previous initiatives most notably about a multi-disciplinary approach to HIV prevention and management.

Although the CARAT initiative is at an early stage of its development regarding HIV and other communicable disease prevention, it is of some concern that these issues do not appear to be addressed as part of the design of the programme.

The English audits showed that in the sample prisons, sentence planning is in place and is successful at identifying prisoner needs in most prisons, although many of the identified needs cannot be met. Referrals to outside agencies before release are inconsistent across the sample prisons. In some of the English sample prisons the staff responsible for sentence planning were unaware of services already available within their own prison and generally unaware of provision in other prisons. This indicates a need for better communications both within prisons and between prisons. The needs of

prisoners, identified by sentence planning, continue to outstretch resources in the prison. The arrangements made by the CARAT worker in most prisons were not monitored.

In Italy, there are links with the community, with SERT and healthcare and a variety of outside agencies. There is not a national policy so provision is inconsistent across the prison estate.

The Italian audits showed that most of the sample prisons agreed there had to be good links with outside agencies. However, it was pointed out that it is easier to continue with treatment started in the community in the prison than it is to continue with treatment started in the prison when the prisoner returns to the community. Some staff thought that more work needed to be done to make links with organisations in the community. However, they also emphasised that building these links is a slow process.

The experience of making outside links is seen as mostly positive and sometimes the relationship depends on personal contacts with the various professionals involved.
Links with outside agencies were seen by most as generally good. There are good links with the workers who come from the SERT to the prison. The aim of the SERT inside the prison is to continue the link with all the drug-addicted prisoners during their time in prison and when they leave. Drug addicts receiving treatment from SERT will continue to receive this treatment after release from prison.

Not all the prisons had a good working relationship with the SERT. For example, in one prison, although there is a formal protocol with SERT there is not a good working relationship in practice. One member of staff from the prison has worked hard to form good working relationships with SERT in order to put into practice the formal drug treatment convention. Individuals from SERT have meetings with the drug-addicted prisoners but the workers from SERT are not linked with the professionals working within the prison. Overall, there are considered to be good therapeutic links with the community with various specialist consultants in most of the sample prisns.. These links have been built up over time. The prison and the community has good links that develop continuity of services with SERT, psychiatric services and hospitals who have specialist facilities to treat those who are HIV-positive or who have AIDS.

There are several voluntary agencies that provide drugs or alcohol services in the community and who also work with prisoners. There are some volunteers working within most of the prisons who are also involved with therapeutic communities. These volunteers provide a useful link with the community.

In one of the Italian sample prisons there is a project run by volunteers that works specifically with prisoners who are HIV-positive. In this prison there is a

section that caters specifically for prisoners who are HIV-positive or who have AIDS. This section is organised by a project called ‘Prometeo’.

The aims of the Prometeo Project are to create a regime within the prison that will prepare prisoners with HIV/AIDS to go back into the community. To do this, the section in the prison has been designed to offer an environment that is conducive to rehabilitation where prisoners have the opportunity to discuss personal problems especially problems of relationships. The programme also encourages self-respect, understanding and confidence amongst the prisoners. It is considered to be useful to have a support group especially for people with AIDS, as they tend to be excluded by other prisoners. On this section, prisoners are out of their cells from 8 am until 8 p.m. Not all the prisoners in this section are HIV-positive, some prisoners have volunteered to be in this section to live and work. This project has been successful because the volunteers are well integrated into the prison and attend the multi-disciplinary drugs and related communicable diseases meeting.

In some of the Italian sample prisons there are volunteers who work particularly with non-Italian national prisoners, for example, one volunteer is connected to the Centre for Immigrants in the local community. She works especially with foreign prisoners who have no one to help them. It is considered not to be possible to meet all the needs of the non-Italian national prisoners because there are so many of them.

Another group who work with non-Italian nationals is African Insieme whose workers understand different cultures, for example, Islam. The workers from this organisation work with staff working in the prison and make the link with the community for the prisoners.

Working in prison as a volunteer can sometimes be a frustrating experience. There is a particular group of volunteers called NAGA who work in one of the sample prisons with foreign prisoners. They work in all the sections of the prison trying to meet the primary needs (no lawyers, no clothes, no soap, etc.) of the non-Italian national prisoners. The volunteer made the point that the organisation focused too much on practicalities helping one person but not confronting the problem of non-Italian nationals in prison. Working with these prisoners can be frustrating as a volunteer, for example, often the prisoners ask them to find a job for them within the prison and the volunteers cannot do anything about this. These prisoners also do not normally speak Italian and the volunteers have to find other prisoners to translate for them. Generally, this group cannot offer a link with services in the community after release, because there are very few services for non-Italian drug users and because the activity of the group outside the prison is not focused on the help the ex-prisoners require.

In other detailed research of an English prison, undertaken by the author, there was a tendency for both prison staff and prisoners to undervalue the work of outside agencies and volunteers. For example, although prisoners indicated that they viewed 'outside workers as trustworthy' but agreed that workers from outside agencies did not spend enough time in the prison. Agencies, for their part, found it difficult to find confidential rooms on the wings in which to talk to prisoners who had requested to see them. The agencies also felt that there were some problems of co-operation from officers on some wings in the prison. The study suggested that prisons need to value outside agencies as having a different perspective to offer and not expect them to work in the same way as prison staff. Prisons need to be clear about what they want from the outside agency and to consider how this service will work within the prison and, to facilitate this, the outside agencies should be involved at the planning stages. The prison needs to teach the outside agencies about the prison environment to enable them to work as effectively as possible in prison. Issues about security can be overcome, for example, by requesting outside agencies to attend security awareness training. Prisons should be aware that good services cost money, paying for services brings the benefits of having control in what services you get. For their part, agencies need to be aware that changes within the prison culture is a slow process.

To improve continuity of care and practice when working with outside agencies, the audits of prisons in Italy and England suggest that:

- continued effort is made to build links with organisations in the community such as the Health Services and SERT to provide prisoners with continuity of care when they leave prison;
- particular attention should be paid to establishing links in the community that meet the needs of migrant prisoners with drug or alcohol addiction.

Conclusion

The above discussion has revealed that there are still a significant implementation gap in the delivery of policy within the sample prisons both in Italy and in England. Basic harm-reduction measures, such as needle exchanges, are not available in either country nor is there any intention in the near future to introduce them. Condoms, which are available in theory in English prisons, are in reality still very difficult to access. Condoms are not available in Italian prisons at all, nor are they likely to be in the near future. Combination therapy, while available for Italian prisoners is not available for English prisoners in a consistent way. Nor is information, leaflets or courses for prisoners, which address risk behaviour while in prison, provided in a consistent way to all prisoners.

Although there are a number of innovative strategies and projects operating within the sample prisons there is still room for improvement in both countries. There needs to be a commitment to invest in consistent provision of harm reduction materials which target the whole prison population. In order to provide continuity of care links with the community should be improved and encouraged.

This summary has highlighted some of the current problems that the sample prisons are facing. While individual prisons are able to change and instigate new practices and policies some are bound by external constraints. For example, in Italy, the introduction of preventative measures such as condoms and decontaminates into the prisons demand a policy shift and official recognition, from the Prison Department in Rome, that risk behaviour does occur within prisons.

In addition, the extent of overcrowding in most of the sample prisons is again in the hands of national criminal justice policies. Overcrowding places strains on staff and reduces the amount of constructive activity available to prisoners and the effective implementation of policies for drug and alcohol addiction.