The Role of Social Work in Total Institutions

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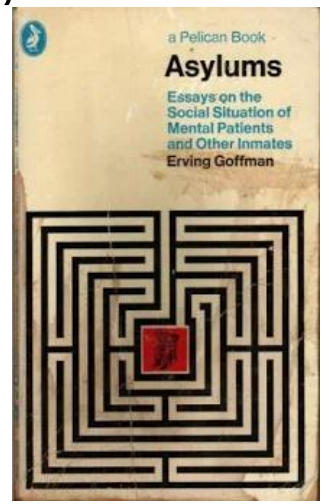
Total Institutions[1]

- *Asylums* is an analysis of life in "total institutions" - closed worlds such as **prisons**, army training camps, naval vessels, boarding schools, monastaries, nursing homes and mental hospitals, where the inmates are regimented, surrounded by other inmates, and unable to leave the premises
- It describes what these institutions make of the inmate, and what he or she can make of life inside them.



1 Goffman, E.: Asylums

Health Social Work in Total Institutions (1/2)

- Social workers in criminal justice settings often **assess new arrivals to the prison**, develop treatment and support plans for prisoners, provide individual therapy and psychosocial educational support groups, provide referrals to medical or mental-health services, and monitor the progress and compliance of prisoners in treatment.
- The social worker **provides a safe emotional climate in which prisoners can express and verbalize them and** provides information

Health Social Work in Total Institutions (2/2)

- to assist people living in prisons by helping them cope with issues in their everyday lives, deal with their relationships, housing problems, and help solving personal and family problems.
- Develops professional relationships
- Able to assessing and managing risks
- Provide information
- Empower people
- Dare to challenge the abuse of human rights
- Maintain confidentiality – not in illegal acts
- Create self-awareness in professional services.

The Nelson Mandela Rules:

Rule 24

1. The provision of health care for prisoners is a State responsibility.

Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

The Nelson Mandela Rules:

2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.

UNODC/ILO (2012): HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions

HIV-Prevention – The Comprehensive Package: 15 Key Interventions

(UNODC/ILO/UNDP/WHO/UNAIDS 2012)

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

[1]UNODC/ILO (2012): HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions

HIV/HCV-Prevention – The Updated Comprehensive Package

(UNODC/ILO/UNDP/WHO/UNAIDS 2012)

[1] UNODC/ILO (2012): HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions

1. Drug dependence treatment, e.g. Opioid Substitution Program: evidence, obstacles, and progress

People Who Inject Drugs and Infectious Diseases in prisons[1]

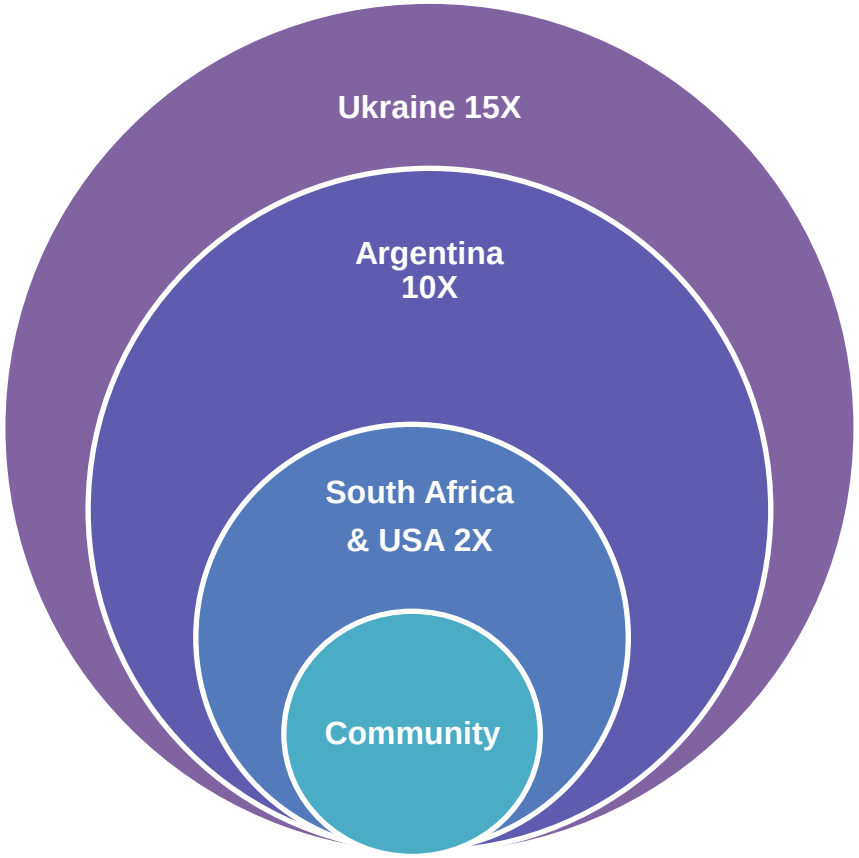
- Unprotected sex,
- multiple sexual partners,
- low and inconsistent condom use,
- intravenous drug use incorporating the
- sharing of syringes, needles and drug use paraphernalia,
- tattooing and body piercing

are among the principal drivers of the global HIV epidemic[4].

1 Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. Lancet Infectious Diseases. 2009;9(1):57–66.

People Who Inject Drugs and Infectious Diseases in prisons[1]

- HIV, STI, hepatitis B&C and TB prevalence **2 - 15 times higher**
- TB incidence rates **23 times higher**



1 UNAIDS Gap Report 2014

The case of Germany: „Druck-Study“ Robert-Koch-Institute/Germany: Imprisonment[1] n=2,077

81% [79.1-82.5] have been incarcerated*

average duration in prisons: 5 years, median 3,5 J; (1M – 30 J)

on the average 5,6x inprisoned

30% [27.3-31.7] of those ever incarcerated injected while in prison

11% [8.2-13.8] of those ever incarcerated and injected while in prison started their intravenous drug use in prisons

1 Zimmermann, R. et al. (2014): Ausgewählte Ergebnisse der DRUCK-Studie für die Praxis. 6. Fachtag Hepatitis C und Drogengebrauch Berlin, 23.10.2014

European Court of Human Rights in the case of Wenner vs. Germany: OST!

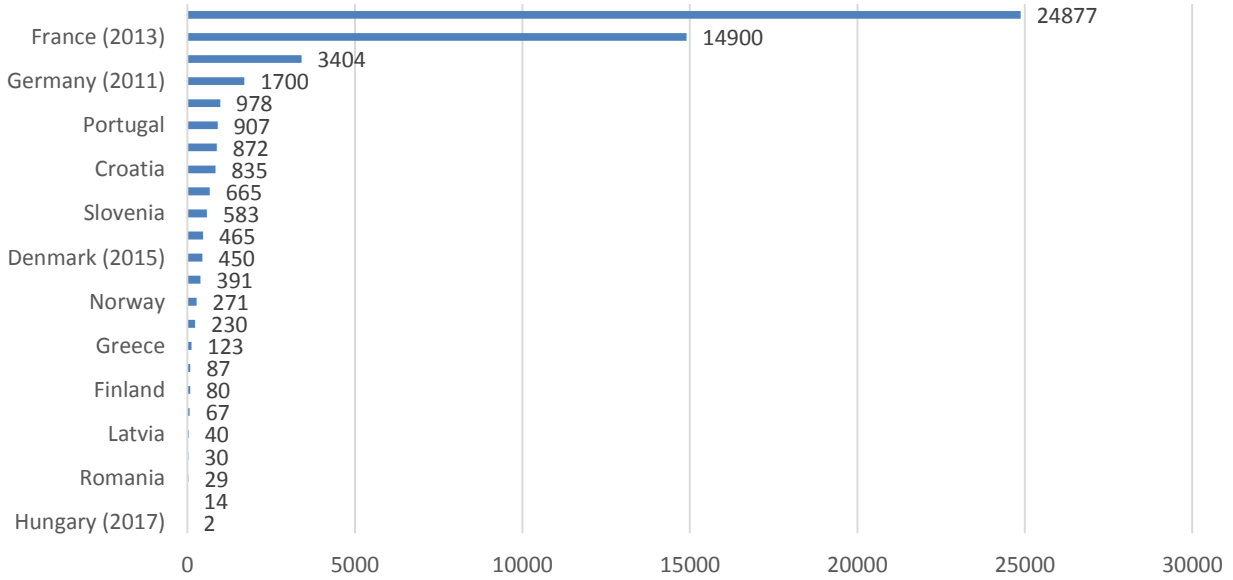
- manifest and long term dependence to opioids
- denial of opioid substitution treatment (OST) in Bavarian/German prison
- The Court found that the physical and mental strain that Mr Wenner suffered as a result of his untreated or inadequately treated health condition could, in principle, amount to inhuman or degrading treatment.
- the failure to adequately assess Mr. Wenner's treatment needs involved a violation of the prohibition of inhuman or degrading treatment
- **Law more powerful than science!**

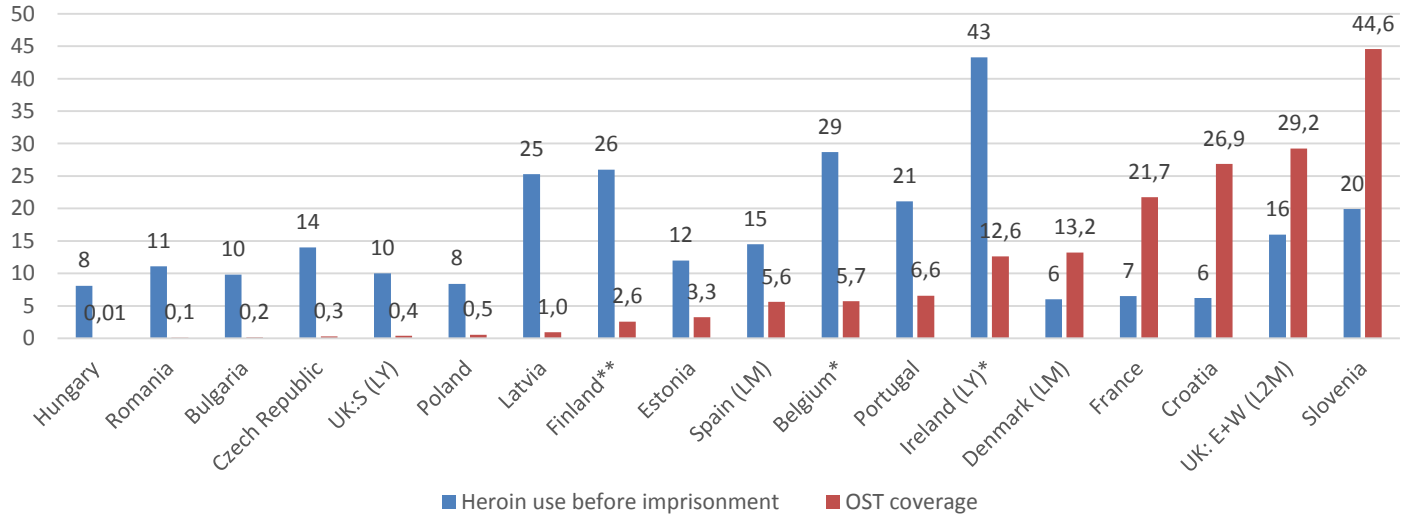
OST in European Prisons[1]

Number of inmates in OST in 2016

Total= 52 000 prisoners

(data of 24 countries)





Prevalence (%) of heroin use before imprisonment among prisoners and percentage* (%) of prisoners being on OST in 2016/2017 by country

- N of OST clients divided by N of prisoners based 2016 SPACE stock data
- **1** Stöver et al. 2021

Treatment for drug users in prison: EU and national policy framework[1]

Political documents of reference:

- Council Resolution 2002 on drug treatment in prison
- 2004: European Parliament recommendation on the Rights of Prisoners in the EU
- 2 EU Drug Strategies 2000- 2012 and 2013-2020:
- Corresponding 4 years EU Drugs Action Plans

Two Principles: equivalence and continuity of care

National policies

- Historically health care within the Ministry responsible for prison
- Prison health under Ministry of Health (FR, IT, SI,UK,NO,SE,SP-ongoing)
- Mixed model: supervision by MoH (Croatia)

Plans:

- 12 countries with prison health objectives in national drugs strategy
- 9 countries cover drugs in their prison health strategies

1 EMCDDA

Problems of implementation I[1]

- Available in all countries except 2 (GR, SK)
- Large variability in coverage
- Not available in all prisons
- As maintenance treatment or detoxification
- Methadone (~70%), and buprenorphine (~30%)
- Provided by external providers
- Mainly used as continuation from community - 8 countries possible to initiate (AT, EE, FIN, FR, GE, LU, SI, SP)

1 EMCDDA: Linda Montanari 2017

Problems of implementation II[1]

- Percent of prisoners receiving OST:
  - >10% in 7 countries; 3-10% in 9 countries; <3% in the other countries
- Rarely with psychosocial interventions (e.g. SP: 20% - Integrated Drug Treatment System in England)
- Variable doses: e.g. LU: 21 mg per 140 days – RO 100 mg
- Increasing OST provision, but still low in prison
- Distinction between formal guidelines/recommendations and actual implementation
- Little information available

1 EMCDDA: Linda Montanari 2017

Systematic OST review of prison[1]

- Review of 21 studies (incl. 6 RCTs) shows that OST is effective among the prison population:

++ reduced heroin use, injecting and syringe-sharing in prison, if doses adequate;

++ increases in treatment entry and retention after release;

++ post-release reductions in heroin use;

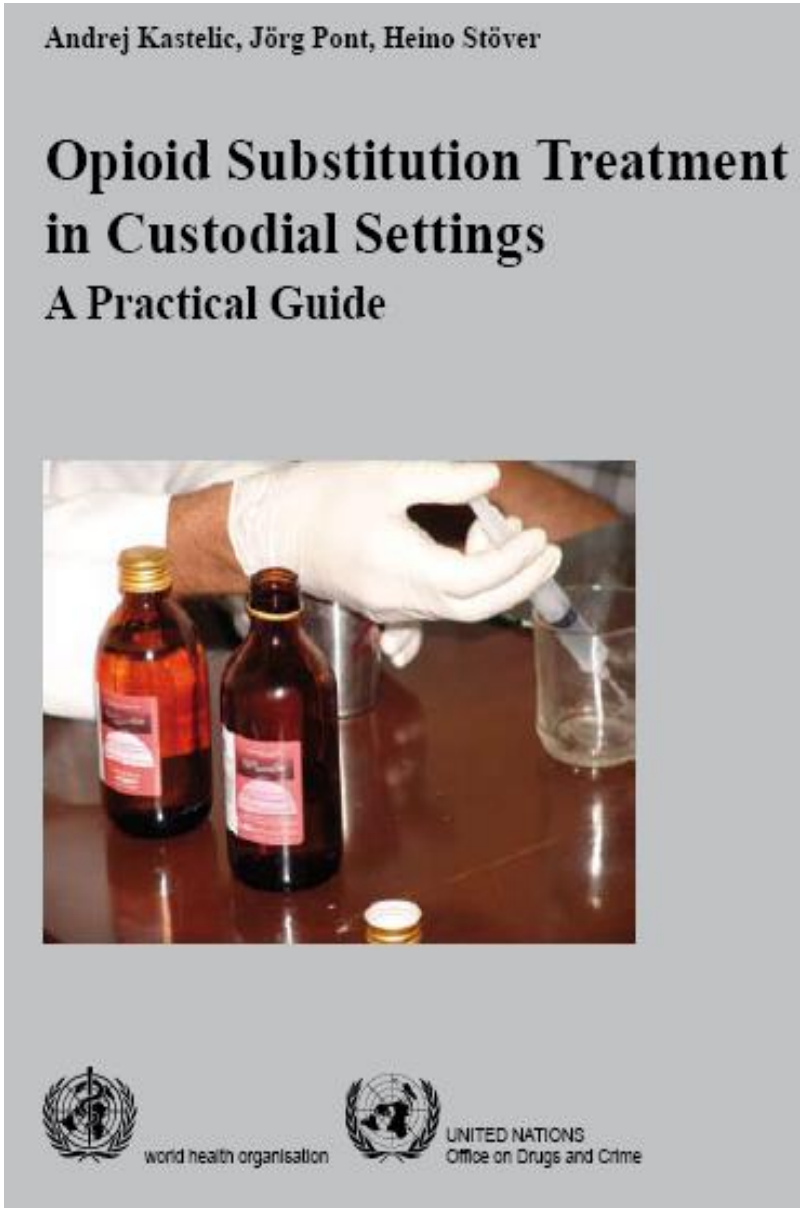
+ pre-release OST reduces post-release deaths;

+/- evidence regarding crime and re-incarceration equivocal;

? lack of studies addressing effects on incidence HIV/HCV;

Disruption of continuity of treatment, especially due to brief periods of imprisonment, associated with very sigificant increases in HCV incidence.

1 Hedrich et al. 2012; Addiction



Adopted to the national situation and translated into several languages (e.g. Russian)

Progress?
30y OST in European prisons[1]

- Coverage still low
- Detoxification models heterogenous
- Maintenance varies
- OST as relapse prevention only in few countries
- OST provision in prisons varies

- from country to country,
- from region to region,
- from prison to prison,
- from doctor to doctor within the same prison

1 Stöver/Casselman et al. 2006

Ostacles: Why is the introduction of OST going so slow[1]?

- Abstinence predominant concept
- Juridical concerns
- Lack of knowledge
- Lack of infrastructure
- Mixing up OST medications with street drugs by staff and medical doctors
- Political reasons

1 Stöver et al. 2020

Conclusions

- Prison-based OST is a highly effective means of treating opioid use disorder
- OST is a starting point and stable therapy for treating other disorders and infectious diseases
- Highly effective of **reducing the risk of death** (75% reduction) among people in the first 4 weeks after release from prison.

Roles and responsibilities of prison staff and health care workers

Roles and responsibilities of medical staff[1]

- OST a treatment like any other
- State-of-the-art treatment and drug provision
- Daily supervised intake of methadone
- Urine controls
- Documentation
- Doctor-patient-relationship
- Ongoing communication

1 Kastelic, Pont, Stöver 2008

Roles and responsibilities of security staff[1]

- No discrimination or stigmatization!
- Daily guidance to the medical unit
- Understanding the philosophy of OST

1 Kastelic, Pont, Stöver 2008

Roles and responsibilities of health care staff and social worker[1]

- OST and psycho-social care
- OST as a basis for further planning
- OST and throughcare
- OST and rehabilitation

1 Kastelic, Pont, Stöver 2008

Social Worker to organise referral and to initiate self help groups[1]

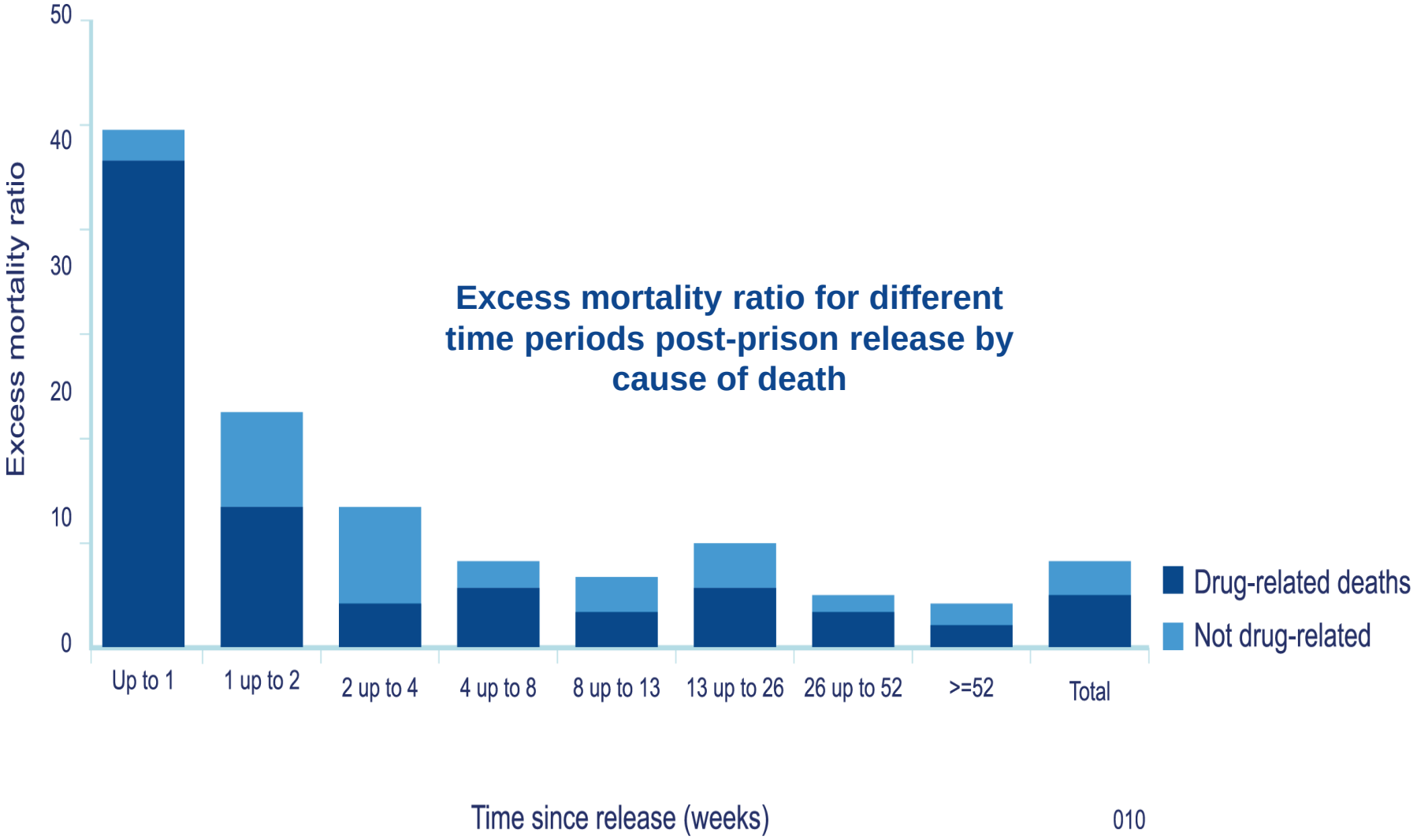
- “Therapy instead of punishment”
- AA, NA
- “Prison-based therapeutic communities – a comprehensive staff training course[1]

1 available via Pompidou Group

2. Social Work and Drug-related Death (DRD) after release from prisons

Epidemiology and interventions

https://harmreduction.eu/projects/my1st48h



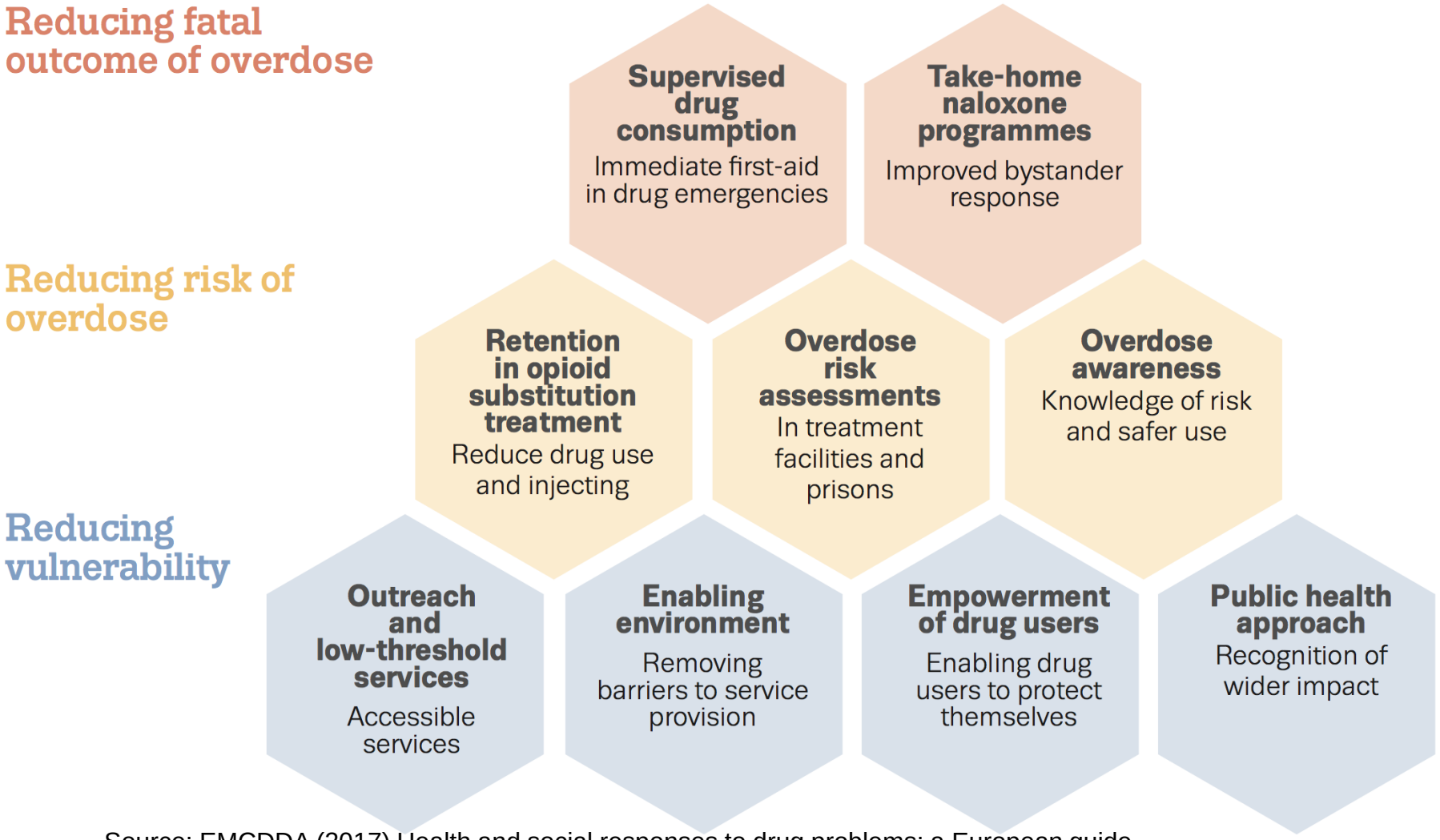
Adapted from Singleton N, Pendry E, Taylor C, et al. (2003): Drug-related mortality among newly released prisoners. London: *Home Office Research, Development and Statistics Directorate* (Report No. 187).

High mortality after release from prisons

- England/Wales (first week): X 29 (M) X 69 (F)
- Denmark (first two weeks): X 62 (M/F).
- France (first year): X 24 (M 15-34); X 274 (M 35-54)
- Ireland: Comparison of drug-related deaths (DRD) with and without prison experience:
  - 28% of DRD one week after release
  - 18 % of DRD one month after release

Source: 2012 Selected Issue; TBC: Baussano, 2010; Psychiatric disorders: Palijan, 2009

Interventions to reduce opioid-related deaths

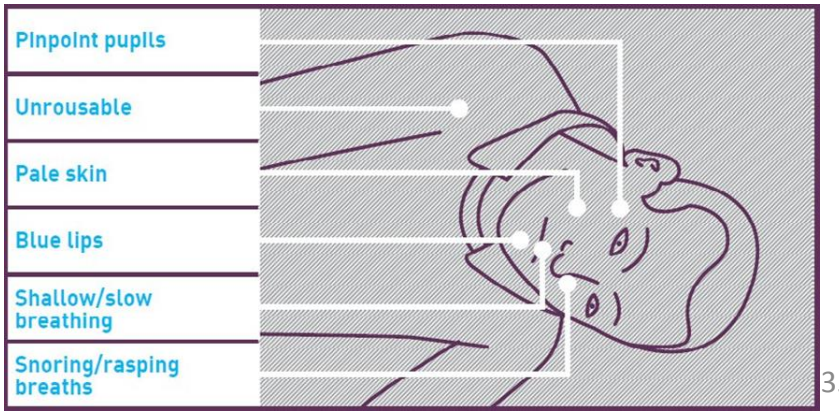


Source: EMCDDA (2017) Health and social responses to drug problems: a European guide.

Available in English and French, soon in German, Czech

High mortality after release from prisons

- …
- The Scottish Model
- Implementation Guidance
- Naloxone Training
- Top Ten Tips for Naloxone Programmes
- Implementation Checklist
- …



Naloxone into the hands of those most likely to witness an overdose!

- There are often several hours between the overdose and the death
- The person is likely to have had a previous non-fatal overdose
- A combination of drugs have been taken
- Witnesses are present
- The person is an older (35-44 yrs) drug user with a long history of problematic drug use
- The person is not in treatment, but in a large number of cases has been in treatment within 6 months prior to their death

Procedures and methods

- Training often delivered 6 weeks prior to liberation, in combination with other pre-re- lease programmes
- Release Day: THN-Kit is provided
- Staff Training
- Peer Education =>

Stöver et al, Naloxone-on-Release Guidelines for naloxone provision upon release from prison and other custodial settings http://www.sdf.org.uk/wp-content/uploads/2018/07/My-first-48-hours-out-Guidelines-for-naloxone-provision-upon-release-from-prison-and-other-custodial-settings.pdf

Procedures and methods

- Increase the availability of naloxone to people likely to witness an overdose after release
- Increase awareness of the signs of an overdose and equip people to respond effectively
- Inform policy makers of the benefits of naloxone-on-release from prison

Stöver et al, Naloxone-on-Release Guidelines for naloxone provision upon release from prison and other custodial settings http://www.sdf.org.uk/wp-content/uploads/2018/07/My-first-48-hours-out-Guidelines-for-naloxone-provision-upon-release-from-prison-and-other-custodial-settings.pdf

Prison Peer Education THN - delivered by prisoners (1/3)

- Promote the training for trainers well in advance
- Provide a named member of staff as the regular contact for all peers
- Provide regular support sessions and progress meetings with peers
- Have all staff involved at the beginning of setting up a programme, i.e. prison staff, health staff etc.
- Incentivise the training for prisoners
- Allow all prisoners to apply for a place on the programme

Prison Peer Education THN - delivered by prisoners (2/3)

- Promote brief interventions to deliver training (10-15 minutes)
- Have an internal communication strategy i.e. Prison magazine, radio, TV Channel.
- Recruit long term prisoners, who will be around for a while
- Engage prisoners who may already have a reputation or influence in the pris- on estate (they are your motivators to other prisoners for the programme to be successful)

Prison Peer Education THN - delivered by prisoners (3/3)

- Proper recognition for individuals who are involved in delivering training, should be celebrated and encouraged
- Create naloxone posts for prisoners as their prison job
- Ensure peer educators have a clear structure to provide details of prisoners
- trained to the staff who will place the naloxone in their belongings

Top Ten Tips for Naloxone Programmes (1/6)

1. Make ‘training’ brief

A quick ten minute conversation is enough to provide someone with the basic skills to save a life. Never underestimate the potential outcome of a brief intervention!

2. Don’t tell someone to come back at a later date, just get it done!

Opportunistic conversations while you have the person there in front of you can be the difference between life and death. You don’t know if you’ll ever see this person again, make sure they’re equipped!

Top Ten Tips for Naloxone Programmes (2/6)

3. Make sure the training and supply happens in the same place

Your programme will be much more successful if you can physically hand over the naloxone after the training. Adding in additional steps may mean many people do not end up with a supply.

4. Involve peers!

Peers have instant credibility among the target group and hugely enhance the rate of distribution, particularly when they are also enabled to make the supplies.

Top Ten Tips for Naloxone Programmes (3/6)

5. **If someone refuses naloxone from you, you're doing something wrong. Change your message.**

The key part of any programme is about relationships. If you can show someone that you genuinely care about whether they (or their friends) live or die, then no-one will refuse the offer of naloxone from you.

6. Be creative, don't expect people to come to you

Outreach! Go to where the people are, or the services they frequent, and don't rely on an appointment-based programme.

Top Ten Tips for Naloxone Programmes (4/6)

7. **Prioritise the supply to people who use drugs**
People who use drugs are most likely to witness an overdose. This should always be where the most effort is placed

Top Ten Tips for Naloxone Programmes (5/6)

8. **Make sure everyone on opioid agonist treatment has a supply**

Everyone you see on OAT should automatically be receiving a supply. You are providing a powerful opiate, you should also provide the antidote. (Yes, treatment is a protective factor but this is about ensuring coverage and makes sense for it to be normalised in this way).

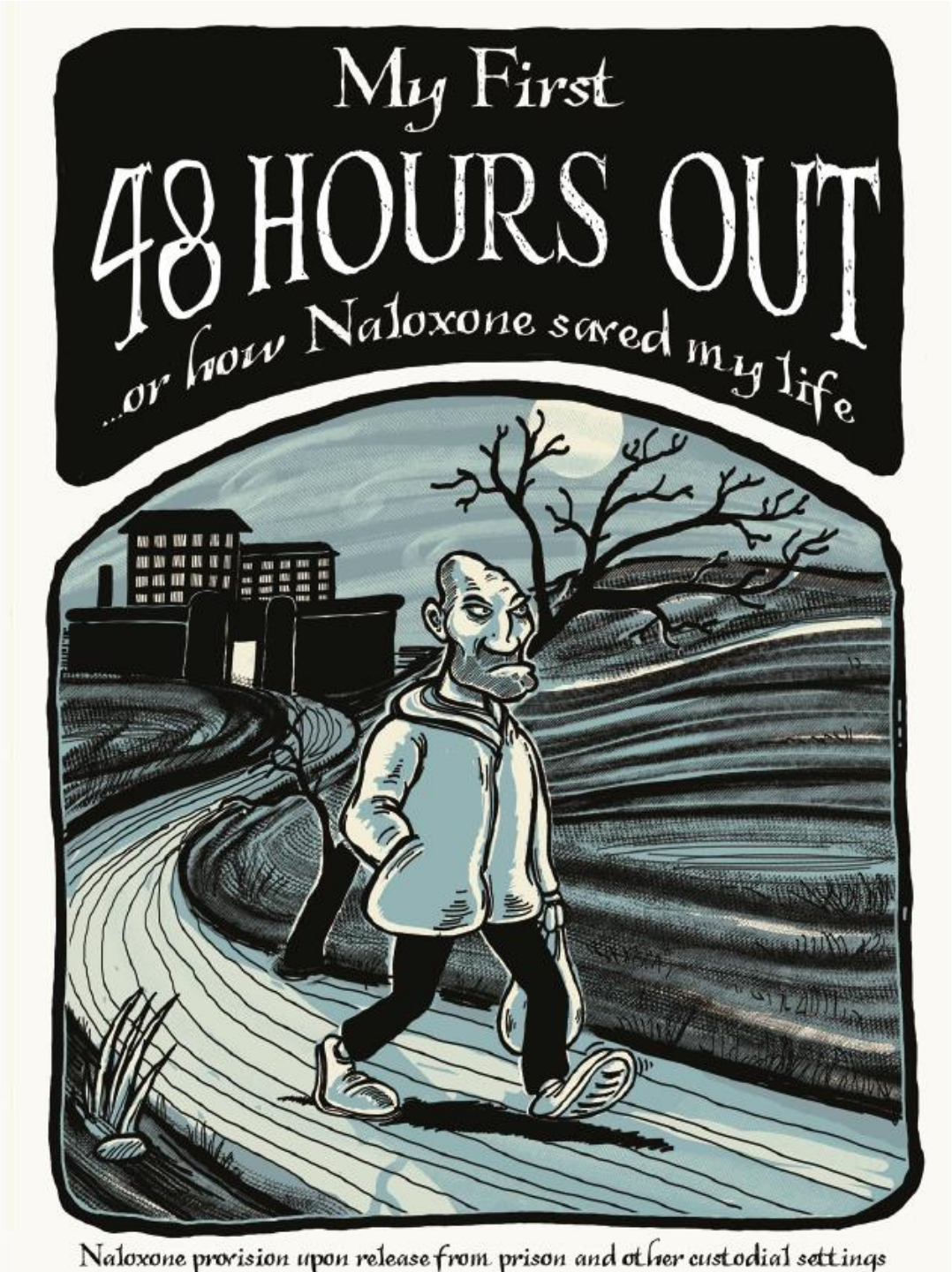
9. **Prioritise, normalise and standardise in all drug services**

The biggest risk of death for your client group is accidental and preventable overdose

Top Ten Tips for Naloxone Programmes (6/6)

10. **Always encourage and support people to talk about their experience of using THN**

If someone has used naloxone to save a life - congratulate them! This may also have been a traumatic experience and they may need some support. It's also an opportunity for a training refresher and of course a re-supply of naloxone.


My First
48 HOURS OUT
...or how Naloxone saved my life
Naloxone provision upon release from prison and other custodial settings


In the first 48 hours after leaving prison, you are at the highest risk of an...
OVERDOSE
That's the last time...
...the last fucking time. I am not going back inside!


Naloxone is an antidote to an OPIOID OVERDOSE
I've been supplied with Naloxne in my kit bag...
But I am never going to use again...
Not EVER...
Not even ONCE!

2 Hours Later...

If you do use, make sure you use clean works to avoid Hepitits & HIV

After a break from using, your tolerance to HEROIN drops. The same dose that used to sort you out could now lead to an overdose.

Signs of an overdose

* Breathing problems
* Making gurgling sound
* Pale skin with blue lips
* No response to noise or touch
* Pin point pupils

If you use alone there is nobody to help you

Don't waste time doing things that don't work!

Don't inflict pain

Don't give them any other drugs e.g. Stimulants

Don't put them in bath or shower.

Don't walk them around

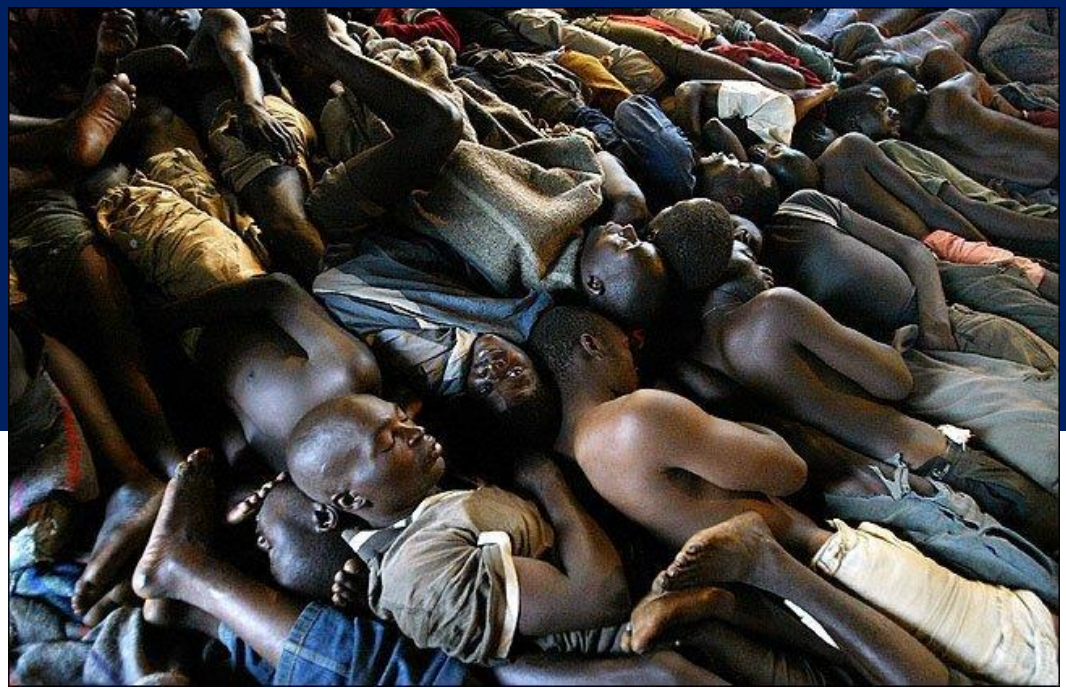
Don't fuck off & leave them on their own

STAY WITH THEM!

E-Learning Course on THN

(soon avaliable, see: https://harmreduction.eu/)

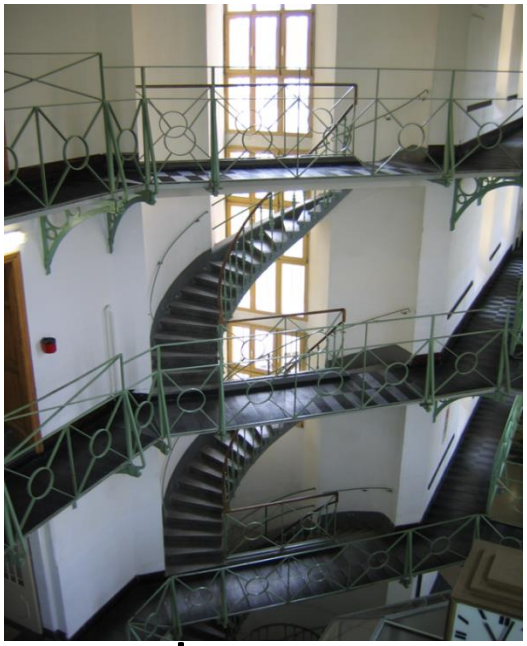
3. Condom provision in prisons



Sexuality in prisons, risks and Ccndom Programs

Sexuality in Prisons 1/2

- Sexual deprivation
- Threat to sexual identity
- Prostitution,
- Sexual violence, rape
- Sexually transmitted infections (STIs)
- Male and female sexuality
- > 50% of prisoners report about consensual sex (Hensley et al. 2000) – „situational homosexuality“



[1]Döring, N. (2006): Sexualität im Gefängnis: Forschungsstand und –perspektiven. Z Sexualforsch 2006, 19

Sexuality in Prisons 2/2

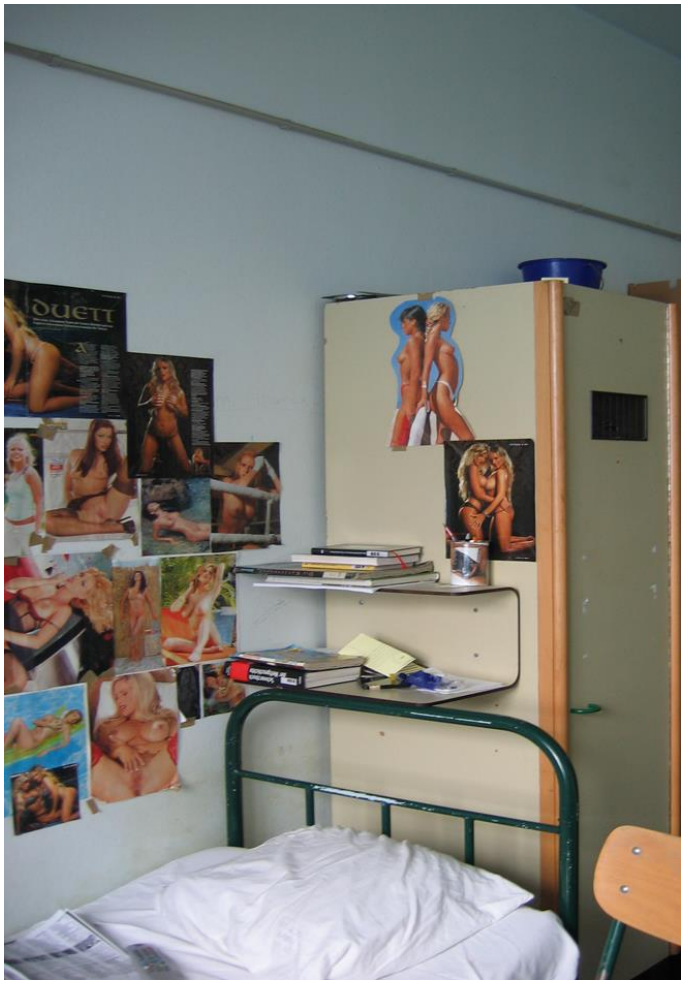
- Homosexual – passive ‚female' part
- Taboo stronger in male than in female prisons
- Conjugal visits in a few prisons – for married prisoners only
- Widespread homophobia: barrier to prevention
- Safer sex programmes

Sexuality in Prisons in Mass Media

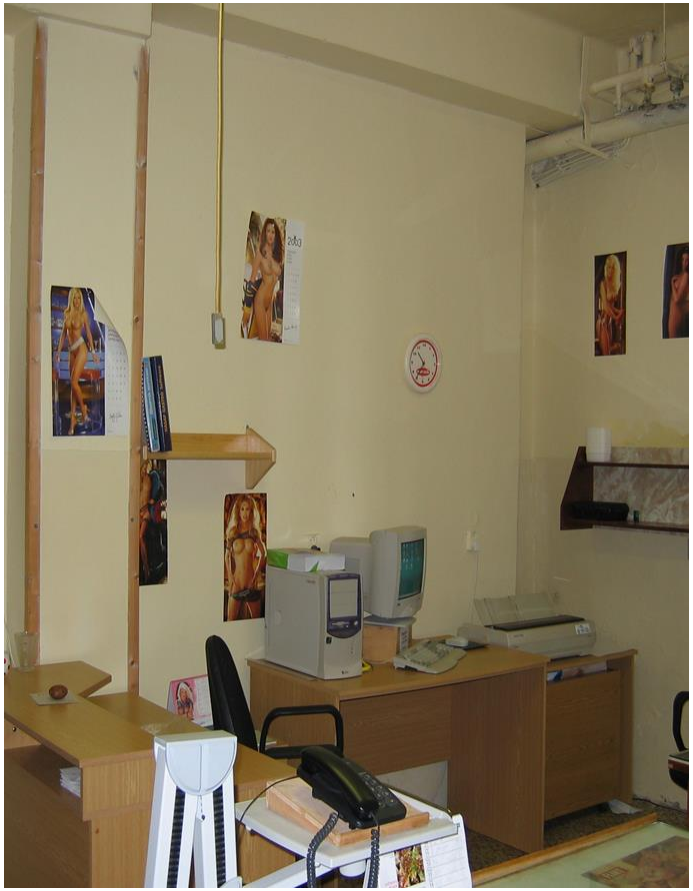
- Fictional/non-fictional
- Series
- Voyeristic
- Soft sex films – pornography
- US: „Women in Prisons (WIP) - „chicks in chains" with strongly sexualizing elements
- Germany: „Hinter Gittern – der Frauenknast" (RTL, since 1997)

[1]Döring, N. (2006): Sexualität im Gefängnis: Forschungsstand und –perspektiven. Z Sexualforsch 2006, 19

Sexualizing athmosphere – pin ups in a men's prison – prisoner cell



Sexualizing athmosphere – pin ups in a men's prison – staff room!



Condoms: from Maputo (Mozambique) to Munich (Gemany) to Maseru (Lesotho)

- **Maputo/Mozambique**: ca. 24% of prisoners HIV+ - no condoms: „…might increase sexual activity …“
- **Munich/Germany**: HIV-prevalence among prisoners 1,5% of men, that is 30-times higher than in the general population
- condoms available only via application – medical service
- 2005-2007 provision of approx. 40 condoms to approx. 8,000 prisoners per year
- Official legitimation: „prisoners are informed to behave responsibly right in the beginning“[1]
- Lesotho prison service has installed „condotainer“

[1]Bayerische Staatszeitung vom 29.08.2014

…and to Berlin[1]…

[1]Study visit with the Czech delegation to Berlin (5th-7th October 2016)

Study Visit with the Czech delegation

Berlin/Tegel prison:

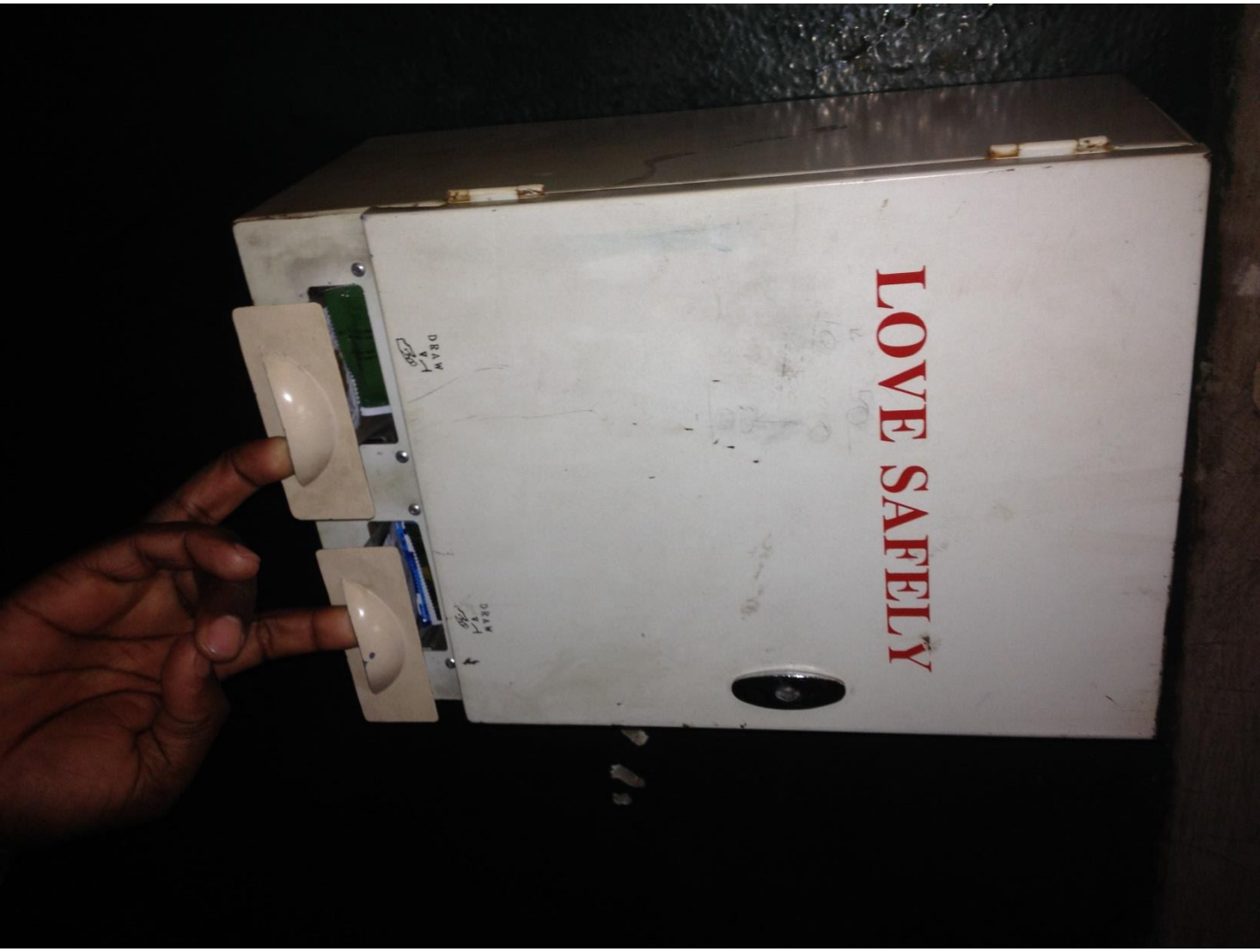
- Filling of wooden condotainer has been given up ages ago
- Condoms are available on request via health unit
- A (female) nurse is responsible
- “Almost no condoms are being given out since years”

Other parts of Germany – access to condoms via:

- Merchant
- Priest, chaplain, paster
- Health unit
- Social worker

Condotainer
San Francisco/US Prison

Condotainer Maseru Prison



Condom automats in Prague, Czech Republic

Conclusions

Future developments

- More attention on the the topic of sexuality in prisons is needed
- Let‘s talk about sex – breaking the taboo of sexuality in prisons
- Realistic and pragmatic programs have to be introduced
- Decent, anonymous access to condoms
- Utilizing international standards for changes (e.g. **the Nelson Mandela Rules**, CPT)

Condom provision - problems

- Lack of monitoring and evaluation
- Provision of condoms without lubricants
- Inappropriate way of condom distribution (on demand/selling,…)
- And…

Condom provision

- To distribute condoms through indirect ways such as condom automats or put them in an invisible place
- To launch systematic monitoring and evaluation programs
- To provide condoms with lubricant
- To consider the WHO recommendation of “combination interventions” to maximize the effectiveness of condom programs

Contact

- **hstoever@fb4.fra-uas.de**

www.isff.info

www.naloxoninfo.de

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- EU Action Plan on Drugs. Available online: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52017XG0705%2801%29

Websites und

- **Harm Reduction Coalition**
  In the Overdose Prevention section of their website they have a great selection of documents covering: News and Updates, Overview of Overdose, Tools and Best Practice Information, and Policy and Advocacy documents.
- **COPE Australia**
  Community Overdose Prevention and Education (COPE) is a community-based opioid overdose prevention initiative funded by the Victorian Government. COPE provides training and support to primary health and community organisation staff. These trained staff will provide education to individuals who may be opioid users o potential overdose witnesses, such as a family member or friend.
- **Understanding the risks of mixing medications & street drugs**
- **AMA Webinars**
  The American Medical Association has resources available about Prescription Opioid Overdose and Public Health Responses.
- **Ontario Harm Reduction Distribution Program: Naloxone Program**
  This website contains information relative to the Ontario Provincial Naloxone Program: naloxone order forms, staff training resources, and client educational resources. It also has a comprehensive Community-Based Naloxone Distribution Guidance Document.
- **Overdose Prevention Alliance**
  This website offers different manuals and tools for the implementation of a community-based overdose prevention program. It offers links to existing programs and legal resources. It can help you locate the program nearest you.
- **Breathe (the overdose game)**
  This website presents the "Breathe" game which is an instructional and entertaining way to learn, understand and try to respond to an overdose before it happens.
- **EHRN: Training on Overdose Prevention & Response**
  The Eurasian Harm Reduction Network (EHRN) is a regional network with a mission to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and protecting human rights at the individual, community, and societal level.
- **Naloxone.Org.UK**
  Here is a comprehensive website about naloxone. It includes updates about the National Naloxone Program in Scotland and N-ALIVE, a large prison-based research trial providing overdose and naloxone education to individuals being released. Links at the bottom of the page include a naloxone finder, external resources, and law/policy information.
- **Project Lazarus**
  Community-based Overdose Prevention from North Carolina and the Community Care Chronic Pain Initiative.
- **SPHERE**
  Useful downloadable resources including posters to engage with different audiences about overdose. Includes tools for drug and alcohol treatment providers to incorporate overdose into relapse prevention and discharge planning, conversation starters and an Opioid Overdose Prevention Card Game.

…Videos

- **Videos:**
- The Chicago Recovery Alliance:
- http://www.anypositivechange.org/menu.html
- Training Videos:
- http://www.naloxoneinfo.org/run-program/training-videos
- Ohio Attorney General:
- https://www.youtube.com/watch?v=m9wgPiuCtGI
- Using Injectable Naloxone to Reverse Opiate Overdose / MultcoHealthPresents
- https://www.youtube.com/watch?v=wsN0ijLnK2k
- Michel Geier, PharmD
- https://www.youtube.com/watch?v=mA1-YkKqCzY
- Naloxone nasal spray demonstration
- https://www.youtube.com/watch?v=Jis6NlZMV2c
- BmoreHealthy
- https://www.youtube.com/watch?v=YyDdMdLvdBc
- Naloxone Instructional Video / Healthy Communities of the Capital Area
- https://www.youtube.com/watch?v=NLo25AQNyeM