PART B: SELECTED ISSUES

11 Drug-related health policy and health services in prison

11.1 Prison systems and the prison population

The execution of criminal justice in Germany is the domain of the German *Laender*. Since 2006 the *Laender* have also been responsible for legislation in this area. All of the *Laender* have in the meantime issued laws on the execution of criminal justice for youth. Baden-Wuerttemberg, Bavaria, Hamburg, Lower Saxony and Hesse have issued their own prison laws for adults. The general Prison Law (Strafvollzugsgesetz) continues to apply in the remaining *Laender.* There is no national data collection procedure on the health of prison inmates in Germany. Instead there are above all regional data surveys and individual studies, in some cases focusing on sub-populations of individual facilities.[127]

The Federal Ministry of Justice (FMJ) has compiled data for the indicator database of the World Health Organisation (WHO) and the European Network on Drugs and Infections Prevention in Prison (ENDIPP) from the individual German *Laender* and hence 195 prisons as of 31 March 2008 (Indikatorendatenbank, BMJ 2009). Pertinent results from this survey will be commented on in the following at the appropriate places. One major limitation on all this data is that information is always only available from some German *Laender,* which means that the results cannot be clearly attributed or assigned to specific *Laender.*

The WHO's indicator database has prompted Baden-Wuerttemberg to initiate an annual health report on inmates in Baden-Wuerttemberg (Reber & Wulf 2009, Reber 2011). The data survey at the level of prison facilities was performed for the first time in 2008. The last report was published in the summer of 2011.

In addition to the data which has already been collected, the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (Deutsche Beobachtungsstelle fuer Drogen und Drogensucht – DBDD) has requested the Federal Government's Commissioner on Narcotic Drugs and the ministries of justice of the German *Laender* to answer a comprehensive questionnaire on the health situation of inmates in their *Laender*. The topics in this survey include inter alia medical and psychosocial health care structures at penal institutions, training of prison guards on how to deal with prisoners who consume drugs, tests for drugs and infectious diseases as well as intramural therapy services for prisoners who consume drugs. As of the completion of this report, the DBDD had received answers from 13 German *Laender*. Responses had yet to be received from Bavaria, Hamburg and the Saarland. In addition, a survey was conducted by the DBDD with the *Laender* ministries of justice in 2005 which was commissioned by the Working Group for the German Statistical Report on Treatment Centres for Substance Use Disorders (AG DSHS). The situation regarding treatment of addictions and substance abuse disorders was surveyed

[127] See chapter 11.5.2 regarding the considerable limitations of the data.

at penal institutions in the individual German *Laender.* The results of this survey can be examined in the REITOX Report 2008 (chapter 9.3.1).

In November 2010 the DBDD carried out a workshop entitled “Drugs and Imprisonment” with financial support from the Commissioner on Narcotic Drugs and the Federal Ministry of Health. The objective of the event, which approximately 120 persons attended, was to foster the exchange between experts in the fields of theory and practice and stimulate a joint discussion. Speakers included representatives from the ministries of justice of the Federal *Laender* North Rhine-Westphalia, Hesse and Berlin as well as the Rhineland-Palatinate Pension Insurance Scheme and Paritaetische Baden-Wuerttemberg. International speakers included experts from the Spanish Ministry of the Interior, the European Monitoring Centre for Drugs and Drug Addiction and the Federal Health Agency of Switzerland. The conference helped stimulate the discussion about reasonable health care of inmates consuming drugs and with substance addictions. The different activities in the treatment and care provided to offenders addicted to drugs within Germany and in the EU became evident at the conference. The key importance of comparable data was stressed and the offices responsible in the areas of criminal justice and health at the *Laender* and national levels were encouraged to jointly establish an appropriate monitoring system. The Federal Ministry of Health will investigate to what extent financial support can be made available for “consensus events”, the aim of which could be the compilation of appropriate data and the establishment of more uniform treatment standards for inmates addicted to drugs in Germany.[128]

This chapter refers to drug consumers, drug addicts and intravenous drug users depending on the particular study. As a result of the different indicators used for these respective terms – and especially to demarcate these from disorders relating to ICD – it is frequently only possible to compare research results produced by these studies to a limited extent.

11.1.1 Contextual information

Under the provisions of the Prison Rules and Guidelines (Vollzugsgeschaeftsordnung, VGO Nr. 73), prisons are required to report the numbers of inmates at the end of the reporting month as well as incoming and outgoing inmates in the reporting month. The Federal Statistical Office issues summaries on Germany for three selected calendar months (March, August and November) based on the aggregated figures submitted by the *Laender* and publishes these in the Internet. These summaries cover the prison facilities of the *Laender*. Closed correctional facilities (psychiatric hospitals and withdrawal facilities, Maßregelvollzug) or juvenile correctional facilities (Jugendarrestanstalten) are not included (Statistisches Bundesamt 2010c).

According to the annual survey carried out by the Federal Statistics Office (DeStatis), there were 60,693 inmates and detained persons in German detention facilities and prisons on 31 March 2010. The percentage of women among inmates has risen slightly over the last few years, but at about 5% is still low (Statistisches Bundesamt 2010c). 55.9% (33,907) were

[128] The charts used in the presentations can be downloaded at www.dbdd.de.

serving sentences of up to two years, 29.7% (18,018) terms of between 2 and 15 years and 3.4% of inmates (2048) were serving life sentences (Statistisches Bundesamt 2010c). In 2009 there were 10 times as many persons beginning prison sentences as inmates (637,552). Of these, 17% (108,832) were first-time incarcerations, while there were approximately the same number of releases (608,204) (Statistisches Bundesamt 2010a). Table 11.1 provides an overview of the number of penal institutions, their capacity and the actual number of inmates as of 31 August 2010 in the individual German *Laender*. This shows that as of this date there were 185 organisationally autonomous prisons with a capacity totalling almost 80,000 prisoners as of this date, which were 90% full with more than 70,000 prisoners at the point in time of the survey (Statistisches Bundesamt 2011b).

Table 11.1 Prisons and capacity as of 31 August 2010 broken down by German *Laender*

Laender	Individual prisons	Capacities		Occupancy as a %[1)]
Germany (total)	185	77,995	70,103	90
Baden-Wuerttemberg	19	8,126	7,337	90
Bavaria	36	11,942	11,706	98
Berlin	8	5,172	4,774	92
Brandenburg	6	2,123	1,510	71
Bremen	1	748	616	82
Hamburg	6	2,593	1,772	68
Hesse	16	5,767	5,222	91
Mecklenburg-Wst. Pomer.	2	1,547	1,426	92
Lower Saxony	14	7,107	5,595	79
North Rhine-Westphalia	37	18,343	17,181	94
Rhineland-Palatinate	10	3,606	3,473	96
Saarland	3	896	833	93
Saxony	10	3,840	3,438	90
Saxony-Anhalt	5	2,456	2,073	84
Schleswig-Holstein	6	1,695	1,353	80
Thuringia	6	2,034	1,794	88

1) Occupancy is expressed as a % of capacity in each of the *Laender*

Statistisches Bundesamt 2011b.

Because the percentage of addicts and consumers of illegal drugs in German penal institutions cannot be clearly quantified, the number of persons incarcerated as a result of violations of the Federal Narcotics Act (*Betaeubungsmittelgesetz*) is frequently used. This estimate is relatively imprecise, however, because first of all it counts people who, although they have violated the law in connection with drugs, may not themselves have consumed any illicit substances, as could be the case, for example, with some dealers. Secondly, a large percentage of drug consumers are not taken into account because for example persons who

are sentenced as a result of offenses in connection with procurement of drugs are listed under other categories of violations against the Federal Narcotics Act in the statistics. A total of 67,025 persons were charged with violations of the Federal Narcotics Act in 2009[129] (Statistisches Bundesamt 2010a) and 59,432 sentenced, among them 17% children and adolescents (Statistisches Bundesamt 2010b). There were a total of 8,880 persons (14.6% of all inmates) serving time in prison facilities as a result of violations of the Federal Narcotics Act as of 31 March 2010. Of these, 5.7% (507) were female, while 3.6% (319) were serving sentences as juvenile offenders. Table 11.2 shows that the percentage of inmates sentenced for violations of the Federal Narcotics Act has declined only slightly, but continuously, since 2008. This trend can be witnessed for all types of criminal offenses and among both genders. In 2009 a total of 51,723 persons were sentenced to prison (7.1% of all imprisonments) including short-term military imprisonment (Strafarrest) under the Federal Narcotics Act, of these 18,013 actual incarcerations (including 11,706 suspended sentences) and 33,710 fines. Of the actual incarcerations, 8,840 were for less than one year and 9,173 for more than one year (Statistisches Bundesamt 2010a).

Table 11.2 Number of detainees and drug-related crimes

		Detainees and persons under preventive detention			Adult detainees		Juvenile detainees		Preventive detention
		Total	Males	Females	Males	Females	Males	Females	
2010	Detainees N	60,693	57,568	3,125	51,056	2,917	5,979	205	536
	BtMG N	8,880	8,373	507	8,074	486	298	21	1
	BtMG %	14.6	14.5	16.2	15.8	16.7	5.0	10.2	0.2
2009	BtMG %	15.0	14.9	16.5	16.2	17.0	5.1	10.5	0.4
2008	BtMG %	15.3	15.1	18.2	16.3	18.9	6.7	9.8	0.7
2007	BtMG %	14.9	14.8	17.4	16.2	15.0	6.2	8.9	0.2
2006	BtMG %	14.8	14.7	18.2	15.7	18.8	6.8	11.4	0
2005	BtMG %	14.6	14.4	19.2	15.4	20.1	7.3	10.2	0

Note: „BtMG N“: Number of persons detained for offences committed against the BtMG, „BtMG %“: share of persons detained for offences against the BtMG.

Statistisches Bundesamt 2010c.

11.1.2 Characteristics of the population

Out of 60,693 inmates as of 31 March 2010, 5.1% (3,125) were females and 22% (13,374) non-German nationals (Statistisches Bundesamt 2010c). 66.2% (40,174) were single, 17.5% (10,642) married, 1.3% (765) widowed and 15.0% (9,112) divorced. 15.2% (9,204) of inmates were on day-release. 0.4% (222) of the inmates were between 18 and 21 years of

[129] Persons charged mean persons who have appeared before court and for whom a ruling has been issued. Persons who are not sentenced are, for example, acquitted, the procedure is dropped or similar; for details regarding the reasons see DeStatis Fachserie 10, Reihe 3 “Abgeurteilte nach Art der Entscheidung”.

age, 28.0% (17,015) between the ages of 21 and 30, 48.6% (29,515) between 30 and 50 and 11.9% (7,221) over 50.

11.2 Health policy in prison

11.2.1 Framework conditions surrounding health services in prisons

Legal framework conditions

The German Prison Law (Strafvollzugsgesetz) from 1976 still applies in most of the German *Laender*. It governs "the act of imprisonment in penal and correctional institutions" (§1 StVollzG). Since the reform of the Federalist system, which was adopted by the German Bundestag on 30 June 2006 and entered into force on 1 September 2006, law-making power has been devolved from the Federal Government to the *Laender*. The German Prison Law is being replaced step by step by the respective *Laender* prison laws and administrative regulations (§125a of the German Constitution (GG[130])), which in part cite the German Prison Law. The German Prison Law still applies in 11 German *Laender*. There are *Laender* prison laws now in Baden-Wuerttemberg (JVollzGB since 1 January 2010), Bavaria (BayStVollzG, since 1 February 2010), Lower Saxony (NJVollzG, since 14 December 2007), Hamburg (HmbStVollzG, since 14 July 2009) and Hesse (HStVollzG, since 28 June 2010). The *Laender* prison laws are largely based on the Federal German Prison Law and usually only differ in terms of various details. The type and scope in the rendering of services in the area of health care is based on the Federal Social Code (SGB V)[131] in all five of the German *Laender* with their own prison laws, for example.

The seventh title of the German Prison Law lays down regulations governing health care for prisoners. Generally speaking, there is an obligation to care for the physical and mental health of prisoners (§56 StVollzG). In addition to this, prisoners are "entitled to treatment when they are ill if this is necessary to diagnose or heal an illness, prevent it from becoming more acute or to alleviate it". This means *inter alia* treatment by a physician and the supply of medication, bandages and dressings (§58 StVollzG). The provisions of Social Code V apply to the type and scope of health services (§61 StVollzG). No individual references are made in the German Prison Law to drugs, substitution or addictions. Medical care of inmates is paid for by the ministries of justice of the *Laender*. A health insurance scheme or the *Laenders'* respective accident insurance scheme assume the costs of work-related accidents (Indikatorendatenbank BMJ 2009).

Although the *Laender* codes scarcely differ from the German Prison Law or from each other, there are nevertheless subtle differences. The Hessian Prison Law stipulates a right on the part of inmates to psychological or psychotherapeutic treatment or care (§26, section 2 HStVollzG). In Lower Saxony the need to inform inmates about healthy living habits is

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130 Grundgesetz (the Basic Law, or German Constitution).

131 SGB V governs the organisation, insurance obligation and services provided by statutory health insurance schemes as well as their legal relationship to other service providers such as, for example, physicians, dentists and chemists.

codified (§23, section 1 HStVollzG and §32, section 1 JVollzGB). The codes of Hesse and Baden-Wuerttemberg furthermore state that it is possible to exercise controls to combat abuse of addictive substances (§4 HStVollzG and §64 JVollzGB).

Implementation of the principle of equivalency

Resolution 37/194 of the General Assembly of the United Nations (Office of the United Nations High Commissioner for Human Rights 1982) states that health-care personnel in prisons have a duty to ensure that prisoners in custody receive protection of their physical and mental health and, if they are ill, that they receive treatment of disease commensurate in quality and standard to that afforded to persons who are not imprisoned or detained. In dealing with prisons and detained persons, the Council of Europe recommends under the caption “Equivalence of care” that health policy in prisons accord with national health policy and be integrated in it. Furthermore, conditions in prison which constitute violations of human rights cannot be justified by a lack of resources (CPT 2010).

In Germany penal laws and regulations themselves stipulate what medical services prisoners are entitled to and with regard to the type and scope of such refer to the Social Code (SGB V) (Meier 2009). Under these provisions, prisoners are not entitled to the entire spectrum of health services which statutory health insurance schemes (GKV) are obligated to provide.

Number of health-care personnel

According to the Annual Penal Statistics of the Council of Europe (SPACE I, Aebi & Delgrande 2011), there were a total of 37,174 employees (in full-time equivalent units) working in German prisons as of 1 September 2009, almost all of them (98.7%) behind prison walls. At 73.6%, general prison guards accounted for by far the largest group of employees in German prisons. By comparison, physicians and nurses were the smallest group with 0.7%. 1.5% were appraisers or psychologists (RM 1321). Each general prison public employee is responsible for 2.7 prisoners on average. For personnel in other areas such as, for example, treatment or educational training, there are 15.5 prisoners for each public employee by comparison.

There are an average of 257 patients for each practicing physician in the general population in Germany, with considerable variation within the country (from 174 to 304 inhabitants per practicing physician) (status: end of 2008, see Table 11.3) (Greß & Stegmueller 2011). There are approximately 260 inmates for each prison physician on average (Meier 2009). This is roughly at the average level for the population as a whole. If one takes the significant fluctuations in the prison population into account (375,671 entries into prison in 2004 with an average of 79,752 inmates for the year), it would be more realistic to set the health-care ratio at 1:560. In interpreting these figures, it must be kept in mind that persons generally consult physicians more in prison than when they are free as a result of the greater strain on health in prisons. No data is available in Germany quantifying this fact in precise terms. The results of a study carried out in all Belgian prisons show that on average penal institutions consult a physician 3.8 times as much as a demographically equivalent group of the general population (Feron et al. 2005). If one assumes a similar level of consultation by inmates in

Germany, a prison physician is accordingly subject to a much higher level of stress and strain with the same care ratio as in extramural health care as a result of the greater demand for his or her services. With the same health-care key (number of physicians and health-care personnel) intramural and extramural, the usually much higher health strain on prisoners displays a structure of health inequality (Stoever et al. 2009). This could be an indication that a denser network of physicians would be needed in intramural health care compared to outside prisons in order to ensure a comparable level of health care. Table 11.3 provides an overview of the intramural and extramural health-care situation with general practitioners per inmate or inhabitant.

Table 11.3 Intramural and extramural health-care ratios

	Intramural 2004[1)]			Extramural 2008[2)]
Federal state	**Number of physicians**	**Average occupancy of correctional facilities**	**Relation of care (physician: patient)**	**Relation of care (physician: patient)**
Baden-Wuerttemberg	26	8,604	1:331	1:261
Bavaria	45	11,964	1:266	1:242
Berlin	34	5,318	1:159	1:197
Brandenburg	11	2,308	1:210	1:304
Bremen	1	733	1:733	1:195
Hamburg	15	3,123	1:205	1:174
Hesse	21	5,883	1:280	1:252
Mecklenburg-West. Pomer.	7	1,634	1:233	1:262
Lower Saxony	32	6,951	1:217	1:292
North Rhine-Westphalia	63	17,727	1:281	1:261
Rhineland-Palatinate	9	3,873	1:430	1:264
Saarland	1	931	1:931	1:242
Saxony	25	4,253	1:170	1:288
Saxony-Anhalt	13	2,822	1:217	1:294
Schleswig-Holstein	3	1,577	1:526	1:259
Thuringia	0	2,051	-	1:282
Total	306	79,752	1:261	1:257

1) Meier 2009.

2) Greß & Stegmueller 2011.

A summary of offices and facilities in the area of medical and psychosocial care of inmates reported by the ministries of justice in response to an enquiry by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) in 2011 is provided by Table 11.4. Saxony-Anhalt reported in addition that one staff member each had been appointed commissioner for addictions at a total of eight prison sites. They have been

assigned the task of supervising the performance of addiction-related work. In addition, 16 staff members have been used as aids for persons afflicted with addictions, performing tasks commensurate with 5.3 full-time positions. Counselling for addicts is offered through external staff at one prison within the framework of a so-called public-private partnership at a juvenile detention centre in Saxony-Anhalt. This is why it is not possible to provide more details on manpower used in this connection here (Saxony-Anhalt Ministry of Labour and Social Affairs, personal information).

According to the indicator database, the number of hospital beds at penal institutions in ten German *Laender* in 2008 was 1,015, with five German *Laender* reporting 230 psychiatric beds (Indikatorendatenbank, BMJ 2009). As a result of the difficulty in attributing the data to specific *Laender*, however, it is not possible to calculate a health service ratio for specific *Laender* or to make any comparisons with the general population, nor can this data be compared with current data.

Detailed information is moreover available for Baden-Wuerttemberg and Munich Prison. There were a total of 32.65 prison physicians (including 7.65 positions for non-full-time prison physicians) available for 7,748 prisoners at prisons and 14 physicians at Hoenasperg Prison hospital in Baden-Wuerttemberg in 2010. There were a total of 304 hospital beds, among them 94 psychiatric ones, at the prisons of Baden-Wuerttemberg at this point in time (Reber 2011). There were a total of 7 physicians and 82 persons from the nursing care service for 1,249 inmates available at Munich Prison in January 2011 (Stumpf 2011).

11.2.2 Health policy in prison

National drug policy in prisons

The respective *Laender* parliaments adopt the laws governing the penal systems of the Federal *Laender*, while the respective ministries of justice are in charge of executing these laws. At the national level this is the domain of the Penal System Committee of the *Laender* (Strafvollzugsausschuss der *Laender* – BMJ 2011, personal information). This is a sub-committee of the Conference of the Ministers of Justice and prepares meetings of this committee. The participants are the heads of the departments in charge of the penal system at the *Laender* ministries of justice. The Penal System Committee of the *Laender* discusses current topics relating to the penal system which are of general interest to the *Laender*. The aim of this meeting is to coordinate developments at the national level. This produces arrangements which, however, are non-binding. When binding agreements are desired, an interstate treaty can be concluded. The Federal Ministry of Justice takes part in the meeting of the Penal System Committee of the *Laender*, but only has the status of an observer.

Drug-related health policy in prison

In the survey carried out in 2011 by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD), the ministries of justice of the *Laender* reported that, with regard to therapy on offer to inmates, most of the *Laender* followed the guidelines of the German Medical Association (*Bundesaerztekammer*). In

addition, some *Laender* cited the guidelines issued by the Association of the Scientific Medical Societies in Germany (Arbeitsgemeinschaft der Wissenschaftlichen Medizin – AWMF), the guidelines of the Deutsche Gesellschaft fuer Suchtmedizin (German Society for Addiction Medicine) and the guidelines for new examination and treatment methods of the Bundesausschuss der Aerzte und Krankenkassen (Federal Committee of Physicians and Health Insurance Schemes) (NUB-Richtlinien).

In response to a survey of Deutsche Aidshilfe (DAH) in the autumn of 2006, with regard to the substitution treatment (Opioid Substitution Therapy, OST) of inmates all of the German *Laender* except for Schleswig-Holstein cited the Narcotics Act (Betaeubungsmittelgesetz – BtMG) and the Amending Regulation on the Prescription of Narcotic Drugs (Betaeubungsmittel-Verschreibungsverordnung (BtMVV) (Knorr 2008). Almost all of the *Laender* furthermore reported that they followed the guidelines of the German Medical Association regarding substitution therapy for opiate addicts. Schleswig-Holstein moreover stated that it followed the Guidelines on the Assessment of Physicians' Examination and Treatment Methods[132], which govern substitution in the statutory physicians' care system. These are actually not binding with regard to substitution in closed prisons, as inmates are not insured under the statutory health insurance schemes while in prison.

[132] Non-recognised Examination and Treatment Guidelines (NUB-Richtilinien) and the Guidelines on the Assessment of Physicians' Examination and Treatment Methods have been updated and are now primarily cited under "Guidelines of the Joint Federal Committee on Examination and Treatment Methods of Treatment by Accredited General Practicioners", "Guidlines on Methods in Treatment by Accredited General Practitioners" (Joint Federal Committee 2011).

Table 11.4 Scope of medical and psychosocial care of inmates in the German *Laender*

	Medical Service			PSB	
Land	**Working hours per week**	**Proportion treatment of drug users (internal, %)**	**Proportion treatment of drug users (external, hours)**	**Internal (%)**	**External (hours)**
Baden - Wuerttemberg	6,432.5	15%	0	5%	15 positions
Berlin	230 x 40	25%	Not applicable	No separate illustration possible, in medical treatment (e.g. in OST) included	Decisive calculation of hours not available
Brandenburg	Physicians: 150, Care providers: 1,360	<1%	Not applicable	0	0
Bremen	5.600	70%	0	50%	0
Hesse	Physicians: 915 Care providers: 4.370	Physicians: approx. 5%-10% Care providers: approx. 5%	0.4-1.2	Calculation of percentage not possible; PSB included in OST	10-60 hours/week (depends on size of facility)
Mecklenburg-West. Pomer.	1,070	Not specified	0	Not specified	0
Lower Saxony	In-prison: 915.2 Locum tenens doctors: 720	30%	Not specified	Not specified	Not specified
North Rhine-Westphalia	Prison: 9,750 Prison clinics: 3,750	30%-40%	0	1,320 hours/week (incl. external facility)	270 Std./Wo.
Rhineland-Palatinate	1,764	approx. 15%-20%	113	10%	Not specified
Saxony	Physicians: 240 Medical institutions: 1,780 Hospitals: 1,360	approx. 1%	Not applicable	Not applicable	Not applicable
Saxony-Anhalt	1,830 (without extraofficial physicians)	Not specified	0	Not specified	0
Schleswig-Holstein	998	5%-80% (je nach JVA)	0	2-5% (depends on correctional facility	35.5 hours/week
Thuringia	1,148	approx. 20%	approx. 6 hours	approx. 20%	approx.15 hours/week.

Models for the rendering of services for drug consumers in prison

Frequently it is not only public penal institutions employees who are available to provide medical and psychosocial care for inmates in prisons, but also external specialists as well. In 2008, for example, in 15 out of the 19 facilities in Baden-Wuerttemberg there were HIV help services at 9 correctional facilities and external health services at 10 facilities (Reber & Wulf 2009, Reber 2011). Approximately 62% of regional AIDS helpers also work at penal institutions in Germany as a whole, primarily in the areas of counselling and support or in conducting group activities or staging information events for inmates and public employees (Knorr 2011). According to SPACE I, there were 1,541 persons employed in the penal system who were not part of the prison administration in 2009 (Aebi & Delgrande 2011). This figure breaks down among individual professions as follows: teachers (24.3%), medical personnel (11.5%), security personnel (8.1%), social workers and probation officers (10.8%). In Bavaria there were a total of 49 full-time positions for external addiction counselling in penal institutions in 2010, which means an increase of 6 full-time positions compared to 2009 (Poth 2011). These were funded by the Bavarian State Ministry for the Environment and Health.

In the short *Laender* reports the Federal *Laender* stated the number of facilities and staff positions which are available in internal and external services for counselling and treatment in prisons (Floeter & Pfeiffer-Gerschel 2011). 11 *Laender* provided statistics on the number of internal services. The data from 9 *Laender* add up to a total of 125 services with a total of 227 staff positions (the latter according to statistics from 10 *Laender*). In addition, 12 *Laender* provided information on the number of external services. The data provided by 11 *Laender* add up to a total of 157 services with 179 staff positions (the latter figure is based on the data from 10 *Laender*). By the same token, the individual *Laender* differed with respect to the weighting of internal and external services. Thus in some *Laender* (for instance, Hamburg and North Rhine-Westphalia) counselling and treatment is provided primarily internally, while in others (e.g. Bavaria and Saxony) it is primarily offered through external facilities.

11.3 Provision of drug-related health services

11.3.1 Prevention and treatment

Drug prevention and information campaigns for inmates

As a result of the high rate of consumers and persons addicted to illegal drugs in German prisons, drug-related prevention and treatment programmes are especially needed there. Deutsche AIDS-Hilfe has been staging a series of events on the topic of “HIV prevention and medical care in the penal system” for several years now, with these events also taking place in penal institutions since 2010 and focusing both on inmates as well as public employees (DAH 2011, personal information).

In response to the enquiry by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) to the ministries of justice in the summer of 2011, 10 out of 13 German *Laender* replied that they distribute information material on

prevention of drug-related health damage, 3 organise information events or training programmes for the inmates and 5 offer to discuss things with the inmates, for example explaining to them their rights or giving them individual counselling.

According to the indicator database of the WHO (BMJ 2009), information material on the prevention of drug-related health damage was provided at all penal institutions in 15 German *Laender*. Counselling was offered by drug specialists or medical personnel at all facilities in 14 German *Laender.* Peer education programmes and safer use training programmes were possible at several facilities in 2 German *Laender.* The greater scope of preventive measures in the penal system in 2008 in comparison to the present statistics need to be interpreted cautiously. It can clearly be seen that the distribution of information material comprises the most widespread method of informing inmates about health risks at both points in time.

More discriminating statistics are available on Baden-Wuerttemberg, Saxony-Anhalt and Bavaria (Nuremberg). Information material, primarily on infectious diseases, was available at 18 penal institutions in Baden-Wuerttemberg in 2008. In addition, there are internal or external drug specialists at all penal institutions, peer education programmes at six and safer use training programmes in nine and counselling is offered for public employees at 17 facilities (Reber & Wulf 2009, Reber 2011). The key tasks of addiction counselling in Saxony-Anhalt include information and motivation work with inmates who are willing to undergo treatment (Saxony-Anhalt Ministry of Labour and Social Affairs, personal information). Raising awareness and informing people is aimed at underscoring the health, material and social repercussions of consuming controlled substances. The “emergency training for drug consumers” project carried out by mudra-Drogenhilfe in Nuremberg addresses consumers in the facilities offering assistance, drug addicts incarcerated in the penal system and professional helpers in the field of drug-related work (mudra e.V. 2011). In training programmes, drug consumers are to be trained to provide first aid in the event of an overdose. The objective of the training is to remove helpers’ fear that they will be subject to penalties and dispel absurd notions of help measures in widespread practice among drug users. Moreover, participants are instructed in safer-use rules, while their understanding of risks and consumption processes is broadened in order to help avoid overdoses. Beyond this, the participants are impressed with the need to seek aftercare in the clinic so that others can benefit from their knowledge and experience. Finally, it is intended to instil first aid among drug consumers as a reaction with positive connotations.

Types of drug treatment and the number of patients

The types of drug treatment and the number of prisoners treated are presented in the following. Not all offenders dependent on controlled substances are held in German penal institutions, however. The principle of “therapy instead of penalty” namely makes it possible to refrain from imposing a legally effective prison term if the offender who is dependent on controlled substances undergoes therapy (§ 35 of the Narcotics Act). Additional background information on the topic of “therapy instead of penalty” can be found in the 2008 REITOX report (chapter 11). There were a total of 147,582 placements under probationary supervision under general criminal law in 2009 (Statistisches Bundesamt 2011d). Of this

amount, 9,578 sentences were postponed (in accordance with § 35 of the Narcotics Act) respectively placed on probation (in accordance with § 36 of the Narcotics Act). A total of 2,748 in this category were ended in 2009, 1,173 of these suspensions of sentences alone which were related to violations of the Narcotics Act. The Rhineland-Palatinate Pension Insurance Scheme (Kulick 2010) cited studies conducted in the Rhineland-Palatinate on this within the framework of the DBDD workshop “Drugs and Imprisonment” which confirm that medical rehabilitation for persons whose sentences have been suspended under the Narcotics Act with the intention of abstaining from drugs and (re-)integration in working life can be just as successful as in the case of other rehabilitated offenders who undergo drug-withdrawal treatment. The crucial factor determining the success of this measure is above all an approvals process based on criteria which is consistent and transparent for the prisoners, as lack of clarity in the perception of the prisoners can be demotivating and lead to a “revolving door” effect. It is only possible to extrapolate the positive results of rehabilitation to the national level to a limited extent, however.

Substitution practice in the various German Laender

Substitution practice in the German *Laender* is marked in part by considerable differences. To obtain detailed information on the current situation, the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) contacted the ministries of justice of the *Laender* in the summer of 2011. All 13 German *Laender* from which information was received replied that detoxification as well as substitute treatment are offered to inmates in their *Land.* Sustained OST can be performed by the same token in 9 Federal *Laender.* OST is only used to reduce dosage levels among new inmates in Brandenburg, Saxony and Saxony-Anhalt. Inmates are offered to begin an OST shortly before being released from prison in Rhineland-Palatinate, while a high dosage of OST is possible before release from prison in 6 German *Laender* (Baden-Wuerttemberg, Berlin, Mecklenburg-Western Pomerania, Lower Saxony, North Rhine-Westphalia and Rhineland-Palatinate).

According to the indicator database of the WHO (Indikatorendatenbank, BMJ 2009), the following types of drug treatment were available at all penal institutions in 2008: rapid medically assisted detoxification (in 14 German *Laender*), rapid detoxification without medication (in 7 Federal *Laender*), abstinence-based treatment with psychosocial assistance (PSB) (in 11 German *Laender*), treatment with antagonists (in 4 German *Laender*) and substitution treatment (in 9 German *Laender*). Psychosocial assistance was only provided in addition to this in all cases in 6 German *Laender*. Rapid medically assisted detoxification was thus being offered at the times of both surveys in almost all of the German *Laender* and even sustained substitution treatment by more than half of the German *Laender.* According to the results of a study by Schulte et al (2009b), substitution treatment is only possible in approximately 75% of the surveyed prisons (n=31).

Saxony-Anhalt[133] in addition stated that assistance and counselling for inmates suffering addictions are *inter alia* part of the main areas of focus for social services (Saxony-Anhalt Ministry of Labour and Social Affairs 2011, personal information). These tasks may be performed by other public employees as well, however.

Because in a survey conducted in the autumn of 2006 by Deutsche Aidshilfe (DAH) no response was received from Hesse, Lower Saxony or Saxony-Anhalt, the answers submitted by these *Laender* for a survey conducted by DAH in 2002 were used (Knorr 2008). This survey indicates that substitution treatment was generally possible in all the German *Laender* at this time. It should be noted, however, that in Bavaria and Saxony the inmate must have a serious or life-threatening illness at the same time. In the Saarland in 2006, OST was only offered in day-release facilities, where inmates are generally covered by statutory health insurance. Further treatment of a substitution which was commenced in an extramural setting was possible in almost all of the German *Laender* at this point in time. In Bavaria and Saxony this was decided on a case-by-case basis (in Bavaria, for example. substitution treatment was continued when the period of imprisonment was only a few weeks), while in Brandenburg on the other hand substitution treatment was discontinued at the time when people went into prison. When an indication was for substitution for the first time in prison, it was possible in most of the German *Laender* at the point in time of the survey to begin treatment, although in Bavaria and Saxony-Anhalt this was only the case when inmates were seriously ill or during pregnancy. It was not possible to begin OST after entering into prison at all in Brandenburg, the Rhineland-Palatinate or Thuringia in 2006. OST during pregnancy, which constitutes an indication for substitute treatment (Bundesaerztekammer 2010), was only offered in Baden-Wuerttemberg, Bavaria, Bremen, North Rhine-Westphalia, Rhineland-Palatinate and Saxony. The length of time of substitution was generally not limited at that time in Baden-Wuerttemberg, Bremen, North Rhine-Westphalia, the Saarland, Saxony and Schleswig-Holstein. Otherwise it was as a rule only offered within the framework of medically supported withdrawal. Methadone and polamidone were used for OST at that time in 15 German *Laender*; while buprenorphine was used in 7 German *Laender*. Hamburg and Mecklenburg-Western Pomerania were the only German *Laender* in 2006 which did not offer psychosocial assistance to support substitution treatment. When substitution was supposed to be performed but no such service was available in the penal facility, it was possible to move the inmates to another prison in all of the German *Laender* except Berlin and the Saarland in 2006.

Substitution was not offered as a "programme" or "therapy" in Bavaria at the point in time when the survey was carried out by the DAH in 2006, but was performed when ordered by the facility physician in individual cases. Substitution can be performed for the following groups of inmates at Bavarian penal institutions (Knorr 2009):

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[133] The applicable regulations governing internal work with addictions in prisons in Saxony-Anhalt can be found in the administrative decrees of the Ministry of Justice from 6 October 2006 – 4558 – 305 – Mbl. LSA Teilausgabe B no. 47, page 349.

- Inmates who were already receiving substitution before entering prison and who only have to serve prison sentences of a few weeks,
- Pregnant women who are using drugs,
- Sentenced juvenile offenders,
- Seriously ill persons for whom withdrawal would lead to a deterioration in the illness afflicting them and
- Inmates undergoing substitution who are being transported or who have been admitted in connection with a court hearing.

The Senate of Bremen provided information in a notice in September 2006 in response to a large-scale enquiry by the parliamentary party groups of the CDU and the SPD on the topic of "methadone – substitution in Bremen penal institutions and aftercare following release from prison". According to this information, treatment with methadone for persons in custody awaiting trial was generally continued in Bremen if substitution had been performed at least six months prior to imprisonment and the inmate did not also use opiates, benzodiazepines, cocaine or alcohol. Treatment with buprenorphine was continued under the same conditions, but using methadone. No new substitution treatment was commenced for persons in custody awaiting trial. The same conditions governing continuation applied during incarceration in Bremen as for persons in custody awaiting trial. In addition, it was possible to begin OST in the case of severe illnesses such as HIV, hepatitis or tumours (somatic indication) or within the framework of a psychosocial treatment strategy for inmates with long histories of drug addictions, unsuccessful therapy attempts and repeat delinquencies (psychosocial indication) to stabilise their health situation. The term of methadone treatment in Bremen at that time was generally not limited. The actual length depended, however, on the previous history (for example the period of time of drug addiction), the personality structure and personal development of the inmate in prison. Consumption of other drugs was monitored by means of urine tests. The treatment could be discontinued if other drugs were taken[134]. Persons who are at risk as a result of additional consumption are supposed to have their dosage reduced and be released from the treatment program. Generally speaking, additional consumption has always been subject to sanctions; this was taken into account, for example, in granting privileges like leaving prison during the day and the planning of release from prison.

The first expert meeting “Heroin in prison – new challenges and opportunities for the penal system“, which was organised by Deutsche AIDS-Hilfe, furthermore took place in 2010. Staff from ministries of health and justice, AIDS services and prison physicians took part in it. The reason for the meeting was that outside of prisons diamorphine was to be administered as part of primary care. This was why the possibility of administering diamorphine in prison was discussed. The meeting of experts concluded that the required preconditions for such would be an expansion of intramural substitution treatment and sufficient political backing. In

[134] Additional consumption of opiates can be an indication that the methadone dosage is too low and it is necessary to raise it.

addition, attitudes towards drug consumers in prison would have to be addressed and reflected upon in a more focused way.

Because detailed information, much of it relatively outdated, however, is only available from individual German *Laender* and not all of the German *Laender* responded to the national surveys, it is not possible to make any definite statements regarding trends in the availability and conditions surrounding execution of OST in German penal institutions. Here it might be more useful to examine the number of substitution treatments in prison.

Number of inmates undergoing treatment for addiction in the individual German Laender

According to the indicator database, a total of 1,361 inmates underwent substitution treatment in 11 German *Laender* in 2008. This corresponds to a share in 4 German *Laender* ranging from 2.5% to 14%, with two German *Laender* even registering 20% and 50% of intravenous drug consumers respectively. In 4 German *Laender* OST was only possible for persons who were already undergoing substitution prior to imprisonment. The continuation of a substitution treatment commenced before imprisonment was the primary indication for treatment at that time (Keppler et al. 2009). Stoever (2011) found that treatment of previously substituted patients upon entering prison was discontinued in 70% of cases among participants in the IMPROVE Study[135]. Although the remaining 30% still underwent substitution after entering prison, there was a clear intention of abstinence.

A total of 674 inmates were provided assistance by prisons' internal addiction counselling service in the penal institutions of Saxony-Anhalt in 2010 (Saxony-Anhalt Ministry of Labour and Social Affairs, personal information). 85 applications were filed for addiction-treatment measures, of which 69 cases were accepted and the costs assumed. A total of 50 cases were admitted to in-patient or partial in-patient withdrawal treatment.

1,486 inmates underwent rapid medically supported withdrawal in Baden-Wuerttemberg in 2010 (Reber 2010), with 108 inmates undergoing rapid detoxification without medication. 276 inmates received psychosocial support in a treatment having abstinence as the objective and 2 prisoners were treated with antagonists. 524 inmates underwent substitution treatment, although this was only for acute detoxification at 15 facilities. OST was possible for inmates who had undergone substitution before entering prison at 17 facilities, with this being possible without any time limit at 11 facilities. Psychosocial treatment was offered to support substitution in more than half of the cases at 12 facilities, while this was offered in fewer than half of the cases or none at all at 11 facilities.

Approximately 120 inmates were undergoing substitution treatment at Berlin prisons in May 2011 (Senate Administration for Health, the Environment and Consumer Protection Berlin 2011, personal information).

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[135] A total of 400 persons with opioid dependencies at drug-counseling centers and physicians' practices in 11 German cities were surveyed in the IMPROVE Study. Of the persons surveyed, approximately 2/3 had already served prison sentences. Only approximately 30% of this group underwent substitution while they were serving their sentences. 70% had to interrupt OST when they entered prison.

In addition, the DAH survey from 2006 cited above also enquired as to the number of inmates undergoing substitution treatment (Knorr 2009). The answers submitted by the ministries of justice are presented in the following. A substitution treatment was possible for inmates at five prisons in Rhineland-Palatinate. An average of 10 inmates received substitution at that time. There were no closed prisons where substitution was provided in the Saarland at the point in time of the DAH survey. For this reason, it was not possible to transfer prisoners to another penal institution within the Saarland offering treatment possibilities. In North Rhine-Westphalia, OST was generally possible at all penal institutions in 2006.

It was reported at a conference staged by akzept e.V. (2010) that the number of substitution patients in North Rhine-Westphalia had tripled since the launch of the treatment recommendations on therapy for opioid dependency in prisons at the beginning of 2010 (the number of substitution patients in prison in April 2011 was approximately 1000). This trend was also reported at the DBDD workshop “Drugs and Imprisonment”, which took place in November 2010 (Husmann & Render 2010).

The number of substitution places in Bremen is not fixed. Approximately 100 to 120 inmates received substitution at Bremen prisons in 2006, however. According to a study carried out in 2005, 30% of inmates at Bremen prisons were drug addicts (notice by the Senate dated 19 September 2006). Assuming a total of around 700 inmates, there were thus approximately 200 persons with drug backgrounds in prisons in Bremen. According to a notice issued by the Bremen Senate, a total of 101 inmates were being treated with methadone as of 1 September 2006. This corresponds to 12% (Bremen) or 16% (Bremerhaven). According to information provided by the Hessian Ministry of Justice, there were a total of 1,407 drug withdrawals and 339 withdrawals in the case of mixed intoxication carried out in 2004. A majority of these took place at the beginning of prison sentences (Koetter 2010). Substitution treatment was carried out in continuation of treatments which began outside of prison in most of the cases (500 continuations in 2009), with a lower number also starting while the treated persons were serving sentences (20 cases in 2009). OST was discontinued in 9% of the cases, generally as a result of repeated consumption of other drugs. Psychosocial treatment was offered by the internal prison social service or external drug-counselling offices at Hessian prisons in 2004.

No data is available from other German *Laender* on the number of treatment places or actual cases of substitution (Knorr 2009). The number of places has not been determined in Brandenburg to date because of the limited need for treatment. Substitution treatment is generally speaking possible in all facilities in Hamburg, Lower Saxony, Schleswig-Holstein, and Thuringia, while it is possible in some facilities in Mecklenburg-Western Pomerania.

The German Statistical Report on Treatment Centres for Substance Use Disorders (DSHS) has kept a series of tables on ambulatory counselling during prison sentences since 2008 (Pfeiffer-Gerschel et al. 2011c). Because this series of tables only comprises eight facilities and it cannot be ruled out that individual results are only available for one or two facilities or heavily influenced by them, these figures must be interpreted extremely cautiously, as no information whatsoever is available on the mechanisms for selecting participation, nor can

anything be said regarding the representativeness of the participating prisons. In addition there are indications that there are problems with the documentation. For instance, some persons crop up in the overall data set, but not in the separate tables on external counselling in prisons. The average age of men with illegal drug problems who made use of ambulatory aid in prison in 2010 was 28.3 (N=582) (2009: 30.2 years of age; 2008: 29.2 years of age; 2007: 28.3 years of age), while the average for women was 32.2 (N=21) (2009: 29.9 years of age; 2008: 28.4 years of age; 2007: 26.9 years of age). Thus the average age of men in 2010 declined compared to the previous year for two years in a row after it had risen in each of the two previous years. Among women the average age has increased continuously by 1.5 to 2.5 years of age each year. It is particularly interesting that 71.4% (2009: 82.4%) of women serving sentences in prison who underwent treatment as a result of a drug problem were treated for a primary opioid problem, while this percentage among men was only 24.2% (2008:28.2%). In prison the percentage of men whose main diagnosis is stimulants (47.1%) who are undergoing treatment is significantly higher than among persons who undergo out-patient treatment outside of prisons. In contrast to this, treatment of men in prison as a result of cocaine (7.7%) is of a similar magnitude to outside prisons and a primary cannabis problem (18.4%) plays a smaller role than with ambulatory treatment outside of prison; no case is documented for women (Table 11.5).

Table 11.5 Outpatient treatment of drug problems in prison

Main diagnosis	Male		Female		Total	
	N	%	N	%	N	%
Opioids	141	24.2	15	71.4	156	25.9
Cocaine	45	7.7	0	0.0	45	7.5
Stimulants	274	47.1	6	28.6	280	46.4
Hypnotics/Sedatives	5	0.9	0	0.0	5	0.8
Hallucinogenics	1	0.2	0	0.0	1	0.2
Cannabinoids	107	18.4	0	0.0	107	17.7
Mult./other substances	9	1.5	0	0.0	9	1.5
Total	582	100.0	21	100.0	603	100.0

Pfeiffer-Gerschel et al. 2011c.

Effectiveness

The project "Health Care in Prison", which is being carried out by the German Centre for Addiction Issues affecting Children and Adolescents (DZSKJ) and the judicial authorities of the Free and Hanseatic City of Hamburg, is currently performing an evaluation of a therapy preparation station for drug addicts and abusers who are incarcerated in Hamburg prisons. It is to be evaluated to what extent a therapy preparation station can have a positive impact on acceptance of further treatment following release from prison. The survey of data, which took

place between April 2008 and March 2010, also examined whether the treatment program had an influence on the motivation of participants to undergo therapy and not drop out. The final results were not yet available at the point in time of this report (DZSKJ 2011, personal information).

In a survey of the literature on the effectiveness of substitution treatment in prison, Stallwitz und Stoever (2007) found that this type of treatment reduces both heroin consumption as well as the frequency of injections and risks of infection associated therewith, such as, for example, sharing syringes and needles. OST can moreover contribute to health services available in prison being used more frequently. In addition, participation in methadone programs in prison leads to a decline in activities in the drug-related subculture and drug-related penalties. Moreover, there is evidence that long-term substitute treatment during imprisonment in tandem with psychosocial care can encourage inmates to undergo drug treatment after being released from prison. It has furthermore been demonstrated that inmates undergoing substitution are involved in drug trafficking less often, have a lower risk of dying directly after being released from prison, more frequently undergo subsequent drug treatments and exhibit lower rates of relapse when receiving long-term substitution then persons not undergoing substitution (Keppler et al. 2011).

Prisons can also profit from substitution treatment (Stoever & Michels 2010). For instance, withdrawal symptoms of inmates can be controlled more effectively, the ability of inmates addicted to drugs to work and their productivity is raised and inmates undergoing substitution are more approachable, improving their integration in everyday prison life.

Treatment of drug-related infectious diseases

Schulte et al (2009b) have analysed data from physicians in 31 German prisons representing 14,537 inmates. They found that 14.3% of inmates were infected with hepatitis C and 1.2% with HIV. These results thus confirm prevalence rates established in an earlier study (Radun et al. 2007). This prevalence rate is many times greater than that of the general population (see Table 11.6). Approximately 90% of persons who were HIV positive and only barely 6% who were hepatitis C positive were undergoing treatment at the point in time of the survey in 2008. At the workshop “Drugs and Imprisonment” (see chapter 11.1) staged by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction, representatives of prison facilities voiced doubt that these findings could be extrapolated to the overall population of Germany. It is namely unclear which prisoners (e.g. with short or long prison terms) are represented by the random samples examined.

Table 11.6 Infectious diseases in prison

	Injecting drug users	Hepatitis C	HIV
Detainees	21.92–29.61 %	14.32–17.01 %	0.81–1.22 %
General population	0.3%	0.4–0.7%	0.05%
Factor	73–98	26–32	16–24

Radun et al. 2007;Schulte et al. 2009b.

Study results from the project “Infectious Diseases in German Prisons – Epidemiological and Sociological Surveys among Inmates and Staff” indicate that roughly one in every 11 inmates is unaware of his infection with AIDS/HIV, one in every 10 is unaware of his infection with tuberculosis and one in every nine unaware of his infection with hepatitis B and C (Eckert & Weilandt 2008). In this study 2.0% stated that they were HIV-positive, 2.3% stated that they had a positive infection status for tuberculosis, 6.2% for hepatitis B and 16.4% believed that they were infected with hepatitis C.

13 German *Laender* responded to the enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011. Of these, only three *Laender* provided information on the number of tests for infectious diseases conducted when persons entered prison. 50% percent were tested in Baden-Wuerttemberg (8,630 out of 17,298 persons entering into prison), approximately 13% in the Rhineland-Palatinate (approximately 300 out of 2,389); Schleswig-Holstein stated that approximately 40% of cases had been tested for infectious diseases. Only 5 German *Laender* (Hesse, Saxony-Anhalt, Saxony, the Rhineland-Palatinate and Schleswig-Holstein) provided information on the number of infected inmates. According to the figures, 0.6% of inmates tested HIV positive upon entering prison in these *Laender*, 1.5% for hepatitis B (the information comes from 2 German *Laender*), approximately 15% for chronic hepatitis C (the information comes from one of German land) and 0.03% (three persons) for tuberculosis (this information comes from 2 German *Laender*).

In a survey conducted by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011, all 13 German *Laender* stated that there was a possibility for inmates to undergo antiretroviral therapy (against HIV). Aside from Saxony, an antiviral therapy (against HCV) is also possible in prison in these *Laender*. None of the German *Laender* whatsoever were able to provide any information on the scope of therapies performed and the utilisation of therapy places.

In the survey performed for the indicator database of the WHO (Indikatordatenbank, BMJ 2009) the number of persons infected varied considerably among incarcerated intravenous drug users depending on the infectious disease and the German *Land* which was reporting. Thus in 2008, for instance, the share of HIV infections reported was between 1% and 20% (3

Laender), hepatitis A infections 0% (2 *Laender*), hepatitis B infections between 5% and 44% (3 *Laender*) and hepatitis C infections between 75% and 82% (3 *Laender*). It was possible to be inoculated against hepatitis B at all prisons free of charge in 15 German *Laender*, while risk groups were vaccinated in 12 German *Laender* and vaccination was available upon request. In 3 *Laender* vaccination was offered to all inmates when they entered prison. An antiretroviral hepatitis C therapy was possible for inmates at all penal institutions in 14 German *Laender*. Five *Laender* stated that they had a total of 692 prisoners with hepatitis C. 118 inmates were treated for hepatitis C in 7 *Laender*. 8 *Laender* stated that they had a total of 168 HIV-positive inmates. And HIV therapy was possible at all penal institutions in 13 German *Laender* at that point in time. 6 *Laender* reported that 142 inmates were receiving antiretroviral therapy. It is almost impossible to extrapolate the total number of infected persons and the number of treated persons. Because differing numbers of *Laender* responded to the questions, the numbers of treated persons and infected persons cannot simply be placed in relation to one another.

According to health reports on inmates in Baden-Wuerttemberg in 2010 (Reber 2011) 44 inmates were undergoing hepatitis C therapy while 43 were receiving antiretroviral treatment (HIV) in the year under report.

Drug fatalities during and after incarceration

Criminal police data and data from drug consumption rooms show that drug users are especially at risk of dying from an overdose after being released from prison (Frietsch et al. 2010). The WHO estimates that the risk of fatality for drug-dependent former inmates who have relapsed is more than 100 times greater in the first few weeks after release from prison. One study showed that the risk of dying of an overdose two weeks after release from prison was 34.2%; 12 weeks after release from prison this rate was 7.7% (Wolff 2010). These fatalities frequently occur as a result of unsupervised overdoses. According to Stoever, the crucial factor in these accidents is the lower tolerance of the body following temporary abstinence, ignorance as to the level of purity of the drugs used and different drug-consumption behaviour (akzept e.V. 2011). On top of this there are frequently social stress factors following the stay in prison such as, for example, homelessness, unemployment and lack of social contacts. For this reason a major attempt is being made in Hesse to sensitize inmates to the danger of drug fatalities following release from prison (Koetter 2010). DAH and akzept e.V. assume that a reasonable substitution treatment in prison could reduce the number of these drug fatalities because the probability of an overdose following release from prison and the danger of infection during prison could be reduced significantly. The German Medical Association also adopts this position in its guidelines (Bundesaerztekammer 2010). Studies conducted on drug-related emergency cases and fatalities back in the 1990s established these correlations (Herckmann et al. 1993; Soellner 1995). The national model project on the prevention of drug-related emergencies was created in response. This realisation has nevertheless not been integrated as a regular element of practice in prisons. For this reason the issue of prevention of overdoses following release from prison needs to be addressed more.

There are also fatalities resulting from overdoses during imprisonment as well, however. No national data is available on this. The Landtag of Lower Saxony (2010) reports a total of 121 fatalities among inmates (in Lower Saxony between 2003 and 2009) during incarceration, among these 50 suicides and 6 drug fatalities. Because of the dearth of national data, it is not possible to extrapolate any trend or the actual dimension of the problem here, however.

Harm Reduction

9 German *Laender* responded to the enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011 (Baden-Wuerttemberg, Berlin, Bremen, Hesse, Mecklenburg-Western Pomerania, Lower Saxony, North Rhine-Westphalia, Saxony and Schleswig-Holstein), stating that condoms and in some cases lubrication is distributed to inmates free of charge. Almost all German *Laender* moreover stated that they offered inmates tests for infectious diseases.

According to the Indicator Database of the WHO, inmates in 13 German *Laender* allowed themselves to be voluntarily tested for HIV upon entering prison in 2008, while all prisoners were tested in 4 German *Laender* (Indikatorendatenbank, BMJ 2009). HIV counselling always took place before and after the test in only 11 *Laender*. In 11 *Laender* it was possible to take a test for hepatitis B and C upon entering prison on a voluntary basis, while these tests took place with all persons entering prison in 3 *Laender*. Tests for infectious diseases were carried out upon release from prison much less in all of the German *Laender* in 2008. No tests whatsoever were offered in 10 (HIV) and 11 *Laender* (hepatitis B and C) upon release from prison. Condoms were available free of charge at all penal institutions in 12 *Laender* in 2008, while these could also be purchased in 6 of the *Laender*. No disinfection substances were available in any of the *Laender*. In both surveys (2008 and 2011) the *Laender* stated that tests for infectious diseases were generally possible and that condoms were also frequently available free of charge. In neither case was it reported that disinfection substances were made available.

In order to minimize the risk of infection, tattooing in penal institutions is in addition generally prohibited. In spite of this, the number of inmates in prisons with piercing in the month of March in Baden-Wuerttemberg was estimated at 3%, while the number of inmates with tattoos was estimated at 10% (Reber 2011). In order to support inmates attempting abstinence in their endeavour, there were drug-free sections available at some penal institutions in 6 German *Laender* in 2008 (Indikatorendatenbank, BMJ 2009), There were a total of 55 prison places in these sections at 3 prisons in Baden-Wuerttemberg in 2010 (Reber 2009).

Only one project remained in existence in Germany in the wake of the model project "dispensing syringes in prison", which was subsidized by the Deutsche Forschungsgemeinschaft (DFG) until the end of 1998 (Berliner AIDS-Hilfe e.V. 2011). Women addicted to intravenous drugs can exchange sterile syringes at syringe vending machines anonymously at the prison for women in Berlin Lichtenberg. This is aimed at reducing the risk of infection with HIV and hepatitis during imprisonment. In addition, staff of Berliner AIDS-Hilfe e.V. regularly offer information and confidential counselling discussions

without the presence of a guard. Baden-Wuerttemberg in addition stated that no bleach was available at penal institutions in 2010, either. Condoms were distributed free of charge in this *Land*, while in others they were available for purchase. All inmates had the possibility of receiving vaccination against hepatitis B to prevent infectious diseases (Reber 2009).

Trust and confidence in the confidentiality of the physician providing treatment is an important precondition motivating inmates to undergo HIV or hepatitis tests (Knorr 2011). In some regions physicians at facilities pass information on existing HIV infections of inmates to the management of the facility, who then for their part "inform" the staff about existing infections. This data is routinely disclosed and does not depend on the conduct of the inmates. Because the physician-patient relationship is already possibly weakened as a result of the lack of ability to freely choose one's physician, disclosing this information on an existing infectious disease may also have an impact on the future testing behaviour of the inmates. The DAH is currently attempting to obtain a binding clarification of the lawfulness of this mode of procedure (2011).

Preparation for release and continuity of supply following release

For many former inmates, the beginning of medical rehabilitation measures for addicts is fraught with difficulties. Thus a survey conducted at in-patient help facilities for addicts indicates that a majority of persons just released from prison do not have any health insurance (Buerkle et al. 2010): at the facilities surveyed (n=141) 28.7% of the patients from the indication area of drugs had come directly out of prison. 77.3% of them did not have any health insurance. These figures underscore a need for action to be taken to regulate the therapy-related transition between prison and freedom. Some changes are already taking place: for example, inmates with drug dependencies are entitled to a binding commitment to assumption of the costs for drug therapy by the statutory old-age pension scheme since an order issued by Fulda Social Court in November 2010 (AFP 2010). This applies when release from prison before the expiry of the sentence depends on the assurance of a therapy place.

In October 2010 an integration agreement has been concluded among various institutions in Hesse: the Hessian Ministry of Justice and Ministry of Social Affairs, the Regional Directorate of the Federal Employment Agency (Bundesagentur fuer Arbeit), the Hessian Landkreistag and Staedtetag, the Hessian Statutory Welfare Association (Landeswohlfahrtsverband) and the Hessian Amalgamation for Aid to Prison Inmates (Landeszusammenschluss fuer Straffaelligenhilfe Hessen) (Hessian Ministry of Justice 2011, personal information). The aim of this agreement is to establish the required framework conditions for an orderly reintegration in society at the point in time when an inmate is released from prison (Koetter 2010). Thus, for example, social benefits are supposed to be clarified at this point in time. It is not only the question of the funding of therapies, however, but also the communication of this which makes it difficult under certain circumstances for inmates to start therapies after their release. In addition, inmates in Hesse with special needs for help have already been receiving assistance in prison through services offered by non-statutory help services for inmates since 2007.

In Saxony-Anhalt prisoners are referred to in-patient and ambulatory addiction withdrawal programmes already while they are still in prison, while the required legal, organizational and financial preconditions for this are established (Saxony-Anhalt Ministry for Labour and Social Affairs 2011, personal information).

According to the response of the Lower Saxony Landtag from August 2010 to a large-scale enquiry (Drucksache 16/2755), the staff members of the Social Service in Lower Saxony are particularly involved in tasks relating to preparation for release from prison. At present there are almost 200 persons working in this area at Lower Saxony prisons. In addition, the Ambulatory Prison Social Service of Lower Saxony (ambulantes Justizsozialdienst Niedersachsen – AJSD) offers a large spectrum of services from local offices for persons released on probation or under supervision of conduct. In addition to these regional offices and consultation times, the staff of the AJSD can be contacted at additional sites for the persons affected within the framework of visits to their homes and consultation meetings outside their homes. Here there was one probation officer for more than 80 persons participating in clinical trials throughout Lower Saxony in 2009 on average. The contact points for non-statutory aid to inmates primarily concentrate on persons released from prison who are not assigned to any probation helper. The Criminological Service in Lower Saxony will receive data on various strategies and measures which facilitate the transition from prison to freedom and are aimed at promoting integration beginning in 2012. Beyond this, evaluations of a training measure which is designed to prepare inmates with drug dependencies for in-patient drug withdrawal (within the framework of § 35 of the Narcotics Act) are being planned.

The after-care project “Chance” (Kaiser 2010) initiated in Baden-Wuerttemberg addresses persons released from prison who do not have any probation helpers, offering the participants intensive assistance before and even up to 6 months after release from prison. The project has been developed for all persons released from prison and is also accordingly being used with persons dependent on addictive substances in prison. “Chance” is supposed to assist inmates in the transition from prison to freedom on the one hand by helping them with practical everyday things, while on the other hand offering them a continuous contact. The Paritaetische Wohlfahrtsverband Baden-Wuerttemberg states that this release-management supports the resocialisation of inmates, thus reducing the risk of reversion to criminality. The activity of the case managers has led to an improvement in the situation of a number of clients (Institute for Criminology at the University of Heidelberg and Tuebingen 2010). This especially goes for the areas of housing, job and finances. A six-month period of assistance may be too short for clients with multiple problems, however. In these cases it is important to ensure that they receive follow-up assistance. According to the health report on inmates in Baden-Wuerttemberg (Reber 2011), substitution is offered as a supportive measure preparing inmates for release at 12 facilities, continuation of substitution is carried out at 16 facilities, while in 16 facilities inmates are referred to external drug-aid associations. At 11 facilities constant assistance is ensured.

In North Rhine-Westphalia as well, inmates with addictions receive comprehensive aid and counselling services after they are released from prison in order to protect them better

against the dangers of a relapse (North Rhine-Westphalia Ministry of Justice 2011). This is set out in a framework agreement pursuant to so-called transition management for inmates with addictions, which was signed in Duesseldorf on 7 April 2011 by representatives of the Ministry of Justice and the peak associations of the non-statutory welfare care associations, the Staedtetag, the Staedte- und Gemeindebund and the North Rhine-Westphalia Landkreistag. Under this agreement, the penal institution where the inmate is serving his sentence up until his release is to conclude an agreement with a selected aid facility setting out clearly defined measures in the future. This aid facility furthermore offers practical help in everyday things, inter alia looking for a dwelling, counselling on debts or referral to healthcare facilities – for example to resolve insurance issues, to have costs paid by insurance schemes and help arrange further medical treatment.

According to a notice from the Senate in response to a large survey, prisoners in Bremen are usually given the name of institutions providing aftercare in the case of substitution following release from prison to prepare them for release (Bremische Buergerschaft 2006). The patients have to contact these institutions after their release. In order to guarantee a smooth transition from prison to freedom, the Bremen prisons provide substitution four additional weeks after release from prison. In addition, inmates can consult a physician outside the prison prior to release in order to have a preparatory meeting to discuss treatment after release from prison. The prison bears the costs of this.

In response to an enquiry by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction carried out in the summer of 2011, 6 German *Laender* (Baden-Wuerttemberg, Berlin, Mecklenburg-Western Pomerania, North Rhine-Westphalia, Lower Saxony and Rhineland-Palatinate) reported that an increase in dosage is offered to opioid consumers within the framework of an ongoing OST prior to release from prison. Berlin, Saxony-Anhalt, Schleswig-Holstein and Thuringia state that inmates are referred to external addiction therapies, inter alia for an OST. In Bremen a transition substitution is possible after release from prison for inmates and Rhineland-Palatinate offers general transition management. Lower Saxony, Baden-Wuerttemberg and Mecklenburg-Question Pomerania stated that preparation for release is possible if this is necessary, but did not state any specific measures.

More differentiated statistics on preparation for release are provided in the data collection for the indicator database of the WHO (Indikatorendatenbank, BMJ 2009) than for 2011. Thus, for example, information material was handed out at almost all prisons in 12 German *Laender* in 2008, inmates are given counselling on risks and the prevention of drug-related health damage at all penal institutions in 15 German *Laender*, substitution treatment can be initiated at all prisons prior to release from prison in 4 *Laender* and inmates are referred directly to external drug-aid services in 12 *Laender*.

11.3.2 Drug tests

Guidelines on the execution of drug tests

Brandenburg, Baden-Wuerttemberg and North Rhine-Westphalia are the only German *Laender* which issue detailed rules for the health-care system in prisons in so-called

technical regulations. Neither the technical regulations of the *Laender* Brandenburg, Baden-Wuerttemberg or North Rhine-Westphalia (none were available for the other *Laender* at the point in time of the research in the summer of 2011) nor the Infection Protection Act (IfSG) (national) stipulate an exact procedure for testing for drug consumption and infectious diseases in German prison facilities, however. Although the technical regulations of North Rhine-Westphalia stipulate that the status of drug dependence of inmates is to be determined upon admission and release from prison in the physical examination conducted by the medical service, nothing is stated regarding the exact procedure here, either. Instead, the procedure is individually regulated by each of the German *Laender* and frequently even by each facility. Thus there is no uniform, obligatory arrangement regarding this measure, either for the management of the prison or for the inmates.

Number of drug consumers in prison

Experts assume that in Germany approximately 30% of all male and more than 50% of all female inmates are intravenous drug addicts and that the rates of drug-consuming inmates is many times greater than that of the general population (Keppler et al. 2010). Studies conducted in individual German *Laender* showing that roughly one in every two inmates is "at risk with respect to drug consumption" (North Rhine-Westphalia Ministry of Justice 1992) while one in every three persons must be considered "in need of therapy" (Dolde 2002) suggest that these estimates tend to be conservative. A survey conducted at Oldenburg Remand Prison indicates, for example, that 76% of all inmates receiving medical care have been treated for drug problems (Tielking et al. 2003).

In response to an enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011, all 13 German *Laender* from which responses were received stated that drug tests were carried out in the case of suspicion or known previous drug history when persons entered prison. Only 4 *Laender* were able to provide statistics on the number of positive tests and information on the drugs consumed, however. Lower Saxony stated that approximately 40% and Schleswig-Holstein that approximately 80% to 90% of the inmates tested for consumption of illegal drugs were positive, especially for cannabis. In the Rhineland-Palatinate, around 17% (1,200) of approximately 7,000 inmates tested had a positive test result for illegal drugs, in Thuringia 32% of 19 persons tested (5 cannabis, 1 amphetamine). In addition, all of the German *Laender* stated that tests are performed at irregular intervals as needed or in the case of suspicion of drug consumption during incarceration. Table 11.7 provides details on the execution of drug tests at German penal institutions. The band width of positive test results is enormous, ranging from 17% to 90%. The number of drug tests performed also varies considerably, with no information whatsoever being available on the number of tests or the number of positive test results for most of the German *Laender*.

In the survey conducted for the indicator database of the WHO (Indikatorendatenbank, BMJ 2009) 3 *Laender* stated that in 2008 the portion of inmates who had injected drugs at some point was between 0.5% and 34%. It was reported that drug tests (by means of urine tests) were carried out when there was a suspicion of consumption at all prisons in 2008. Drug tests were carried out on a random basis in 14 German *Laender*, upon entry into prison in 5

Laender, and before home release in 6 German *Laender*. 4 *Laender* stated that in the report year 2008 15% (2,850) of almost 19,000 inmates tested were positive. The ministries of justice have provided the following prevalence rates for consumption of illegal drugs in 2008:

- Cannabis: 15% - 30% (the data comes from 5 German *Laender*),
- Heroin/opiates: 1% - 30% (the data comes from 9 German *Laender*)
- Crack/cocaine: 1% - 20% (the data comes from 9 German *Laender*)
- Amphetamines: 1% - 22% (the data comes from 12 German *Laender*)
- Ecstasy: 1% - 20% (the data comes from 9 German *Laender*)
- Any type of illegal drugs: 8.74% - 36.2% (the data comes from 4 German *Laender*)

At 9% to 36%, the range of values stated for the consumption of any types of illegal drugs in 2008 is relatively great and differs from the values stated in 2011 and moreover varies much more greatly (17% to 90%).

Within the framework of the project ”Infectious Diseases in German Prisons – Epidemiological and Sociological Surveys among Inmates and Staff” inmates were surveyed as to how great they expected the percentage of drug consumers to be among the inmates of the prison in which they were incarcerated (Eckert & Weilandt 2008). The average amount stated for alleged consumption of cannabis or hashish by inmates was 65.4%. The inmates estimated on average that 47.4% were opiate consumers. It was estimated that in sum total half (48.9%) of inmates consumed other controlled substances or medication.

The North Rhine-Westphalia Ministry of Justice reported 6,713 inmates in North Rhine-Westphalian prisons who were dependent on illegal drugs and required treatment as of 31 October 2010. This group accounts for 39.2% of the total number of inmates at prisons (North Rhine-Westphalia Ministry of Justice 2011, personal information).

For Hesse it was reported that in 2009 approximately 10% of the urine tests conducted were positive or were refused. Cannabinoids were mainly found here. Unfortunately the number of tests conducted at this time is unknown, so no statements can be made about the actual prevalence of drug consumption. A total of 64 drugs which were found were confiscated in regular checks of inmates in 2009.

In Baden-Wuerttemberg (Reber 2011) drug tests were also carried out in 2010 by means of urine tests upon admission, generally on a random basis and before inmates were granted the privilege of going out, in some cases upon entry into prison as well. Out of 29,934 tests conducted, 4.4% were positive. Out of the 7,423 inmates tested in this manner, 12.0% tested positive. The following substances were consumed before entry into prison: cannabis (40%), heroin/opiates (19%), crack/cocaine (7%), amphetamines (7%) and Ecstasy (5%). In sum total, 21% of inmates took illegal drugs of some sort prior to entering into prison.

Inmates at all prison facilities in Lower Saxony (with the exception of remand pending deportation) were surveyed upon entering prison inter alia about their drug consumption prior to entering prison in 2005 (Criminological Service at the Educational Institute of the Lower

Saxony Prison System 2006). In sum, 40.7% of the participants (299 out of 734) reported that they had consumed illegal drugs in the last 28 days prior to entering prison. The amount of females consuming illegal drugs before entering prison was slightly above that of the men (40.6% versus 37.3%). The highest level of consumption of illegal drugs was registered by juvenile detention with 61.7%. Depending upon the substance, between 1.0% and 26.6% of inmates in prison stated that they had consumed illegal substances shortly before entering prison, primarily hashish or marijuana (26.6%) and opiates (16.8%). In addition, 15.1% of inmates reported that they had consumed drugs intravenously before they entered prison.

Schulte et al (2009b) have analysed data from physicians at 31 German prisons representing 14,537 inmates. The portion of former or current intravenous drug consumers at all prisons was 21.9%. The share of intravenous drug consumers in the general population is approximately 0.3%. This amount is thus almost 70 times higher in prisons. The prevalence levels found by Schulte et al. (2009b) confirm the results of a study conducted by Radun et al. (2007). The data is shown in Table 11.6. Based on the values reported in these studies, one can assume that out of 70,000 inmates in German penal institutions, 15,400 to 20,700 are intravenous drug consumers.

Table 11.7 Performance of drug tests broken down by *Laender* in 2010

Land	Drug tests conducted	Positive Tests	Intervals	Miscellaneous
Baden – Wuerttemberg	25,000 tests	1,429	irregular	Not applicable
Berlin	65,000 tests	139	Not applicable	Number of positive tests only available for correctional facility
Brandenburg	Not applicable	Not specified	Decision on by-case basis	Not applicable
Bremen	Not applicable	Not specified	irregular	Tests are carried out to control substitution, to decide about imprisonment, irregularities, privileges, before starting therapy
Hesse	13,619 Tests among 5,775 detainees	344 (incl. 190 detainees refusing examination)	irregular	Decision of medical service
Mecklenburg-Western Pomerania	Not specified	Not specified	Depends on indication	Not specified
Lower Saxony	Approx. 30% of detainees starting sentence	Approx. 40% of tests	if necessary	Not specified
North Rhine-Westphalia	8,000 – 10,000	Not specified	irrregular	Not specified.
Rhineland-Palatinate	7,000	1,200	irregular	Tests are carried out in case of suspicion resp. in some cases before and after a decision on privileges
Saxony	Not specified	Not specified	decision on by-case basis	Not specified
Saxony-Anhalt	Not specified	68		Not specified
Schleswig-Holstein	Approx. about 30% of detainees starting sentence	Approx. 80% - 90% of tests	irregular	Not specified
Thuringia	Not specified	170	irregular	Tests are carried out in case of suspicion, preparation of privileges

11.4 Quality of treatment

11.4.1 Guidelines for drug-related health services in prison

Quality assurance for drug-related services in prison

In Germany numerous institutions address quality assurance in the extramural health care system, such as for example the SHI-Accredited Care Services Associations (Kassenaerztlichen Vereinigungen – KV), the statutory health insurance schemes (gesetzliche Krankenversicherungen – GKV) and the medical associations. The quality of intramural health care is reviewed with the aid of independent experts usually assigned to the ministry of health in some countries such as, for example, the Netherlands ("inspectorate system") (Stoever 2006). In Germany controls relating to health care in prison are the domain of the ministries of justice, and thus also for ensuring the quality of drug-related services in prisons. The German penal system maintains its own health care system, comparable with the healthcare system for the police or German army. This means certain differences in care for patients within these systems compared to the general population. Inmates do not have the possibility to freely choose their physician, for example.

As a result of the special structure of prisons, supervision of medical services at German prisons is regulated differently than in the extramural area. Thus, the director of the facility is not entitled to issue technical instructions to the facility physician (Keppler et al. 2010). The physician is subject to technical supervision, however, which may be regulated as follows:

- The person in charge of supervision in the ministry (medical director) is a physician.
- The person in charge of supervision in the ministry is not a physician, but rather a lawyer or psychologist, for example. This person makes use of know-how possessed by medical experts who are not part of the ministry of justice in the case of technical medical questions, for example staff at the ministry of health or external physicians who are not affiliated with any public institution.
- Supervision is not the charge of any one person (staff member of the ministry of justice), but rather external physicians, for example experienced physicians at facilities in another German Land, physicians from the ministry of health or retired physicians.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) acts as an external expert. The European Treaty on this stipulates that prison facilities be visited on a regular basis (European Commission 2002). The next to the last visit by the CPT in Germany took place between 20 November and 2 December 2005 (CPT 2006), in the framework of which 17 facilities were visited. Statements made in the CPT report in connection with "healthcare" are only based on three facilities. It was especially criticized that the prisons do not have general physicians available on a sufficient scale. In the view of the CPT, there should be one general practitioner with a full-time position available for each 300 inmates. In addition, in the opinion of the CPT, psychiatric care and care for inmates with drug dependencies are inappropriate. Moreover it

was criticized that not every inmate entering prison at all prison facilities was informed about healthcare or the prevention of infectious diseases (for example with the aid of an information brochure).

Baden-Wuerttemberg states that the same standards and guidelines apply intramurally for drug treatment as extramurally (Reber & Wulf 2009). A system for regular collection of data has been launched in Baden-Wuerttemberg, "Health Reporting on Inmates in Baden-Wuerttemberg", to provide more precise documentation of this procedure. The items used are heavily based on the items of the indicator database of the WHO. General data is requested, for example, on the penal system, prevalence and prevention of infectious diseases and drug consumption, counselling and treatment, quality assurance, informing inmates and public employees of prisons and risk-prevention.

The effectiveness of an OST with methadone was studied in Bremen by the medical service of the prisons there (Bremische Buergerschaft 2006). It is difficult to determine the degree of success, however, for example with respect to resocialisation, as the medical service of the prisons no longer has access to patients and there is no reliable information structure on the biographies of former inmates. Nor is any reliable data available along the lines of a scientifically founded observation over time such as statistics on relapse of this clientele of prisons.

Controls of medical activities by the Technical Agencies of the Supervisory Authorities are laid down in North Rhine-Westphalia in the "Recommendations for Treatment by Physicians Providing Medical Therapy for Opioid Dependency in Prison" (North Rhine-Westphalia Ministry of Justice & Westphalia-Lippe Medical Associations and North Ryan 2010). It issues orders if the borderlines of conscientious discretion by physicians are exceeded or improperly performed. Orders issued by supervisory authorities are limited to specific individual cases.

Guidelines for treating drugs in prison

Imprisonment continues to increase the risk that substitution commenced before entering a penal institution will not be continued (Stoever 2010a). Guidelines can help remove uncertainty and ignorance on the part of prison health care personnel. In order to provide penal institution physicians more certainty, the framework conditions, i.e. treatment strategies, accompanying psychosocial therapy or criteria for discontinuation, should be clearly described. These must take specific conditions in prison especially into account.

The Euro region of the WHO adopted the “Declaration on Health in Prisons as an Element of Public Health” in Moscow in 2003, in which several basic principles are laid down for the treatment of prisoners. Citing the fundamental principles of the United Nations regarding medical ethics in connection with the role of medical personnel, in particular physicians, in the protection of inmates and prisoners against torture and other cruel, inhuman or humiliating treatment or punishment, principal 1, it is laid down that medic al personnel, in particular physicians who are charged with the medical care of inmates and prisoners are obligated to attend to their physical and mental health in the same manner as persons who

are not inmates or prisoners. With reference to principal 9 of the Fundamental Principals of the United Nations regarding the treatment of inmates and prisoners, it is laid down that prisoners are to be granted access to the health services of their country without regard to their legal situation. In addition, the connection between health in prisons and the public health system is stressed and the need arising from this for cooperation between ministries of health and justice. According to the declaration, the quality of healthcare in prisons is of special importance not least because inmates generally constitute a special risk group for health problems and moreover prisons can be risk areas for infection or worsening of illnesses. Moreover, former inmates may act as multipliers for illnesses outside of prison and thus influence the health status of the population at large. This is why it is recommended that staff and medical personnel at prisons be well trained and furthermore have uniform documentation to provide them a better overview of the current situation.

The recommendations for action “Opioid Substitution Treatment in Custodial Settings” (Kastelic et al. 2008), which was compiled by an international group of authors and issued by the WHO and the United Nations, address special aspects of the intramural setting with regard to the recommendations for substitution treatment in prison. A relapse with a high risk of an overdose is likely, according to international studies, if the detoxification has taken place too quickly. That is why the prison doctor should explain to patients in clear terms the advantages and disadvantages of a short or long detoxification so that an appropriate strategy can be selected for the individual case. In contrast to extramural substitution, it is assumed in most countries that a low daily dosage of methadone is sufficient in prison, as it is assumed that 100% of the substitution substance is taken and it is also assumed that consumption of other substances is significantly lower than outside prison. This is supposed to be regularly checked by means of urine tests. A positive urine test should not automatically be reason to discontinue the therapy, according to the international recommendations of the WHO. This should be viewed, rather, as an additional symptom of drug dependence. Generally speaking, according to these international recommendations, substitution treatment should never be used as a reward or punishment, but rather as part of a normal spectrum of treatment.

The physicians’ recommendations on treatment and medical therapy for opioid dependency in prisons in North Rhine-Westphalia (North Rhine-Westphalia Ministry of Justice and Medical Associations of Westphalia-Lippe) stress the positive effect of substitution treatment in prison both with regard to the treatment of opioid dependency as well as attainment of the incarceration objective. That is why the objective stated is to “significantly raise the number of substitution treatments in prison". According to the recommendations for treatment, the objectives are

- to prevent fatalities as a result of decreased tolerance in prison and following release from prison,
- a reduction in illegal and subculture activities,
- an improvement in physical and mental health and

- permanent abstinence.

Similar to the situation outside prison, the patient has to sign a treatment agreement at the commencement of the substitution treatment in which rules are laid down. Among other things, it is stipulated in writing when the treatment is to be discontinued (for example in the event of repeated problematic consumption of other substances, drug trafficking or violence in connection with OST) and that discontinuation does not automatically mean permanent exclusion from OST. The decision on termination of treatment is made by the medical service. There are no fixed conditions with respect to recommencement. Generally speaking, in North Rhine-Westphalia patients who have already received substitution continued to be treated after entering into a prison, while the term of the sentence must not have any influence on the indication for treatment. Nevertheless it is recommended here that it should be possible to obtain a place for continued substitution in the event of substitute treatment in remand pending trial and sentences of less than two years. When inmates are released they should be assured of further treatment.

An administrative regulation issued by the Baden-Wuerttemberg Ministry of Justice has regulated substitution in prisons since 2002. It contains clear provisions regarding the general aims of OST as well as requirements regarding indication, exclusion, admittance, execution, documentation and termination of the substitution treatment. In addition, substitution with diamorphine has also been possible since the revised and amended version of the administrative regulation of 15 July 2011 went into effect (Baden-Wuerttemberg Ministry of Justice 2011).

The foundation for substitution treatment in prison in Lower Saxony is a decree from 2003 which for the most part is based on stipulations in the Narcotics Act and the Guidelines on the Evaluation of Physicians' Examination and Treatment Methods (BUB-Richtlinien): The decree sets out the preconditions and stipulates how substitution is to be carried out. Just like with all treatments by physicians, the physician providing treatment is in charge of the indication and establishes by means of an individual examination whether the substitution treatment is warranted and whether the intended purpose can be achieved in any other manner. Substitution is provided based on the principle of equivalency in line with the stipulations of Social Code V and the respective guidelines.

In accordance with the principle of equivalency, the guidelines issued by the German Medical Association (Bundesaertzekammer 2010) in 2010 also apply intramurally. The guidelines apply to all physicians who perform this treatment. Under the guidelines, it must be ensured when patients switch to hospital treatment, rehabilitation, imprisonment or any other form of in-patient care that the treatment is provided on a continuous basis. Furthermore, substitution treatment can also be provided in accordance with ICD F11.21 (opiate dependency, abstinent at present, but in a protected environment – such as, for example, a hospital, therapy community or prison) in individual cases where this is warranted. In the event of consumption of additional psychotropic substances, the cause of such, such as inadequate dosage or selection of the substitution substance or a co-morbid psychological or somatic illness, should be determined and if possible remedied. If this additional consumption

jeopardises the substitution, withdrawal from the additional psychotropic substance is to be initiated.

The aim of the project “Health Promotion for Young Prisoners“, which is being carried out until 2013 and coordinated by the Scientific Institute of Physicians in Germany (Wissenschaftliches Institut der Aerzte Deutschlands (WIAD)), addresses the development and improvement of health promotion of young inmates. The aim of this project is to implement the guidelines relating to this. The needs both of juveniles in detention who are especially at risk as well as prison personnel and non-governmental organisations are to be taken into account in their development.

11.4.2 Training of prison guards

In comparison to other occupational groups, prison guards are especially confronted with persons who consume drugs. That is why these persons should receive separate training to deal with and raise awareness in connection with drug consumers. The ministries of justice have reacted to this by instituting initial and continuing training programmes on this area.

In response to the enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) in the summer of 2011, 12 out of 13 German *Laender* stated that their prison guards were conveyed specialised knowledge relating to drugs. 2 German *Laender* stated that employees working in prisons received separate special training in drug-related first-aid measures. Beyond this, 3 *Laender* stated that prison guards are trained to become course leaders in prevention programmes for inmates. Other training measures are offered in 9 out of 13 German *Laender* in addition. Of these 9 *Laender*, 4 stated that the topic of drug consumption among inmates is generally treated within the framework of training as a prison guard.

A manual entitled “Minimising damage in penal institutions” (“Schadensminimierung im Justizvollzug”), which is issued by the Wissenschaftliches Institut der Aerzte Deutschlands (Scientific Institute of Physicians in Germany - WIAD) and which was produced by a project funded by the European Commission, is intended to provide continuing training of staff working at prisons (Wiegand et al. 2011). The manual provides suggestions on how the negative impact of certain types of behaviour can be reduced such as, for instance, the transmission of infectious diseases in the case of intravenous drug consumption through needles or sharing of needles. These concepts and strategies especially play a role at prisons, as this involves preservation of and respect for the human rights of prisoners, protection of public health and not least the demonstrated cost effectiveness of preventive measures compared to the costs of treatment, for example after people have become infected. The manual provides information on the topic of infectious diseases and the different ways they are transmitted as well as drug consumption and types of behaviour at risk relating thereto. Among other things, prison guards are to be sensitised to the special challenges of drug consumption. Moreover, the attitudes and understanding of prison guards towards drug consumption and consumers is supposed to be explored.

Baden-Wuerttemberg reported that counselling on the topic of prevention of drug-related health damage to public employees working in the penal system was provided at 17 facilities in Baden-Wuerttemberg in 2010 (Reber 2011). In addition, training in how to cope with drug-related emergencies was carried out at some Berlin prisons (DAH 2010). Here both appropriate behaviour in the event of drug-related emergencies as well as particular risks such as, for example, consumption of drugs following abstinence, are addressed. The administration of naloxon, an opiate antagonist, is also discussed in the training.

11.5 Discussion

11.5.1 Principle of equivalency

The number of substitution treatments outside prison has risen by more than 50% to approximately 80,000 patients at present in Germany over the last five years. Thus around 77,400 of the estimated 81,000 to 171,000 persons with problem consumption of opioids are being reached at present (see chapter 4.2.1). No comparable trend can be witnessed at German penal institutions. Merely approximately 1,700 inmates among the estimated 15,400 to 20,700 opiate consumers are currently undergoing long-term substitution treatment at present (Stoever 2011b). The treatment objectives associated with intramural substitution treatment also place a significantly greater emphasis on the goal of abstinence than substitution treatment outside prison (Schulte et al. 2009b). Thus intramural OST differs in this respect from extramural OST, in which many patients are also provided long-term treatment when they require it[136]. This difference may possibly be explained by the fact that the prison setting is better suited to achieving abstinence than the setting outside prison.

Previously substituted persons were not provided continued treatment when they entered prison in 70% of cases in the IMPROVE study (Stoever 2011). The discontinuation of an OST upon entering prison can, however, lead to physical and psychological problems and increased risk behaviour such as, for instance, sharing of injection devices, and hence raise the risk of drug-related infectious diseases (Stoever & Stallwitz 2008).

The reasons for the relatively low number and in some cases unclear quality of substitution treatments in prison are wide-ranging. Generally speaking, dealing with persons dependent on drugs in prison poses considerable difficulties. Thus for one thing prisons are supposed to resocialise inmates. On the other hand they are confronted with the reality that in spite of an absolute ban against illegal drugs in German penal institutions, a large percentage of inmates consume drugs, some of them in a very destructive manner. On top of this, the possible actions which can be taken by the (medical) prison personnel are often quite limited (Keppler et al. 2011). Thus there are often too few medical personnel available to cope with the number of inmates requiring treatment and the intensity of care they require. Too few

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136 5 to 7 years after the baseline survey in the PREMOS Study 46.0% of the particants (n=162) were in a situation of stable substitution, 12.7% in unstable substitution and 11.7% had an unclear substitution situation at the point in time of measurement (Wittchen et al. 2010). This result does not provide any indication about the effectiveness of short-term substitution, however.

guidelines in the area of drug-related health care in prison frequently leads to marked differences in health care among inmates, first of all between the German *Laender,* but also even between individual penal institutions as well. Considerable regional differences can be seen especially when it comes to substitution – differences reflected in north-south, west-east and urban-rural differences in the rate of opioid addicts receiving substitution (Schulte et al. 2009a).

In spite of these difficulties, prisons theoretically offer a suitable setting for continuous treatment of inmates (Keppler et al. 2011). Medical personnel is present right on site, for instance, and the regular prison guards and staff are generally experienced in dealing with inmates who consume drugs, with a majority of them also having received additional training to be able to report medical symptoms to the right persons among the staff of physicians or nurses at the penal facility. By the same token, the additional areas of responsibility and work required of supervisory personnel should not be forgotten, which is why there are so many of these present.

11.5.2 Methodological limitations and gaps in information

Inter alia as a result of the federal nature of the German penal system there are numerous methodological limitations and gaps in information in this area. This results in fragmentation both with respect to the data available as well as in laws and regulations. Individual *Laender* have had their own prison laws for adults for several years, for instance, while the German Prison Law still applies in others. Moreover, some German *Laender* have administrative regulations governing health care at penal institutions, while others do not. That is why drug-related treatment modalities vary, especially in the area of substitution treatment, not only between the German *Laender* at present, but also among various prisons as well (Stoever 2011b).

Thus, although individual data surveys are carried out at the national level on the topic of health care in prisons such as, for example, within the framework of the information collection for the Indicator Database, this data is frequently obsolete or – like in the case of the Indicator Database – it cannot be attributed to particular *Laender.* As a result reference variables are lacking to match the figures reported. Nor can extrapolations or estimates be made on the basis of the data, as the (little) information may be from very small or very large *Laender* and the values would possibly be highly distorted. Moreover, there are numerous individual regional studies, but they are generally not comparable as a result of the lack of networking between statistics and the non-uniform methods of collecting data and classifying it (ICD diagnoses are only made very rarely). As a result, it is not possible to establish any direct linkages between the data. Sequential or comparative analyses are virtually impossible as a result. Closer cooperation between the ministries of health and justice would possibly help document questions relating to health with the aid of tried-and-proven methods to make intervention more effective. A uniform and reliable document culture at prisons could be promoted by making sufficient human resources available in the area of health care.

The absence of clear, uniform guidelines might have the effect of limiting the possibilities of prison guards to take action, as the lack of uniformity creates uncertainties which impact possible action. The importance of objectives being set by the individual ministries of justice for the development of substitution treatment in prison has been illustrated by the recommendations of North Rhine-Westphalia for treatment (NRW Ministry of Justice and Westphalia-Lippe and North Rhine Medical Associations 2010). It was reported at a conference (akzept e.V. 2010) that the number of substitution patients in North Rhine-Westphalia had tripled since the introduction of the treatment recommendation at the beginning of April 2011 to reach approximately 1,000 – i.e. more than in all other 15 German *Laender* put together. The need for uniform rules and regulations in health care for inmates has been described in this chapter in detail. The example of recommendations for treatment in North Rhine-Westphalia and its influence on substitution practice show that such statutory provisions can actually have an enormous impact.