TRAINER'S MANUAL ON CARE AND TREATMENT OF PERSONS WITH SUBSTANCE USE DISORDERS IN PRISONS

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Contents

Abbreviations

AIDS	Acquired immunodeficiency syndrome
CBT	Cognitive behavioural therapy
CM	Contingency management
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DUD	Drug use disorder
EUDA	European Union Drugs Agency (previously European Monitoring Centre for Drugs and Drug Addiction (EMCDDA))
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
ICD	International Classification of Diseases
MAT	Medication-assisted treatment
MI	Motivational interviewing
MOUD	Medications for opioid use disorder
NGO	Non-governmental organisation
NPS	New psychoactive substances
NSP	Needle and syringe programme
OAT	Opioid agonist therapy
OUD	Opioid use disorder
PWDUD	People with drug use disorders
PWID	People who inject drugs
SC	Synthetic cannabinoid
SUD	Substance use disorders
TB	Tuberculosis
TC	Therapeutic community
THN	Take-home naloxone
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Introduction

Why a training on substance use disorders?

There is clear evidence that prison authorities are facing increasing problems with drug use and other risk behaviours that can be detrimental to the health of people in prison. Persons with substance use disorders (SUD) are over-represented in the prison population and in many countries they are stigmatised and discriminated members of society. Related health problems are caused by the continued and excessive use of substances, and the risk of contracting communicable diseases increases through injecting the substance used. Further, the widespread availability of illicit drugs within a prison is bound to have very negative repercussions on all aspects of prison life as its use contributes to a cycle of disruption and violence, leading to a reduced or unstable regime. Due to the high prevalence of people with SUD in prison, these institutions have an opportunity, but also an obligation, to identify these individuals early and to provide appropriate services before their release. This reinforces the need for a well-trained workforce that is able to meet the complex needs of persons in prison with SUD.

Purpose of the manual

The purpose of this manual is to provide sufficient methodological support and content to support future trainers to conduct cascade trainings of multidisciplinary prison staff (i.e. medical, custodial and psychosocial staff). The trainings will increase understanding of the problems faced by persons with SUD, aimed at improving their care and treatment within the closed institutions, and connecting them to services upon their release, but also at reducing stigma and discrimination surrounding drug use and related disorders.

Structure of the manual

The training package is divided into 12 different topics (i.e. training sessions). Each topic provides an overview of the most important aspects. Some aspects of the training sessions are similar. Repeating certain closely linked aspects of the training will allow the trainers to become more acquainted with the information presented and reinforce the understanding of participants.

Each session begins with a statement of the time required for its delivery in a multidisciplinary setting. The trainer should decide what the core content for a multidisciplinary audience is – the depth of information required from the manual should be decided on by the trainer with careful consideration of the composition of the group of trainees. Trainers are free to modify or amend the sessions, for example by leaving certain parts out or adding new elements. Additional content may be used when presenting issues to be explored in-depth by a specific profession and requiring a longer session (e.g. topics presented exclusively to medical staff).

The main objectives of the training sessions (i.e. what a trainer can hope to achieve) are clearly outlined as well as the range of activities that can be used to achieve them (Annex 1). The proposed activities (e.g. discussion topics, role plays, case studies) are incorporated into each training session.

Further, references to additional resources on respective topics are proposed.

For each of the training sessions, a PowerPoint presentation summarising the most important aspects is provided (Annex 2). These presentations may be used by the trainers. The national context is included in the presentations when applicable. These can be further personalised to fit target groups, for example by adding the context of a specific prison or a medical staff-only training.

A pre- and post-training questionnaire is included in Annex 3. After administering the pre-training questionnaire, analysis should be undertaken on the same day so that trainers can emphasise certain sessions or aspects depending on the current knowledge level of participants. The post-training questionnaire helps trainers evaluate if the learning objectives have been met.

In order to determine the degree of satisfaction of participants, the work of the trainer(s), as well as the compliance of the material with expectations, a survey should be conducted at the end of the training.

Principles of adult learning

Pedagogy is the method and practice of teaching children, based on the principles of cognitive and social development. It emphasises a teacher-centred approach and the use of instructional methods that are appropriate for children's learning needs. On the other hand, andragogy refers to the methods and approaches used in adult education and is directed towards self-actualisation, gaining experience and problem solving.[1]

When designing a training for adults, the following principles of adult learning should be considered:

- focus on the strengths of the adults, who have years of experience and wide knowledge instead of the gaps in their knowledge, using their experience as a resource for the class;
- respect different value systems and lifestyles, keeping in mind that participants have established values, beliefs and views; allow them to disclose their confusion, lack of knowledge, fears, biases and differing views; and respect all kinds of comments and questions;
- create opportunities for interactive and inter-professional dialogue within the group and allow participants to exchange views among themselves;
- remember that the majority prefer different training methods rather than the traditional format of lectures, and use training strategies such as problem solving, case studies and debating for effective learning;
- remember that adults are eager to establish connections between the new knowledge gained and their previous experience and knowledge; present concepts individually, focusing on the practical implementation of these concepts – adults are not willing to learn what they will not use in practice;
- summarise frequently to hold the attention of participants and remind them of what has been presented;
- plan frequent breaks throughout the day;
- provide a safe and supportive environment.

Basic parts of a presentation

Introduction

The subject of the presentation should be shared as well as the importance of the message; an effective introduction will focus the audience and draw its attention to the speaker and the subject at hand.

Body

The main body of the presentation should include the important information to be delivered; the most appropriate approach should be chosen according to the objective, audience and personal presentation style.

Conclusion

The conclusion reminds the audience of the content of the presentation and the important aspects of the message. It should be brief and guiding.

Teaching methods

Lecturing

This is a traditional teaching method where the trainer conveys information to learners who are seated and listening in a passive manner. It allows the conveying of information to a crowded audience and good time management. However, it is difficult to address interests and needs and to get to know the participants; there is lack of high-level cognitive learning. Participants may get bored, drift or pay less attention. If they have a short attention span, a lecture does little to prevent it. A trainer assumes that the learner has learned the topic and moves onto other topics. The participant may misunderstand the subject and the lecturer may not be aware of the problem. The process may be improved by asking questions; checking for understanding; using interactive group exercises to get participants to practice what they are being trained on; and checking progress regularly and giving feedback.

1. Colman H. (2024), "Adult learning theories: everything you need to know", ispring, available at www.ispringsolutions.com/blog/adult-learning-theories, accessed 5 November 2024.

Questions and answers

This is a teaching method based on the learners verbally answering the questions prepared by the trainer. It is a good technique that enables learners to think and be creative. The pace is slower in terms of conveying information when compared to lecturing.

Case study

This is a teaching method where a scenario is presented that is followed by discussion, using a set of mainly direct questions. The benefits are a high level of attention and motivation, active and collective participation, and development of problem-solving skills. However, it may be difficult to draft an appropriate case study.

Discussion

Learners explore possible solutions to a given problem. This requires time and it may be difficult to wrap up the discussion. There are many forms of discussion, such as those involving big groups; buzzer groups (small discussion groups); debates (with opposing panels); forums (collective debates); and brainstorming (e.g. idea bombing) and so on.

Demonstration

This is a teaching method where the trainer uses visual and auditory messages.

Role play

This is a teaching method in which an idea, a situation, a problem or an event is dramatised in front of a group, enabling group members to actually "live" the event and see the details rather than to just listen to someone talking about it or discussing it. Role play gives participants the opportunity to understand how others feel, think and act. It requires creativity and there is a risk that certain participants may monopolise the session resulting in the exclusion of other participants.

The role of the trainer is important; instead of simply assigning roles to the trainees, the trainer needs to talk to each of the players, drawing them out regarding their thoughts about associated aspects of their role and involving them imaginatively in the situation.

Multidisciplinary audience

Conducting training or "teaching" in multidisciplinary contexts can be challenging as people from different backgrounds, with different interests and perspectives, need to be engaged with a single training package. On the other hand, a multidisciplinary audience training setting perfectly reflects a work context, in this case a prison work context.

With regard to prisons, a successful collaboration between custodial staff and treatment teams (i.e. healthcare staff and psychosocial staff) requires a foundation of mutual respect, shared training, and ongoing communication and co-operation. With these elements in place, custodial staff can assist treatment teams and make important and constructive contributions to the assessment and management of persons who have SUD.

A trainer delivering a training for multidisciplinary staff can draw on the following tips.

- Try to create a programme that actively engages every professional group. Show participants how the topic is relevant to each of their practices and professional backgrounds. Use examples, case studies and discussion topics that illustrate real-world problems and solutions that involve multiple disciplines.
- Be aware of your limitations and do not use activities with which you feel uncomfortable. Acceptance of training will be greater if trainers are confident about their knowledge and if trainees believe trainers are qualified in what they present.
- Assess during the training the preferred learning styles among participants, be flexible and adapt your training/teaching methods to the needs of participants.
- Respond to the uncertainties and fears of trainees in an empathetic way. When interacting with participants, make sure to carefully listen and to read between the lines. Patience is important as well as flexibility in allocating time to certain tasks.
- Tell the trainees that you wish the sessions to be as interactive as possible with your main role being to facilitate the discussion. Emphasise that trainees are the experts in their own domain (i.e. prison

environment); their opinions and comments are valuable and they should ask questions and make comments at any point during the session; and the more they participate the better the session will be.

- Motivate your multidisciplinary audiences to engage with each other. Inevitably, the training on treatment and care of persons with SUD in custodial settings should include some purely clinical topics and clinical scenarios. Non-clinical participants (e.g. custodial staff) whose engagement in such topics we may worry about the most, should be included in all group work and discussions; active participation may well be connected to feeling acknowledged.
- Strive to equip the participants with specific skills that they can incorporate into daily practice; equally important is to influence them to improve teamwork and communication.
- A number of rules of engagement should be explained.
- Punctuality: arrive on time for each session. Arriving late is a sign of disrespect to the trainer and to your fellow participants.
- No disturbances: cell phones should be turned off at the beginning of the workshop and should remain off until the end, except during breaks.
- Avoid side conversations: if you are unclear about the topic being discussed or the instructions, please ask the trainer to clarify.
- Respect others: respect each other, yourselves and the trainer. Do not speak when someone else is speaking. Listen actively. The trainer will be facilitating the discussions with your assistance.
- Participation: you are your own best resource. Much of the content of the training will come from you. Each one of you brings a wealth of experience to the sessions. The sessions can only be successful if it is a two-way process and if everyone participates fully. Give everyone a chance to contribute and encourage others to do so.
- Agree to disagree: during the sessions, everyone must feel free to express opinions and concerns. Please see frank discussions as healthy exchanges rather than personal attacks. There will be a tolerance of differences in approaches and strategies. Everyone should contribute to a safe/non-judgmental environment.
- Ask questions: there are no stupid questions. If you do have a question that you do not want to ask in front of others, ask it privately during a break. Please do not think that any question you have is unimportant.
- Give your honest feedback: at the end of the training, you will be given a form for your feedback on making the training better next time. Please be honest! Constructive criticism is appreciated and is the only way that we can improve.

Opening the training

It is recommended to get training participants to know each other and to use the partner interview technique. Participants should be paired off on a random basis (preferably trainees with different professional backgrounds should be in pairs); they should interview each other and then introduce each other in plenary. The task instructions might look like this: "Introduce yourself to your interview partner. What would you like to tell the group about yourself? Share with each other why you are taking part in the training and what sort of experience you can already bring to the subject. What are your expectations from this training? Then introduce your partner to the group."

An engaging opening should include a proper introduction by the trainer, with relatable examples or personal experiences to promote rapport building, trust and a relaxed learning atmosphere. The first (opening) topic may help a trainer in making a success of the session. Quality time should be invested to provide a broad outline of the topic, showing how the information and skills are relevant to the job of the trainees.

Session 1

Why persons in prison with substance use disorders need care and treatment

Duration	45 minutes
Learning outcomes	Participants will identify the problems associated with substance use in prisons and recognise the benefits of care and treatment for the individual, prison community and society as a whole.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.1 ► **Discussion topics**; Annex 1.1 ► **Role play**; Annex 1.1
Proposed references	UNODC (2008), "Drug dependence treatment: interventions for drug users in prison", United Nations Office on Drugs and Crime, available at www.unodc.org/unodc/en/drug-prevention-and-treatment/publications/data/2008/september/drug-dependence-treatment_-interventions-for-drug-users-in-prison.html, accessed 5 November 2024. Council of Europe International Co-operation Group on Drugs and Addictions (Pompidou Group) (2022), "Standards for treatment of people with drug use disorders in custodial settings", Council of Europe, Strasbourg, available at https://rm.coe.int/0900001680a9b0cd, accessed 5 November 2024.

Drugs in prison: supply

According to a UNAIDS report, "Prisons are sites for illicit drug use, unsafe injecting practices, tattooing with contaminated equipment, violence, rape and unprotected sex. They are often overcrowded and offer poor nutrition, limited access to health care and high rates of airborne and bloodborne diseases."[2] Also, officially, prisons are "secure" establishments. Therefore, the presence of drugs within prisons can be a difficult issue for prison authorities to officially acknowledge (as well as different kinds of violence). The participants should be asked whether they agree.

The fact is that drugs are widely available in prisons throughout the world and people will always try to get drugs into prison, despite the maintenance of even the highest security standards. When one route is closed, another will be found. Drugs are brought into prison in food, clothing, shoes, letters, books, baby nappies and so on. Drugs are thrown over prison walls. Drones are used to drop drugs into prison grounds. Drugs may be carried in by prison staff, detained persons and visitors alike. The trainer should ask the participants about some examples of their experience on how drugs are smuggled into prisons.

The buying and selling of drugs forms part of a black market inside prisons. Drugs are available on the accommodation wings and their use and trade may be linked to violent incidents.

Drugs in prisons: why the demand is high

Globally, around one in three incarcerated persons has used drugs at least once while imprisoned. There is no single straightforward explanation for this rate of drug use. The trainer should ask participants for the reasons for such a high percentage of persons in prison who use drugs.

2. UNAIDS (2006), "2006 report on the global AIDS epidemic: a UNAIDS 10th anniversary special edition", Joint United Nations Programme on HIV/AIDS, available at https://digitallibrary.un.org/record/584475?v=pdf, accessed 5 November 2024.

People who commit criminal offences and enter the criminal justice system have higher rates of drug use and injecting than the general population. They are also often repeat offenders and make up a significant proportion of the prison population.[3]

People suffering from SUD are often members of socially deprived communities who lack education, employment or training. Adverse childhood experiences, specific abuse, neglect, and household dysfunction exposures, combined with school exclusion and unemployment/underemployment, are also criminogenic risk factors associated with problematic drug use and psychiatric problems in prison. Stigmatised and excluded from mainstream society, people may relapse as a direct consequence of their frustration and inability to secure a position in "normal" community life and establish everyday routines.

Drug use in prison can be an individual coping mechanism for the "pains" of imprisonment, namely the loss of liberty, desirable goods and services, social relationships, autonomy and security. Drug dealing in prison can also be part of a detained person's attempts to build "personal respect and reputation".[4]

The likelihood of drug use is increased by boredom and the lack of constructive activities in prisons.

Psychiatric co-morbidity (dual diagnosis) is especially apparent among persons who use drugs. According to what is called "self-medication hypothesis", patients may use substances to deal with problems associated with their mental health disorder. If the mental health needs of detained persons are unmet in prisons, they will eventually return to the community and carry with them untreated conditions that may pose a threat to wider society.

Not every instance of substance use will lead a person to become dependent on substances. Substance dependence is the most severe form of SUD. It involves continued substance use despite negative consequences. Substance dependence happens when the reward system in the brain "takes over" and amplifies compulsive substance seeking. Inevitably, some people will enter prisons already suffering from substance dependence and they will try to continue use despite adverse consequences if no treatment is offered. The initial decision to take drugs is voluntary for most people, but repeated drug use can lead to brain changes that challenge a person's self-control and interfere with their ability to resist intense urges to take drugs. It is common for a person to relapse, but relapse does not mean that treatment does not work. As with other chronic health conditions, treatment should be ongoing and should be adjusted based on how the patient responds.

Challenges for prison management and staff

A report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from a Council of Europe member state has concluded that the presence of people who use drugs in prison gives rise to a number of difficulties for the prison authorities. These include health and security issues as well as the choice of forms of assistance that are to be offered to the person concerned. Further, the widespread availability of illicit drugs within a prison is bound to have very negative repercussions on all aspects of prison life and may undermine the motivation of prison officers.[5]

Participants should be asked: "From your perspective, what are the biggest problems related to drug use in your prison?"

The use of drugs in prisons contributes to a cycle of disruption and violence, leading to a reduced or unstable regime. Among other things, the debts connected to drug use are a significant cause of violence, intimidation and self-harm, endangering both staff and other incarcerated people.

The CPT has pointed out several times in its country reports the impact of drug use and related disorders on the prison environment. For example, in its report on a 2019 visit, the CPT stated that "the pernicious effects of drugs in promoting violence, both inter-prisoner violence and assaults on staff, and creating an unsafe environment, including an increase of drug-related medical interventions required, was evident". The relevant authorities acknowledged the problem: "the use of drugs in prisons is one of the biggest challenges facing

3. EMCDDA (2023), *Prisons and drugs: health and social responses*, European Monitoring Centre for Drugs and Drug Addiction, available at www.euda.europa.eu/publications/mini-guides/prisons-and-drugs-health-and-social-responses_en, accessed 5 November 2024.
4. Deuchar R. and Densley J. (2024), "Exploring the intersection of drug addiction and mental ill-health in Scottish prisons: a qualitative study of incarcerated men", *Journal of Drug Issues* Vol. 54(3), pp. 326-45, available at http://dx.doi.org/10.1177/00220426231161282, accessed 5 November 2024.
5. Extract from a 2001 monitoring report by the CPT on one European country; more information on specific reports is available at www.coe.int/en/web/cpt/states, accessed 7 November 2024.

the criminal justice system today; it is seen as prevalent and contributing to violence, crime and vulnerability within prisons, as well as hindering the delivery of effective regimes".[6]

The constantly changing nature of psychoactive substances adds a further dimension of complexity, which will be addressed in a different session. The rapidly increasing prevalence of new psychoactive substances (NPS) in prisons is placing additional demands on security staff resources in terms of supply disruption, searching and detection activities. Also, the need to manage persons in prison behaving abnormally or dangerously, to transfer persons in prison to hospital or to manage long-term challenging behaviour has huge implications for custodial staff. As with all illicit drug use in prison, the covert nature of NPS use, the unpredictable effects of the drugs and delays in seeking medical help all combine to have a significant impact on staff providing health and psychosocial care.

Furthermore, health challenges arise from the fact that people who inject drugs (PWID) often continue injecting drug use inside prisons. Unsterile injection equipment is often shared in the absence of the provision of needles and syringes, which facilitates transmission of diseases such as human immunodeficiency virus (HIV) and hepatitis C (HCV).

Prison staff are in daily contact with persons who use drugs. At the end of a shift, staff return home to their families and friends. Neglecting the health of those who are detained may result in the transfer of prison health problems into the wider community, just as community health problems come into prison. Prison health is not confined behind bars, and this makes prisons and the criminal justice system an important setting for drug-related interventions.

Further, the risk of suicide in prison is high for those with SUD and for those experiencing withdrawal (i.e. without appropriate support). In addition to individual risks, it poses additional difficulties for custodial staff who need to be engaged in suicide watch (i.e. intensive monitoring and protection of persons who may attempt suicide).

Benefits of treatment in prisons

The treatment of SUD in prisons has benefits for the patient, other persons in prison, prison staff and society. To be effective, treatment must begin in prison and be sustained after release through participation in community treatment programmes. Care on an ongoing basis helps those discharged from prisons avoid relapsing and committing crimes. These two outcomes are big pluses and potential lifesavers.

SUD are risk factors for both offending and reoffending. There are strong links between opioid use and dependence and criminal behaviour. People with opioid dependence who are not in any treatment programme often commit crimes to obtain money to purchase drugs, and crimes are committed under the influence of drugs. Therefore, a significant number of patients who are not in treatment will reoffend and return to prison, creating a "revolving door" between prison and the community.

Several studies have recorded very high levels of criminal involvement by persons who use drugs before entering treatment, with these levels reduced by around half after a year of methadone maintenance treatment. Benefits are greatest during and immediately after treatment, but significant improvements remain for several years after treatment. Reductions are most marked in drug-related criminal behaviour.[7]

Prisons not only protect society by containing offenders but are also often tasked with helping them to lead law-abiding lives after their release. We know that good healthcare and drug treatment can reduce reoffending.

The trainer should ask: "What security measures/initiatives are used to try and keep drugs out of prison? How effective are they?"

Supply reduction initiatives are often more "politically acceptable" on both a local and national level as prisons are "secure" institutions. However, there are drugs in prison, and there will always be people trying to get drugs into prison and use drugs within prisons. Applying standard security procedures as a measure to reduce supply is insufficient if carried out in isolation. A multifaceted strategy should be in place involving measures to reduce demand for drugs and associated harm, as well as providing suitable training to staff.

6. Extract from a 2019 monitoring report by the CPT on one European country; more information on specific reports is available at www.coe.int/en/web/cpt/states, accessed 7 November 2024..
7. Kastelic A., Pont J. and Stöver H. (2008), *Opioid substitution treatment in custodial settings: a practical guide*, WHO/UNODC, BIS-Verlag, Oldenburg, available at www.researchgate.net/publication/238066234, accessed 7 November 2024.

Benefits of an effective treatment can be summarised as:

- extension of life;
- reducing risk of infection;
- achieving abstinence;
- stabilising pattern of use and social life;
- improving physical health;
- reducing criminal activity;
- improving public health;
- reducing costs to social welfare and the criminal justice system;
- reducing emergencies and hospitalisation.

Healthcare and psycho-socio-educational services should be adequately staffed with a close-knit interdisciplinary team of persons with appropriate expertise and training; due regard should also be given to the potential contribution of prison officers in this context.

The trainer manages role play.

Persons in prison, even though they live behind the walls of a prison, are part of the broader community, and governments have a legal obligation to ensure that they enjoy at least the same standards of care as all other citizens of the country.

The trainer summarises the key points and highlights the next session.

Session 2

Disorders due to substance use

Duration	60 minutes
Learning outcomes	Participants will enhance their understanding of disorders due to substance use, particularly opioid use disorder (OUD), and increase their motivation to use non-discriminatory terminology.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.2 ► **Demonstration** Video: "Why are drugs so hard to quit?", National Institute on Drug Abuse, available at www.youtube.com/watch?v=YefKGTu_Xf8&t=12s, accessed 7 November 2024. ► **Discussion topics**; Annex 1.2
Proposed references	Pompidou Group (2022), "Standards for treatment of people with drug use disorders in custodial settings", Council of Europe, Strasbourg, available at https://rm.coe.int/0900001680a9b0cd, accessed 7 November 2024. "Mental, behavioural or neurodevelopmental disorders", 6A00-6E8Z, in WHO (2018), *The ICD-11 classification of mental and behavioural disorders*, Geneva, available at https://icd.who.int/en, accessed 7 November 2024. American Psychiatric Association (2022), "Opioid use disorders", available at www.psychiatry.org/patients-families/opioid-use-disorder, accessed 7 November 2024.

This is quite a "technical" session. It is important that the trainer keep custodial staff on board by ensuring that they engage in discussion, and explaining some of the technical terms in simplified, easy-to-understand language. In a multidisciplinary session, it may be worth asking the healthcare staff if they can explain some of the terms used.

The 11th revision of the International Classification of Diseases (ICD-11)[8] replaced the term "Mental and behavioural disorders due to psychoactive substance use" in the 10th revision with "Disorders due to substance use or addictive behaviours" (i.e. two separate sections).

Disorders due to substance use and addictive behaviours are mental and behavioural disorders that develop as a result of the use of predominantly psychoactive substances, including medications, or specific repetitive rewarding and reinforcing behaviours.

With "addictive behaviours", the individual is not addicted to a substance, but they are addicted to the behaviour or the feeling experienced by acting out a given behaviour (i.e. gambling, overeating, internet use). Those disorders are beyond the scope of this training.

A psychoactive substance is a substance that, when taken in or administered into a person's system, affects mental processes such as consciousness, cognition, perception, mood and emotions.

The list of such substances has been broadened from 9 in ICD-10 to 14 in ICD-11.[9] In addition, 14 substances of "other classes" have been added (non-mentioned, unknown, non-psychoactive substances, etc.).

The terms "substance use" and "substance use disorders" (SUD) refer to the use of substances included in ICD-11 and disorders due to the use of those substances.

8. The new revision of the ICD came into effect on 1 January 2022.
9. Alcohol, cannabis, synthetic cannabinoids, opioids, sedative hypnotics and anxiolytics, cocaine, stimulants including amphetamine, methamphetamine or methcathinone, synthetic cathinones, caffeine, hallucinogens, nicotine, volatile inhalants, MDMA and related drugs, dissociative drugs including ketamine and phencyclidine.

The terms "drug use" and "drug use disorders" (DUD) refer to the use of drugs in the sense that drugs are substances under the control of the international drug control conventions,[10] and disorders due to drug use.

In this manual the terms "substance use", "substance use disorders", "drug use" and "drug use disorders" are used depending on the context.

The structure of the ICD-11 classification implies that diagnosis should start from the substance rather than the clinical syndrome. Disorders due to substance use include disorders that result from a single occasion or repeated use of substances that have psychoactive properties, including certain medications.
The primary diagnosis classes are:

- episode of harmful psychoactive substance use;
- harmful pattern of psychoactive substance use;
- substance dependence.

These categories are hierarchical and mutually exclusive in such a way that only one of these can be diagnosed for one substance group, therefore removing overlap and ambiguity.

An episode of harmful psychoactive substance use refers to an episode where damage has been caused to someone's physical or mental health, such as cannabis use causing disorientation and unpleasant thoughts or feelings of anxiety and paranoia in a person who does not have a harmful pattern of cannabis use, or alcohol use as a contributor to traumatic brain injury in an adolescent who does not have a harmful pattern of alcohol use.

A harmful pattern of psychoactive substance use is a pattern of continuous, recurrent or sporadic use of a substance that has caused clinically significant damage to a person's physical health or mental health or has resulted in behaviour leading to harm to the health of others.

Substance dependence is a pattern of repeated or continuous use of a substance with evidence of impaired regulation of use of that substance. Impaired control over substance use is characterised by a craving or strong urge to use the substance and failed attempts to cut down or control its use.

Substance dependence is characterised by an increasing precedence of substance use over other aspects of life, including maintenance of health and daily activities and responsibilities, such that substance use continues or escalates despite the occurrence of harm or negative consequences (i.e. including repeated relationship disruption, occupational or scholastic consequences, and negative impacts on health).

Further, substance dependence is characterised by physiological features indicative of neuroadaptation to the particular substance. Namely, when a psychoactive substance is consumed, it alters the levels of neurotransmitters in synapses. The process of homeostasis then attempts to restore the rate of neurotransmission to normal levels. Thus, the role of this complex set of mechanisms is to counteract the effects of the drug. The more often a substance is used, the more accustomed the brain becomes to its effects, and the more established its pattern of homeostatic responses to the substance's presence becomes. This is called neuroadaptation.

The common effect of neuroadaptation is an increased tolerance to the substance or a decrease in response to a substance dose that occurs with continued use. This means that increased doses of a substance are required to achieve the effects originally produced by lower doses. It is worth mentioning that the tolerance change does not create an overall immunity over time that means the body gets used to toxins.

Another physiological feature indicative of neuroadaptation to the substance is withdrawal syndrome. This is defined as a group of symptoms of variable clustering and degree of severity that occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. When regular substance use stops, or is reduced, the altered neuroadaptation balance starts to revert to its original state. This can cause withdrawal symptoms that last until homeostatic mechanisms restore balance (or until consumption of the drug is resumed). In some circumstances, normal functions can be restored in a few days, but in others, complete restoration may take a considerable time, or may never be possible. Withdrawal symptoms tend to be the opposite of effects produced by the presence of the substance in the body. Substance withdrawal varies greatly with individuals, the kind of drugs and circumstances and, in some cases, can be life-threatening and may require intensive medical care. Repeated use of the substance or pharmacologically similar substances often takes place in order to prevent or alleviate withdrawal symptoms.

10. International drug control is based on three United Nations conventions: the Single Convention on Narcotic Drugs, 1961; the Convention on Psychotropic Substances, 1971; and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. The terms "controlled" or "illicit" are often used interchangeably when referring to substances scheduled in accordance with these conventions.

Substance use is a broad term that encompasses every instance of using substances such as alcohol, drugs, nicotine, cannabis or prescription medications. SUD, however, is a medical condition that refers specifically to problematic use of these substances, to the extent that the person experiences negative consequences to several areas of their life. A qualified healthcare professional can diagnose whether a person's substance use is problematic and meets the diagnostic criteria for SUD. Early identification of SUD and an adequate response can be facilitated by classification into different categories, from an episode of harmful psychoactive substance use to substance dependence. Each can be addressed with different intervention schemes. For instance, there are substance use patterns that may benefit from brief psychological interventions while others require more extensive treatment (e.g. medication-assisted treatment, or MAT, for opioid dependence).

According to ICD-11, there are a number of diagnoses that can be added to the primary ones, which include, *inter alia*, substance intoxication and different substance-induced mental disorders.

Opioid use disorder

Opioids are natural, semi-synthetic or synthetic chemicals that interact with opioid receptors in the body and brain and reduce the intensity of pain signals and feelings of pain.

While the terms "opioids" and "opiates" are sometimes used interchangeably, "opiate" refers specifically to natural compounds derived from the poppy plant, such as morphine, while "opioids" may be natural or derived in a laboratory.

Synthetic opioids such as fentanyl and semi-synthetic opioids such as heroin are synthesised to mimic the effects of natural opiates such as morphine. They are developed to be stronger and more potent than natural opiates. For example, fentanyl is 50 times more potent than heroin and 100 times more potent than morphine.

Prescription opioids, including pharmaceutical fentanyl, are prescribed for acute pain (such as when recovering from injury or surgery), chronic pain, active-phase cancer treatment, palliative care and end-of-life care. Many people rely on prescription opioids to help manage their conditions under the care of a physician. Prescription opioids are generally safe when taken for a short time and as directed by a doctor but can be misused and have addiction potential.

Opioids bind to, and activate, opioid receptors on cells located in many areas of the brain, spinal cord and other organs in the body, especially those involved in feelings of pain and pleasure. When opioids attach to these receptors, they block pain signals sent from the brain to the body and release large amounts of dopamine throughout the body. This release can strongly reinforce the act of taking the drug, making the user want to repeat the experience.

In addition to the reduced perception of pain, opioids can also cause drowsiness, confusion, euphoria, nausea and constipation. At high doses, they can slow and stop breathing, which can lead to death.

The *Diagnostic and statistical manual of mental disorders, fifth edition* (DSM-5) describes OUD as a problematic pattern of opioid use leading to problems or distress, with at least two of the following occurring within a 12-month period:

- taking larger amounts or taking drugs over a longer period than intended;
- persistent desire or unsuccessful efforts to cut down or control opioid use;
- spending a great deal of time obtaining or using the opioid or recovering from its effects;
- craving, or a strong desire or urge to use opioids;
- problems fulfilling obligations at work, school or home;
- continued opioid use despite having recurring social or interpersonal problems;
- giving up or reducing activities because of opioid use;
- using opioids in physically hazardous situations, such as driving while under the influence;
- continued opioid use despite ongoing physical or psychological problems likely to have been caused or worsened by opioids;
- tolerance (i.e. the need for increased amounts or diminished effect with continued use of the same amount);
- experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms.

The video, "Why are drugs so hard to quit?", should be presented.

OUD is a chronic disorder, with serious potential consequences including disability, relapses and death. While OUD is similar to other SUD in many respects, it has several unique features. Opioids can lead to physical dependence within a short time, as little as 4-8 weeks. In other words, the body will become used to opioids so that it has difficulty functioning without them. With chronic use, abruptly stopping use of opioids leads to withdrawal symptoms, including generalised pain, chills, cramps, diarrhoea, dilated pupils, restlessness, anxiety, nausea, vomiting, insomnia and very intense cravings. As these symptoms are severe, it creates significant motivation to continue using opioids to prevent withdrawal.

It is of crucial importance to understand that OUD is not a "self-acquired bad habit" – a common misconception. OUD is a chronic and relapsing disorder of the brain caused by repeated exposure to exogenous opioids. Differences in grey and white matter have been found in individuals with OUD compared with a control group. This may explain the range of neural network dysregulation and cognitive impairments seen in OUD.

Unfortunately, outdated views about OUD persist in many parts of the world and the disorder may primarily be seen as a public safety and criminal justice problem.

Persons with opioid dependence are often subjected to heavy stigmatisation of their condition; they may be victims of social exclusion from the general public but may also encounter stigmatisation on the part of the healthcare providers that leads to substandard care and, on some occasions, even the refusal to treat those desperately in need. These aspects of stigmatisation may actually enhance and reinstate opioid use; social exclusion and humiliation experienced may drive people into a vicious cycle.

Discussion on stigma

OUD is best managed within the public health system. Considered the "gold standard" of treatment, MAT for OUD is an evidence-based treatment as it has been shown to help people stay in treatment, and to reduce opioid use, opioid overdoses and risks associated with OUD, including HIV and HCV. Medications are also used to relieve cravings, relieve withdrawal symptoms and block the euphoric effects of opioids. The dosage of medication used in treatment does not cause euphoria (a high); it helps restore balance to the brain circuits affected by continuous opioid use.

Counselling and behavioural therapies may be an important part of treatment alongside medications aiming at encouraging motivation to change and education about treatment and relapse prevention.

Different levels of treatment may be needed by different individuals or at different times, including outpatient counselling, intensive outpatient treatment, inpatient treatment or long-term therapeutic communities (TCs).

OUD requires continuing care to be effective. Evidence-based care involves several components, including personalised diagnosis and treatment planning tailored to the individual, and long-term management.

OUD is a chronic disorder with the potential for both recovery and recurrence; this is similar to the system of care for patients with other chronic diseases (such as diabetes, asthma and cardiovascular disease). A support system should be designed to manage periods of remission and exacerbation by modifying interventions to match the severity of the problem. Even in the face of ongoing opioid use or intermittent relapses to use, appropriate treatment delivered repeatedly is essential, particularly for preventing death. The "appropriate treatment" components are:

- access to medications for OUD (MOUD);
- effective behavioural interventions delivered by trained professionals;
- co-ordinated care for OUD and other conditions (i.e. mental and somatic);
- recovery support services, such as mutual aid groups, peer support specialists and community services.

The trainer summarises key points and highlights the next session.

Session 3

International standards in the legal framework on the treatment and care of persons with substance use disorders

Duration	45 minutes
Learning outcomes	Participants will recognise that the appropriate legal frameworks should safeguard the treatment of persons with substance use disorders (SUD) when used as an alternative to incarceration or provided within criminal justice settings. They will also identify gaps in national legislation.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.3 ► **Discussion topics**; Annex 1.3
Proposed references	Pompidou Group (2022), "Standards for treatment of people with drug use disorders in custodial settings", Council of Europe, Strasbourg, available at https://rm.coe.int/0900001680a9b0cd, accessed 7 November 2024. Pompidou Group (2022), "Guidance paper on developing strategies for raising standards on drug treatment in the criminal justice system", Council of Europe, Strasbourg, available at https://rm.coe.int/2011-guidance-paper-pompidou-web-a4/1680a9793e, accessed 7 November 2024. UNODC/WHO (2019), "Treatment and care for people with drug use disorders in contact with the criminal justice system: alternatives to conviction or punishment", available at www.unodc.org/unodc/drug-prevention-and-treatment/publications/data/2019/october/treatment-and-care-for-people-with-drug-use-disorders-in-contact-with-the-criminal-justice-system---alternatives-to-conviction-or-punishment.html, accessed 7 November 2024.

Alternatives to imprisonment

There is a dynamic relationship between drug use and offending. Due to that relationship, many people with SUD come into contact with the criminal justice system.

People with drug use disorders (PWDUD) may be involved in different types of offences. They may engage in possession; purchase or cultivation of controlled drugs for non-medical personal consumption; drug supply-related offences; and other kinds of behaviour that state parties are expected to establish as criminal offences pursuant to the international drug control conventions. They may also engage in offences such as robbery, theft, assault, burglary and more serious crimes that are driven by drug use and SUD as an underlying factor.

When imprisoned, people who use drugs often continue to do so. Numerous studies have shown that drug use, including injecting drug use, is highly prevalent in many prisons, where the sharing of needles and syringes is commonplace. Unsafe injecting practices in prison, where infections with HCV, the hepatitis B virus (HBV) and HIV are high, place PWID at increased risk of these blood-borne infections through the use of contaminated needles and syringes.

When a person with an SUD comes into contact with the criminal justice system, it provides an opportunity to encourage that person to receive appropriate treatment as SUD are primarily a health problem, not criminal behaviour. This can be done either by simply facilitating a referral to treatment, or by means of a process of interaction between the criminal justice system and the healthcare system whereby the person with an SUD is given the opportunity to receive treatment. The actions of the criminal justice system will vary depending on

whether the person with an SUD takes up the treatment option and depending on the reasons for which the person with the SUD came into contact with the criminal justice system. The process of facilitating treatment as an alternative to conviction or punishment (or as an addition to conviction or punishment) is foreseen in the international documents, although it is not universally applied.

When alternatives to conviction or punishment are used to replace imprisonment, they contribute directly to the reduction of the prison population. Prison overcrowding severely affects the quality of nutrition, sanitation, prisoner activities, physical and mental health conditions, and the care available for vulnerable groups, in addition to generating interpersonal tension and violence. Many persons in prison do not have access to education, work or other programmes, thus reducing the prospects of assisting them with their rehabilitation.

Another advantage of using alternatives to imprisonment is that they can help reduce reoffending, and thereby help reduce the prison population in the long term. Numerous studies have shown that reoffending rates are generally lower among cases of those sentenced to non-custodial sanctions, as opposed to imprisonment. By focusing on the treatment of the underlying SUD, alternatives to incarceration address the underlying cause of the criminal conduct rather than the symptoms. As such, alternatives to incarceration can help break the "revolving door" of criminal behaviour, substance use and imprisonment.

Sentencing of persons with DUD to alternative, non-custodial measures should be exempted from inclusion on criminal records in order to avoid unintended negative consequences for future resocialisation and social rehabilitation.

In general, no treatment should be given to a patient without their informed consent, and nobody should be compelled to undergo medical treatment against their will. At the beginning of treatment as an alternative to conviction or punishment, the offender should receive an explanation, orally and in writing, of the conditions, including their obligations and rights. The nature, risks and benefits of the alternative should be explained as well as the consequences of breaking the conditions of that alternative, including the likely impact on criminal proceedings (i.e. the possibilities of revoking the alternative to conviction or punishment in the case of lack of compliance). The person in question should also be informed that some information related to treatment will be revealed to the court.

The applicable international legal framework embodies numerous principles that relate to the treatment of PWDUD who come into contact with the justice system. Seven principles can be drawn from various components of the international legal framework that relate directly to the critical need to utilise treatment and care strategies for PWDUD who come into contact with the justice system.

1. DUD are a public health concern requiring responses that are health centred. PWDUD should not be punished for their DUD but be provided with appropriate treatment.
2. The use of alternatives to conviction or punishment at all stages of the criminal justice system for offenders with DUD on the basis of an assessment using established criteria should be encouraged.
3. Proportionality is required at all stages of the diversion and supervision process.
4. A diversion to treatment should be made with the informed consent of the offender.
5. The implementation of alternatives to conviction or punishment should respect legal and procedural safeguards.
6. Specific attention to special groups and their access to treatment as an alternative to conviction or punishment is required to avoid discrimination.
7. Persons in prison with DUD may not be deprived of their right to health and are entitled to the same level of treatment as the general population.

Imprisonment of persons with SUD

Not all persons with SUD may be eligible for treatment as an alternative to conviction or punishment. When people with SUD commit a more serious drug-related offence or any other particularly serious offence and are imprisoned (whether untried or convicted), treatment and care should be provided in the prison setting following the same quality standard as in the community.

People with SUD kept in prisons should have access to essential prevention and treatment including:

- mechanisms of early identification and referral to treatment;
- prevention of transmission of blood-borne infections, namely "harm reduction";

- pharmacological and psychosocial treatment of SUD;
- treatment of additional psychiatric and physical health conditions;
- rehabilitation services and throughcare links with community health;
- social services in preparation for their release.

Appropriate legal regulations are also required for enabling internationally recognised and recommended harm reduction measures in prison, such as needle and syringe programmes (NSPs).

The European Court of Human Rights is continuously increasing its case law confirming the obligation of states to safeguard the health of persons deprived of their liberty who are in their care. In the Court's case law, issues related to medical treatment of such persons principally arise under Article 3 of the European Convention on Human Rights (no one shall be subjected to torture or to inhuman or degrading treatment or punishment). In some instances, in cases of the suspicious death of a prisoner, an issue may also arise under Article 2 of the Convention (everyone's right to life shall be protected by law). Some illustrative cases will be discussed during the training.

The trainer leads a discussion on international standards versus national legislation, and possible gaps.

The trainer summarises the key points and highlights the next session.

Session 4

Principles of medical ethics applied to the treatment of persons with substance use disorders

Duration	60 minutes
Learning outcomes	Participants will acknowledge that the treatment of people with drug use disorders (PWDUD) is healthcare, and that they should be subject to the same ethical principles as the rest of the prison population.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.4 ► **Discussion topics**; Annex 1.4 ► **Case study**; Annex 1.4
Proposed references	Lehtmets A. and Pont J. (2014), "Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being", Council of Europe, Strasbourg, available at https://rm.coe.int/prisons-healthcare-and-medical-ethics-eng-2014/16806ab9b5, accessed 7 November 2024. WHO/UNODC (2020), *International standards for the treatment of drug use disorders*, available at www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders, accessed 7 November 2024.

Disorders due to substance use are included in the ICD. Therefore, treatment of PWDUD is healthcare and all principles of medical ethics should be vigorously respected.

According to the revised United Nations Standard Minimum Rules, the Nelson Mandela Rules, for the treatment of prisoners:[11]

Rule 24

1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.
2. Health-care services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.

Rule 25

1. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation.

Rule 27

2. Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff.

11. United Nations Office on Drugs and Crime (UNODC) (2016), United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), A/Res/70/175, United Nations General Assembly, available at https://undocs.org/Home/Mobile?FinalSymbol=A%2FRES%2F70%2F175&Language=E&DeviceType=Desktop&LangRequested=False, accessed 7 November 2024.

According to the CPT:

- a prison doctor acts as a patient's personal doctor. Consequently, in the interests of safeguarding the doctor/patient relationship, they should not be asked to certify that a prisoner is fit to undergo punishment, nor should they carry out body searches or examinations requested by an authority, except in an emergency when no other doctor can be called in;
- every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based on law and only relate to clearly and strictly defined exceptional circumstances that are applicable to the population as a whole;
- respect for confidentiality is essential to the atmosphere of trust that is a necessary part of the doctor/patient relationship; it should be the doctor's duty to preserve that relationship and to decide on the manner in which the rules of confidentiality are observed in a given case.[12]

The trainer should ask: "Is 'real' confidentiality possible in a correctional setting?"

The principles of patient consent and confidentiality play a major role in the treatment of DUD. Informed consent is a prerequisite to any treatment. There is no place for compulsory treatment of PWDUD because this amounts to a violation of human rights and has been shown to lack efficacy. Moreover, there is no justification for the permanent presence of custodial staff during medical examinations as well as the delivery of therapy.

Treatment programmes that are complex in medical, legal and psychological terms often do not only rely on the verbal or written informed consent of the patient but require a formal contract to be signed by the patient and the therapist. While a contract might suggest elements of coercion and generate mistrust in the patient-physician relationship, it underlines the agreed-on obligations of patient and therapist, which can be used to remind both parties or demand these obligations. If they are explained and discussed properly, they can enhance understanding of the treatment programme.

The task of prison healthcare services should not be limited to treating sick patients, but should also include preventive measures. Preventive healthcare for PWDUD includes different harm reduction measures within the prison as well as the continuity of treatment following discharge.

Protective care for PWDUD by healthcare professionals relates to their particular vulnerability in prison: PWDUD rank low in the prisoner hierarchy; face the prejudice of other persons in prison and staff; and run the risk of getting into debt, with subsequent threats of bullying, violence, coercive sex work and pressure to divert prescribed drugs. A considerable proportion of PWDUD also suffer from mental disorders ("dual diagnosis") and need additional treatment, care and protection. Some of these problems can be avoided by providing appropriate treatment, but often sensible placement changes and additional protective measures may become necessary. In this respect, a high level of co-operation among healthcare and custodial staff is crucial.

A vitally important part of the treatment of PWDUD in prison is the absolute professional clinical independence of healthcare providers. All clinical decisions on the indications for treatment, the type and duration of treatment, the type and dosage of medication treatment and so on should only be taken by the responsible healthcare professional based on an individual assessment of the patient and mutual agreement and should not be overruled or ignored by non-medical prison staff. Treatment for DUD in prison is a medical treatment independent of custodial measures. This clarification is particularly important for those patients who have been sentenced by the courts to undergo treatment while serving their prison term.

The treatment of PWDUD in prison also requires the professional competence of all care providers involved. Primary healthcare (PHC) providers should be trained in screening and identifying PWDUD upon admission to prison to treat withdrawal syndrome, to inform them about risks and available harm reduction and treatment programmes, and to screen for somatic and mental co-morbidities. Therefore, PHC providers should have a basic knowledge of identifying mental disorders in order to arrange specialised (secondary) care. They should be supported by clinical psychologists, psychiatrists, substance use therapists and social workers trained in the treatment and psychosocial care of PWDUD. Many prisons are not sufficiently staffed with these professional profiles and competencies, so support should be sought by contracting civilian services and non-governmental organisations experienced in the treatment and care of PWDUD.

Custodial staff should also, in their initial and continuous training, be taught about the basics of current concepts regarding SUD and related treatment. Moreover, professionalisation of staff should see the role of a prison officer evolving from that of essentially a "turnkey" with no responsibility other than that of static security. They should be encouraged to extend their role into interacting positively with inmates, taking part in

12. Hungary, CPT visit 2007, paragraph 22, available at https://rm.coe.int/1680696b06, accessed 9 December 2024.

rehabilitation programmes and being an integral element in a multidisciplinary approach towards the welfare of a prisoner. This would not only provide a far more challenging and interesting job for the prison officer, but it would also address the rehabilitation aspect of prison.[13]

The European Prison Rules state (72.3): "The duties of staff go beyond those required of mere guards and shall take account of the need to facilitate the reintegration of prisoners into society after their sentence has been completed through a programme of positive care and assistance".

The session should end with the case study followed by a discussion.

The trainer summarises the key points and highlights the next session.

13. Extract from a 2014 monitoring report by the CPT on one European country; more information on specific reports is available at www.coe.int/en/web/cpt/states, accessed 7 November 2024.

Session 5

Evidence-based pharmacological treatment of persons with opioid use disorder

Duration	75 minutes
Learning outcomes	Participants will explore medications for opioid use disorder (MOUD) and learn how treatment providers can ensure that a good standard of care is delivered within a prison setting.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.5 ► **Discussion topics**; Annex 1.5 ► **Case study**; Annex 1.5
Proposed references	WHO/UNODC/UNAIDS (2004), *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, available at www.who.int/publications-detail-redirect/who-unodc-unaids-position-paper.-substitution-maintenance-therapy-in-the-management-of-opioid-dependence-and-hiv-aids-prevention, accessed 7 November 2024.

Terminology

The term "medications for OUD" (MOUD) is self-explanatory; it mainly refers to medications used for the treatment of OUD. Using MOUD aligns with the way other psychiatric medications are understood (e.g. antidepressants for depression, antipsychotics for psychosis) as critical tools that are central to a patient's treatment plan.

MAT also refers to pharmacological therapy, but it is just a part of a larger treatment and recovery plan. MAT comprises a comprehensive form of healthcare for people with OUD. In addition to pharmacological therapy (MOUD), MAT also includes:

- provider and community educational interventions;
- co-ordination/integration of SUD treatment and other medical/psychological needs;
- psychosocial services/interventions.

Both terms are used in this manual; MOUD in the context of pharmacological treatment only; MAT in the context of a comprehensive programme.

The term "opioid agonist treatment" is used mainly in reference to earlier publications.

The expressions "opioid substitution" and "replacement therapy" should be avoided as it is a misconception that medications merely "substitute" one drug or one dependency for another.

In this session, we will concentrate mainly on pharmacological therapy/medications. The other components of MAT programmes will be discussed in the next sessions. Persons with OUD should be provided with a comprehensive form of healthcare.

Evidence-based pharmacological treatment

Research has shown that MOUD are effective. Their use can save lives by reducing the chances of an overdose; helping people stay in treatment; helping a person manage triggers and cravings; and giving people a chance to develop other life areas in recovery.

Generally, MOUD are prescribed to people who meet the clinical criteria for opioid dependence. However, restrictive regulations regarding the admission criteria are counterproductive with regard to access to treatment and in preventing HIV and hepatitis transmission. In principle, everyone with OUD who is in need of treatment and expresses a desire for MOUD can become stabilised under such treatment after appropriate

assessment and treatment induction. Some groups, such as pregnant women or people living with HIV or other illnesses, should be given priority. This, however, should not entail compulsory HIV antibody testing.

OUD is associated with a range of medical, legal and psychosocial problems. A person is suitable for MOUD if the individual and social harms associated with the opioid use are likely to be reduced by entering into treatment. Additional problems should be addressed from the very beginning, either by the programme itself or through referral to an appropriate service.

The most important limitation is that, in most cases, a person has to receive treatment for a long period of time. The long-term aspect negatively affects both public spending and the individual person. The person treated for an OUD becomes a long-term patient who depends on the medication and often also on the person who prescribes it. In some cases, this dependence can lead to a passive attitude where the patient adopts, through a state of "learned helplessness", a "sick role". Involvement of the patient in defining treatment goals, in decisions on dosing and, as much as possible, offering choice and empowerment may reduce this attitude.

The trainer should ask participants about access to MOUD in (their) prison.

Access to MOUD in prisons

Upon admission to prison, persons with opioid dependence may undergo detoxification. Medically supervised withdrawal or "detoxification" is the process of taking a person off an opioid on which they are physically dependent. The term "detoxification" is usually called "medically supervised withdrawal management" to destigmatise the process. The process can be fast or slow and can be done under a variety of levels of care and supervision.

Abrupt cessation of opioids without using withdrawal syndrome ameliorating medication (known colloquially as "cold turkey"), may amount to inhumane treatment as the person experiences physiological and psychological withdrawal symptoms (i.e. nausea, vomiting, diarrhoea, agitation, anxiety and suicidality).

Supervised withdrawal management may include MOUD (e.g. methadone or buprenorphine). However, given the often relapsing/remitting nature of OUD, detoxification alone is only effective in producing long-term change for a minority of people who use opioids. Although it seems intuitive to start treatment for OUD with "detoxing" and stopping all opioids, this is not always the best course of action. Sometimes imprisoned people wish to detoxify quickly and become completely drug free; they do not wish to have contact with drugs and other people using drugs anymore, or to hear or talk about opioid dependence and drug-related problems. They either intend to utilise imprisonment as a drug-free period or wish to start a new life and be ready and "clean" upon their release from prison. However, relapses with a risk of overdose are likely to happen, particularly when detoxification occurs too fast. Release from prison is associated with an increase in drug-related deaths due to the restart of drug, mostly opioid, use after a period of abstinence, and reduced use also reduces opioid tolerance (i.e. within a week). In order to avoid relapse and overdose post release, it is recommended that the person is maintained on a stable dose of MOUD until released and after release; treatment should be prioritised for those about to be released from prison. It is highly recommended to focus on the long-term plan for treatment with MOUD.

Issues such as the maximum dose or maximum length of treatment should be left to the practitioner's clinical judgment, based on an assessment of the individual. Decisions on MOUD are clinical decisions and should be taken exclusively by medical professionals in co-operation with the person in question and must not be influenced in any way by non-medical staff or the prison administration.

Classes of medication

Agonist

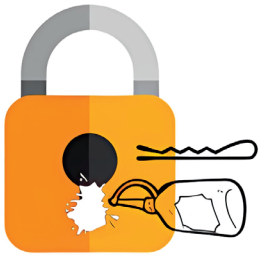
Mimicking or impersonating naturally occuring neurotransmitters, like a hairpin picking a lock, agonists are able to unlock a cell to produce an effect.

Agonist medications and opioids activate receptors in similar ways. Agonist medications reduce cravings and withdrawal symptoms. They do not produce euphoria. They can be a life-saving treatment when monitored by medical professionals. Methadone is one of the better-known medications used to treat OUD. Buprenorphine is a partial agonist and produces a lower level of activation than methadone.

Antagonist

Working in the opposite way, antagonists block the receptor, like jamming glue into a keyhole, so that it may not be opened.

Antagonist medications block or interfere with a cell's activity. They work by slowing down the biological reaction that feeds into substance use. As the cells are not activated, antagonist medications are not addictive. They have no potential for abuse. Naltrexone is a long-acting MOUD. Naloxone blocks the effects of opioids in a person's body to stop and reverse opioid overdose.



Mixed Agonist-Antagonist

With dual-action, mixed agonist-antagonists act as the hairpin picking the lock to produce an effect, at the same time, acting as glue blocking the receptor to prevent an effect.

Mixed agonist-antagonists may act as an agonist for one type of receptor while working as an antagonist for another type of receptor.[14]

Medications for opioid use disorder

Methadone

Methadone is a synthetic opioid agonist that has an effect similar to that of morphine. It is well absorbed from the gastrointestinal tract, irrespective of formulation type (syrup versus tablet), and has very good bioavailability of 80-95%. The estimated elimination half-life of methadone is 24-36 hours, with considerable variation across individuals (10-80 hours). This pharmaceutical profile makes methadone a useful medication because it allows oral administration, single daily dosage, and achievement of steady-state plasma levels after repeated administration with no opioid withdrawal during a usual one-day dosing interval.

The most common side effects include increased perspiration, constipation and disturbance of sleep, reduced sex drive, reduced power of concentration as well as weight gain. Such undesirable side effects generally occur at the beginning of treatment and ameliorate over time. For some patients, these side effects persist over longer periods of treatment, but mostly remain without medical consequences. In total, taken all together, these side effects affect less than 20% of patients in methadone therapy.

Methadone is a safe medication with no lasting deleterious physical or physiological effects. Contrary to what is popularly assumed, it has no direct damaging effects on bones, teeth or organs. However, for some patients, detoxifying from methadone might be very difficult and take a relatively long time.

Methadone is a cheap medication; it is easy to administer and the intake can easily be supervised.

14. Recovery Research Institute (n.d.), "Pharmacotherapy – Medications", available at www.recoveryanswers.org/resource/pharmacotherapy-medication-assisted-treatments, accessed 7 November 2024.

The World Health Organization Regional Office for Europe (1990) suggests standard terms for methadone treatment:

- detoxification: short term (decreasing doses over one month or less) and long term (decreasing doses over more than one month);
- maintenance: short term (stable prescribing over six months or less) and long term (stable prescribing over more than six months).

Evidence suggests that methadone treatment is more effective when higher dosages are prescribed on a maintenance basis. Applying short-term detoxification with decreasing dosages restricts its therapeutic potential.

When initiating methadone in prisons, it is crucial to keep continuity in mind. It is essential that prison healthcare professionals work closely with the country's health services; this will lead to a higher standard of treatment, more effective treatment and continuity of care. Since many detained people experience immediate relapse after release, they should be informed about the risks of detoxification and possibilities to continue methadone treatment in the community. It is the role of the prison healthcare team to ensure continuity of methadone in the community after release. This should be thoroughly planned and arranged in good time prior to the release of the prisoner.

The absolute condition for an effective start is to provide the patient with relevant information, particularly on the risk of overdose, which should include the following:

- the delay of the peak effect of methadone (i.e. 2-4 hours);
- the accumulation of methadone over time resulting in a greater effect (i.e. over 3-5 days or more), even on a fixed dose;
- the risks of multiple drug use, especially other opioids, cocaine, benzodiazepines and alcohol;
- potential interaction with other medications.

Buprenorphine

Buprenorphine is a semi-synthetic opioid partial agonist (i.e. it activates the opioid receptors in the brain, but to a much lesser degree than a full agonist) and a potent analgesic. Buprenorphine is not well absorbed and has poor bioavailability, and the usual route of administration is therefore sublingual. It is less likely than methadone to result in opioid overdose, even when taken with other opioids at the same time. The effectiveness of buprenorphine is similar to that of methadone at adequate doses, in terms of reduction in illicit opioid use and improvements in psychosocial functioning. However, buprenorphine may be associated with lower rates of retention in treatment. It is currently more expensive than methadone.

Buprenorphine is acceptable to people who use heroin, has few side effects and is associated with a relatively mild withdrawal syndrome. When used in opioid pharmacological therapy for pregnant women with OUD, it appears to be associated with a lower incidence of neonatal withdrawal syndrome.

The main disadvantage of sublingual buprenorphine therapy in the prison setting is that because it can take between five and ten minutes for the tablet to be absorbed sublingually, there is a risk of removal and subsequent sale. Experience shows that this can place the patient who is prescribed such medication at risk of harassment and bullying to remove their medication. In many prisons, the consumption of buprenorphine is directly observed. However, such a practice is very labour intensive due to the time taken for the medication to be absorbed sublingually.

In some countries, Espranor is available; this is a tablet containing buprenorphine that is administered on (not under) the tongue and dissolves rapidly.

A combination product of buprenorphine with a small amount of naloxone (4:1 ratio) has also been developed to reduce potential diversion and misuse (i.e. through intravenous use). Naloxone is poorly absorbed sublingually, which limits its pharmacological effect. However, if the tablet is crushed and used intravenously, the naloxone is bioavailable and can precipitate severe opioid withdrawal, which can potentially deter further such abuse by this route.

The recent approval of subcutaneous buprenorphine depot injections provides another alternative to sublingual buprenorphine therapy, particularly in the prison setting.

The trainer should ask the following questions.

- When do you feel someone should be excluded from a MOUD/MAT programme (i.e. prisons and community)?

- Have you (i.e. medical staff) ever initiated buprenorphine/methadone in prison?
- What are the obstacles?
- Can you "guarantee" continuity of care, namely, do you work closely with the public health service and healthcare professionals?

During a CPT visit to a Council of Europe member state, it appeared that persons receiving methadone were under pressure exerted from treatment staff to withdraw from their methadone therapy in order to obtain benefits such as leave, extended visits and work.

The trainer should ask: "What do you think about this attitude? What are the risks? Might this happen in your prison?"

Naltrexone

Naltrexone is an opioid antagonist. If a person abstains from opioids, then therapy with naltrexone can be started during imprisonment, or prior to release from prison, as part of relapse prevention programmes.

A single maintenance dose of naltrexone binds to opioid receptor sites in the brain and blocks the effects of any opioid taken for the next 24 hours. It produces no euphoria, tolerance or dependence. Patients generally require 5-10 days of abstinence from opioids before induction into naltrexone.

The effectiveness of naltrexone treatment clearly hinges on compliance with treatment, combined with active psychosocial support and the motivation to take the medication each day or every second day.

One caution with naltrexone is an increased sensitivity to opioids. If someone uses opioids after taking naltrexone, their body may react to smaller amounts, increasing the risk of overdose and death.

Naloxone

Naloxone is the antidote in opioid overdose, a life-threatening condition associated with respiratory depression, with respiratory arrest leading to cardiovascular collapse and death.

It is non-addictive, may be dispensed by injection (i.e. intramuscular/subcutaneous and intravenous) or by intranasal application, and has almost no side effects when used at the correct dosage. Intranasal administration is quick, non-invasive and easy to use, as compared to parenteral injection, and protects against accidental intra-vessel injection. Naloxone is fast-acting, and adequate respiration will typically resume within 3-7 minutes of its intramuscular administration. Repeated doses may be needed.

Many of those who die from opioid overdose are not alone at the time of death, suggesting that an early intervention, such as the administration of naloxone, can prevent opioid-induced deaths. However, many people who overdose fail to receive proper medical attention because their peers and other witnesses, often other persons who use drugs, do not recognise the seriousness of the situation, delay calling or do not call emergency services for fear of involving the police and legal repercussions, and do not have access to naloxone. Programmes that combine training on overdose risk and management with the distribution of naloxone to potential bystanders are called "take-home" naloxone (THN) programmes. They aim to make naloxone more readily available in places where overdoses might occur. The successful implementation of these naloxone programmes has prompted calls for widespread adoption of this approach.

The trainer manages the case study. The trainer summarises key points and highlights the next session.

Session 6

Psychosocial treatment of persons with substance use disorders

Duration	60 minutes
Learning outcomes	Participants will understand the benefits of psychosocial care for persons with substance use disorders (SUD) and commit to delivering evidence-based psychological interventions.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.6 ► **Discussion topics**; Annex 1.6 ► **Individual work**; Annex 1.6 ► **Role play** (alternative exercise); Annex 1.6
Proposed references	Pompidou Group (2022), "Standards for treatment of people with drug use disorders in custodial settings", Council of Europe, Strasbourg, available at https://rm.coe.int/0900001680a9b0cd, accessed 17 November 2024. SAMHSA Advisory (2021), "Using motivational interviewing in substance use disorder treatment", Substance Abuse and Mental Health Services Administration, available at https://library.samhsa.gov/product/advisory-using-motivational-interviewing-substance-use-disorder-treatment-based-tip-35, accessed 17 November 2024. Yates R. et al. (2021), "Prison-based therapeutic communities (TCs): a handbook for prison administrators, treatment professionals and trainers", Council of Europe, Strasbourg, available at https://rm.coe.int/2021-ppg-prisontc-handbook-eng-web/1680a2abe6, accessed 17 November 2024.

As explained in the previous session, in addition to pharmacological therapy, MAT also includes different psychosocial interventions.

There are many benefits of psychosocial care for people with DUD such as:

- the restoration of family relationships, employment and inclusion in society;
- increase in the share of patients who abstain from psychoactive substances;
- increased motivation to stop/reduce drug use;
- help for patients to clarify their recovery goals;
- help in educating patients about withdrawal symptoms/overdose and providing strategies to minimise this;
- mental health support.

Evidence-based psychosocial treatments address motivational, behavioural, psychological and social factors and have been shown to reduce drug use, minimise associated risks, increase adherence to treatment, prevent relapse and promote abstinence.

Evidence-based psychological interventions include:

- cognitive behavioural therapy (CBT);
- motivational interviewing (MI);
- motivational enhancement therapy;
- contingency management (CM); community reinforcement approach;
- mutual help groups (including 12-step groups);
- therapeutic communities (TC).

When delivering this session to a multidisciplinary audience, it is suggested to focus on MI, with just a mention of the other evidence-based psychological interventions. Correctional staff will understand MI and its relevance to their work (i.e. it can be implemented by them).

Cognitive behavioural therapy

CBT is a form of psychological treatment that has been demonstrated to be effective for a range of problems, including SUD. The core theory of CBT is that thoughts create feelings, and feelings create behaviours. By replacing negative thoughts, we can increase positive feelings and actions.

Faulty beliefs or thinking trap the individual in how they view themselves, others and the surrounding environment. This is called "cognitive distortion". CBT treatment usually involves efforts to change thinking patterns (i.e. dysfunctional thinking) and replace them with newly developed coping skills and cognitive strategies.

Examples of cognitive distortion include:

- a person attending a party with friends believes that not taking cocaine with peers will make everyone think they are strange;
- a person who uses heroin after promising never to take it again self-identifies as a failure;
- a person experiences a relapse in their recovery and decides not to go back to treatment because they feel it will happen again.

In a CBT session, the therapist might try to incorporate various cognitive distortion exercises that can help people change their negative thoughts.

- Reframing: patients learn to balance negative thoughts with more positive ones. For example, someone might replace the thought, "I am incapable of doing this treatment" with, "I am struggling, but I am getting help to improve."
- Thought records and journalling: patients track their thoughts to identify triggers for anxiety or unhealthy behaviours, then work with their therapist to cope with these triggers.
- Behavioural activation: patients practice new behavioural habits to shift their mood, which can gradually transform thought patterns into more positive ones.

Motivational interviewing

MI and motivational enhancement therapy comprise treatment techniques that recognise the patient's autonomy and values, and build a therapeutic alliance through empathy, with the therapist's role advisory rather than authoritative.

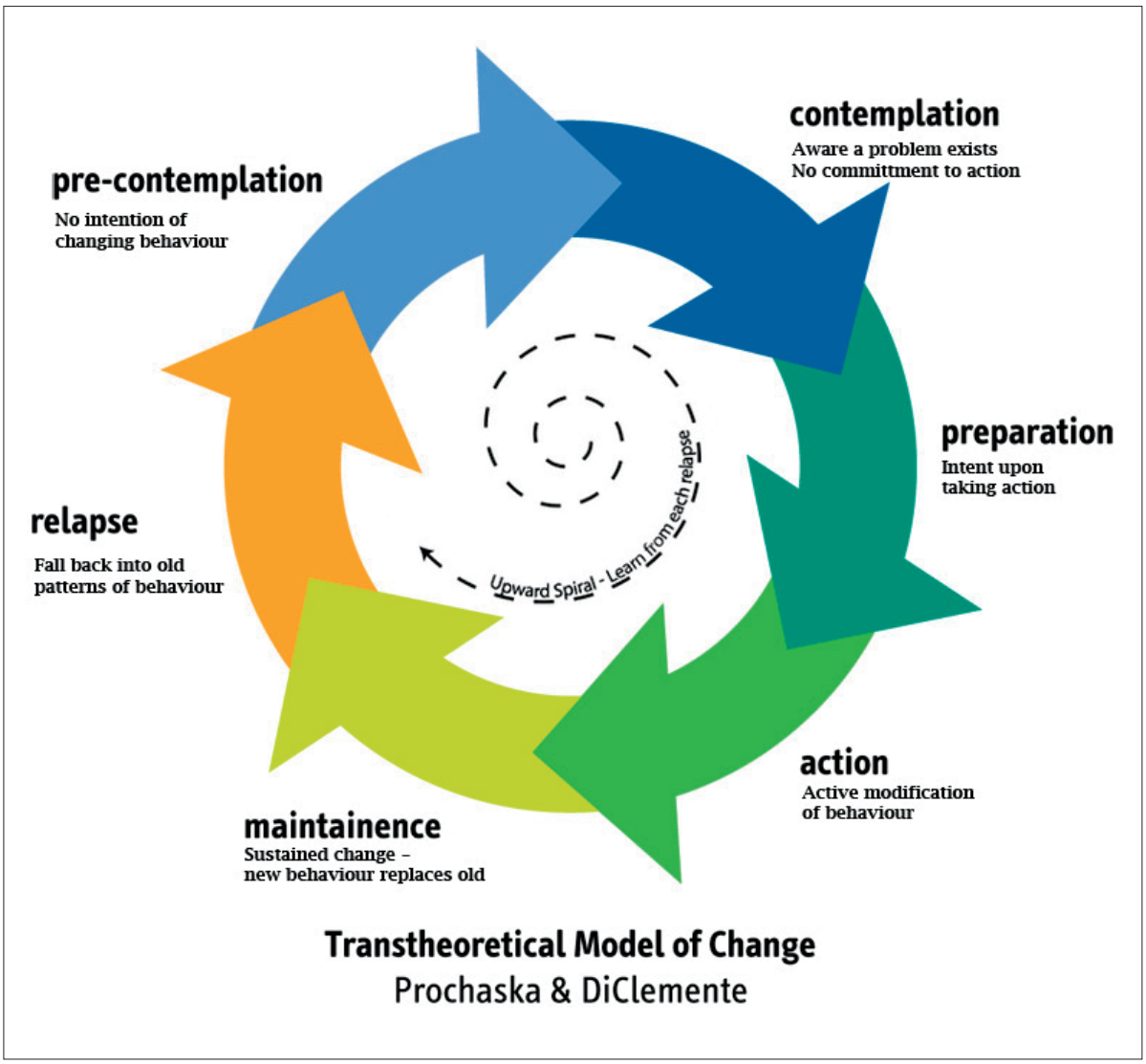
When a patient does not seem motivated to make a change or to listen to a specialist's common sense advice, we most often assume that something is wrong with that patient and that there is little that can be done. These assumptions are usually false. No person is completely unmotivated. The way a person talks to patients about their health status can substantially influence their motivation towards making a behavioural change.[15]

Motivation can be understood not as something that one has, but rather as something one does. It involves recognising a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, it turns out, many ways to help people move towards such recognition and action.[16]

In MI, the specialist does not play the role of an authority. It is crucial not to send the message: "I am an expert, and I will tell you how to live your life." Responsibility for change lies with the client (prisoner) and strategies of MI are persuasive rather than forced, supportive rather than argumentative.

In the field of substance dependence and in the broader field of changing unhealthy behaviours, motivation plays an extremely important role and underpins many of the behaviour change decisions made by patients.

15. Rollnick S., Miller W. and Butler C. (2008), *Motivational interviewing in health care: helping patients change behavior* (1st edn), The Guilford Press, New York.
16. Miller W. and Rollnick S. (2023), *Motivational interviewing: preparing people for change* (4th edn), The Guilford Press, New York.



Source: The relationship blog[17]

There are four distinct principles that guide the practice of MI. The therapist employing MI should respect these principles throughout treatment.

1. Express empathy

Empathy involves seeing the world through the patient's eyes, thinking about things as the patient thinks about them, feeling things as the patient feels them and sharing in the patient's experiences.

2. Support self-efficacy

A client's belief that change is possible (self-efficacy) is needed to instil hope about making difficult changes. In MI, therapists support self-efficacy by focusing on previous successes and highlighting skills and strengths that the patient already has.

3. Roll with resistance

From an MI perspective, resistance in treatment occurs when the patient experiences a conflict between their view of the "problem" or the "solution" and that of the therapist, or when the patient feels their freedom or autonomy is being impinged upon. These experiences often draw on the patient's ambivalence about change. In MI, therapists avoid eliciting resistance by not confronting the patient and, when resistance occurs, they work to de-escalate and avoid a negative interaction, instead "rolling with it". A frequently used metaphor is "dancing" rather than "wrestling" with the patient.

17. Simcha (2009), "The five stages of change", The relationship blog, available at www.therelationshipblog.net/2016/06/the-five-stages-of-change/, accessed 9 December 2024.

4. Develop discrepancy

A therapist practising MI works to develop discrepancy by helping patients examine the discrepancies between their current circumstances/behaviour and their values and future goals. When patients recognise that their current behaviours place them in conflict with their values or interfere with the accomplishment of self-identified goals, they are more likely to experience increased motivation to make important life changes.

Motivational interviewing		**Authoritarian-Confrontational**	
Collaboration A relationship of active collaboration; a partnership between physician and patient and a process of making decisions together	"What do you want to do about your drug use?"	An unequal power relationship in which the expert physician directs a passive patient, telling them what to do	"You need to quit using drugs now and go upon release to a rehabilitation clinic."
Evoking patient resources Understanding the patient's perspective, evoking own motivations and resources for change	"What are the benefits of your drug use?" "What makes you think it might be time to change something about the way you use drugs?"	Providing "ready-made" solutions, methods and information for change	"You will have to stop using drugs and start exercising at least three times a week."
Respect for patient autonomy Respecting the patient's decision regarding their behaviours	"I am here to help you put into practice the decision you make about drugs."	Coercion, manipulation, telling the patient what they "must" do	"Stop using drugs! Are you ashamed of yourself/taking drugs for ages like that/mocking your family/entering prison again…?"

Often called micro-counselling skills, the therapist's behaviours are employed to move the process forward by establishing a therapeutic alliance and eliciting discussion about change.

1. Open-ended questions are those that are not easily answered with a "yes/no" or short answer containing only a specific, limited piece of information. Open-ended questions invite elaboration and thinking more deeply about an issue.
2. Affirmations are statements that recognise the strengths of a patient. Affirmations are a key element in facilitating the MI principle of supporting self-efficacy.
3. Reflections or reflective listening is perhaps the most crucial skill in MI Interviewing. Some types of reflections are more helpful when the patient seems resistant and others more appropriate when the patient offers statements more indicative of a commitment to change.
4. Summaries are a special type of reflection where the therapist recaps what has occurred in all or part of a session(s).

Change talk

"Change talk" is defined as statements by the client revealing consideration of, and motivation for or commitment to, change. In MI, the therapist seeks to guide the client to expressions of change talk as the pathway to change. Research indicates a clear correlation between client statements about change and outcomes, namely client-reported levels of success in changing a behaviour. The more someone talks about change, the more likely they are to change.

There are specific therapeutic strategies that are likely to elicit and support change talk in MI.

- Ask evocative questions: ask an open question, the answer to which is likely to be change talk.
- Explore decisional balance: ask about the pros and cons of both changing and staying the same.
- Good things/not-so-good things: ask about the positives and negatives of the target behaviour.

- Ask for elaboration/examples: when a change talk theme emerges, ask for more details: "In what ways?"; "Tell me more?"; "What does that look like?"; "When was the last time that happened?"
- Look back: ask about a time before the target behaviour emerged. How were things better, different?
- Look forward: ask what might happen if things continue as they are (status quo). Try the miracle question: "If you were 100% successful in making the changes you want, what would be different? How would you like your life to be five years from now?"
- Query extremes: what are the worst things that might happen if you don't make this change? What are the best things that might happen if you do make this change?
- Use "change rulers": ask: "On a scale from 1 to 10, how important is it to you to change [the specific target behaviour] where 1 is not at all important, and 10 is extremely important?"; follow-up: "And why are you at ___ and not ___ [a lower number than stated]?"; "What might happen that could move you from ___ to [a higher number]?"; alternatively, you could also ask, "How confident are you that you could make the change if you decided to do it?"
- Explore goals and values: ask what the person's guiding values are. What do they want in life? Using a values card sort activity can be helpful here. Ask how the continuation of the target behaviour fits in with the person's goals or values. Does it help to realise an important goal or value, interfere with it or is it irrelevant?
- Come alongside: explicitly side with the negative [status quo] side of ambivalence. "Perhaps ___ is so important to you that you won't give it up, no matter the cost."

The trainer should conduct a discussion on strategies that are likely to elicit and support change talk.

Contingency management

CM is a therapeutic strategy that applies rewards to reinforce positive behaviour and treatment goals such as compliance and abstinence. It is often combined with CBT and monitored with drug testing for feedback. It is mainly used in probation services.

CM to reduce stimulant use involves participants receiving something of value, such as a gift card, voucher or chance to win a prize, as a reward for the achievement of a specific and measurable desired behaviour, most commonly a negative urine drug test for stimulants (current footnote 16; EU Drugs Agency) A systematic review (Hayley et al. 2020) described the broad benefits of CM, including greater drug abstinence, higher utilisation of other treatments and medical services, and reductions in risky sexual behaviour specifically for those who use methamphetamines.[18]

Community reinforcement approaches and mutual help groups

Community reinforcement approaches and mutual help groups generally belong to long-term treatment strategies. The focus in community reinforcement approaches is to help individuals find healthier, more adaptive ways to meet their social and emotional needs than using substances. It comprises a broad group of behavioural interventions that provide or withhold rewards and negative consequences quickly in response to at least one measurable behaviour (e.g. substance use as measured by a drug test).

A mutual help or self-help group is a group in which participants support each other in recovering or maintaining recovery from alcohol or drug dependence, or from the effects of another's dependence, without professional therapy or guidance. Examples of mutual support groups are Alcoholics Anonymous and Narcotics Anonymous.

Therapeutic community

A TC is an environment that helps people get help while helping others. It is a treatment environment: the interactions of its members are designed to be therapeutic within the context of the norms that require each person to play the dual role of client-therapist. At a given moment, one may be in a client role when receiving help or support from others because of a problem behaviour or when experiencing distress. At another time, the same person assumes a therapist role when assisting or supporting another person in trouble.

18. European Union Drugs Agency (n.d.), "Contingency management to reduce stimulant use", available at www.emcdda.europa.eu/best-practice/evidence-summaries/contingency-management-reduce-cocaine-use_en, accessed 17 November 2024.

A TC within a prison is a dedicated section with strict rules where residents participate in an intensive daily programme of group work and community meetings aiming at mutual aid and self-help and gaining life skills and vocational training. Traditional models of long-term residential treatment include strict abstinence and only psychosocial treatment methods, whereas modern approaches may involve the use of medication to decrease drug cravings and manage co-morbid psychiatric symptoms. Indispensable requirements for a TC in prison are the absolute informed consent of participants, management by licensed specialists for treatment of DUD and professional medical supervision, preferably by a psychiatrist.

The trainer makes a presentation of dedicated educational-therapeutic units (Unidad Terapéutica Educativa (UTE)) in Spanish prisons, followed by discussion.

Role play is suggested as an alternative activity.

The trainer summarises key points and highlights the next session.

Session 7

New psychoactive substances

Duration	45 minutes
Learning outcomes	Participants will study new psychoactive substances (NPS) in general and their use in prison settings. They will also learn to identify potential signs and symptoms of NPS use and develop strategies to manage these cases effectively.
Teaching techniques	▶ **Lecturing** (PowerPoint presentation); Annex 2.7 ▶ **Demonstration** Video: "New psychoactive substances in prison", European Union Drugs Agency (EUDA), available at www.emcdda.europa.eu/media-library/video-new-psychoactive-substances-prison_fr, accessed 17 November 2024. ▶ **Discussion topics**; Annex 1.7
Proposed references	Public Health England (2017), "New psychoactive substances (NPS) in prisons: a toolkit for prison staff", available at www.gov.uk/government/publications/new-psychoactive-substances-toolkit-prison-staff, accessed 17 November 2024. EMCDDA (2018), *New psychoactive substances in prison – Results from an EMCDDA trendspotter study, June 2018*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg Publications Office of the European Union, Luxembourg. EUDA (n.d.), "Early warning system on NPS", available at www.emcdda.europa.eu/publications/topic-overviews/eu-early-warning-system_en, accessed 17 November 2024.

NPS are substances designed to produce the same or similar effects to drugs such as cannabis and cocaine. NPS have not been scheduled under the international drug control conventions of 1961 and 1971 but could pose similar threats to public health as do substances scheduled under these conventions. The focus is on synthetic substances rather than those derived from plants.[19]

In the past, NPS were often sold in shops as research chemicals and advertised as "not for human consumption" to get round the law; therefore the name "legal highs".

The 2013 World Drug Report highlighted that NPS had become a growing public health concern with significant increases globally in both supply and demand. Characterised by an extremely dynamic market, their increasing availability, especially over the internet, has radically changed the current nature of the drugs scene. The common misconception that NPS are safe because they are not legally controlled or banned in some countries has contributed to their popularity and use, often with disastrous effects.

The term NPS is a legal definition and there is no universally agreed way to categorise them. Often, NPS are considered in five, somewhat overlapping, functional categories related to their chemical structure, and psychopharmacological desired and unwanted effects.

- Stimulant-type drugs: these drugs have a significant stimulant/alerting effect on the brain and mimic substances such as amphetamine, cocaine and ecstasy.
- Downer/tranquiliser/sedative-type drugs (aka "depressants"): these drugs have a significant inhibitory and relaxing effect on the brain and mimic various sedating, anti-anxiety and opioid-like drugs (and alcohol). The category includes new drugs from the benzodiazepine family.
- Hallucinogenic drugs: these drugs make users hallucinate, feel relaxed and happy, or agitated and confused. These drugs mimic substances like LSD (lysergic acid diethylamide).

19. Peacock A. et al. (2019), "New psychoactive substances: challenges for drug surveillance, control, and public health responses", *The Lancet* Vol. 394, Issue 10209, pp. 1668-1684.

- Dissociative drugs: a category of drugs that mimic substances such as PCP (phencyclidine) whose main effect is to cause a feeling of detachment, as if the mind and body have been separated, with some people feeling incapable of moving. They can also cause hallucinations and have both stimulant and depressant effects.
- Synthetic cannabinoids (SCs): these are synthetic drugs that are designed to mimic the action of the active chemical found in cannabis and are traded under such names as Spice, Clockwork Orange, Black Mamba and Exodus Damnation. They are not derived from the cannabis plant. These could be included as downer-type drugs with psychedelic effects, but given their current wide range and potency, they are described here as a separate group.[20]

NPS are usually manufactured in China and, to a much lesser extent, India. A number of NPS have been linked to paranoia, psychosis, seizures and deaths. Many are untested or had only limited testing on humans, so not all the risks of taking them, alone or in combination with other substances, are yet known. Many NPS can cause a very similar range of problems to the drugs that they mimic, including a risk of dependence developing with repeated use. Some appear to be more dangerous even than the traditional drugs they mimic. In addition, all these risks are likely to be exacerbated by their use with other substances, including alcohol.

New psychoactive substances in prisons

The use of NPS in prisons was first reported in the UK around 2013 and in the years to follow in other European and non-European countries. Their popularity among persons in prison is due to:

- strong and "new" effects;
- the difficulty of detecting them in drug tests (however, new tests may detect some NPS);
- easy to smuggle;
- less expensive than most other drugs;
- all the other reasons: drug dependence, boredom, self-medication, a desire to pass time and so on.

The trainer should ask: "How do the drugs get into prison? How can we reduce the smuggling-in of drugs?"

Although prisons have comprehensive security systems in place to detect contraband items, NPS more easily evade standard detection methods as they are often colourless, odourless and active in very small quantities. In addition to traditional smuggling routes – such as visitors, guards, persons in detention (day-release), throwing over the walls, hidden in goods being sold in shops – some new routes of smuggling have been invented. NPS may be sprayed onto clothing, food items, letters and even children's drawings sent into prisons.

To reduce supply, different measures have been introduced across European prisons such as: photocopies of letters (UK, Germany); training of drug detection dogs (Scotland); no external provider of goods; and the extensive training of staff.

The use of NPS in prisons has been associated with self-harm, suicide attempts, aggression and assaults, ambulance call-outs, organised crime, bullying, debt and suicides. NPS pose a substantial challenge to health and the security of the prison environment. Custodial and healthcare staff need to manage persons in prison who may display outbursts of anger, slurred speech, hallucinations, psychosis and significant mental deterioration.[21]

Synthetic cannabinoids

SC merit particular consideration because of their prevalence in prisons compared to other illicit drugs. These drugs contain a wide range of active chemicals that stimulate the brain's receptors in a variety of ways and can be more than 100 times more potent than natural cannabis. This fact, combined with their long half-life, can result in unpredictable, severe and long-lasting adverse effects.

- Desired effects are relaxation, euphoria, disinhibition, feeling energised and altered consciousness. Chronic use of SC is associated with tolerance that may develop more quickly for SC than for natural cannabis.
- Withdrawal symptoms are gastrointestinal cramps, nausea, tremor, hypertension, tachycardia, coughing, headache, craving, anxiety, restlessness, irritability, depression and suicidal ideation.

20. Home Office (2015), *New psychoactive substances (NPS) – Resource pack for informal educators and practitioners*, available at www.gov.uk/government/publications/new-psychoactive-substances-nps-resource-pack, accessed 17 November 2024.
21. Corazza O. et al. (2020), "Novel psychoactive substances in custodial settings: a mixed method investigation on the experiences of people in prison and professionals working with them", *Frontiers in Psychiatry* Vol. 11, available at https://doi.org/10.3389/fpsyt.2020.00460, accessed 17 November 2024.

- Acute adverse effects are convulsions, cardiovascular effects including myocardial infarction, acute shortness of breath, acute kidney injury, vomiting, transient loss of vision and speech, reduced levels of consciousness, anxiety, aggression, extreme bizarre behaviour, amnesia, confusion, panic attacks, inappropriate affect, hallucinations, paranoia, delusions, psychosis and death.
- Chronic adverse effects are psychosis, cognitive impairment, catatonic states, dependence, persistent vomiting and withdrawal symptoms on reduction or cessation of use.

SCs are perceived to pose significant problems connected to violence, self-harm, suicide and mental health issues.

Further, the increased number of emergency calls related to the use of SC in prisons reported by several countries can have a direct impact on prison routines. For every person transferred to a hospital, one or more prison staff has to leave the prison establishment, with a direct impact on the organisation of other activities in the prison, such as education, sport or work activities. Reduced opportunities to take part in meaningful activities may lead to boredom among persons in prison; this has been referred to as one of the main drivers of substance use. Due to an increased number of emergency calls, health professionals working in the prison context may also have less time to provide regular prison healthcare. These issues may have a direct impact on entire prisons and the well-being of their prison population.

In the absence of rapid urine tests to confirm the use of NPS, an assessment has to be clinical, based on history, where available, and recognising the clinical presentation. Healthcare staff should address the presenting symptoms rather than the specific drug suspected to have been used: namely, treat what you see.

Some of the extreme effects of SC, such as convulsions, bizarre behaviour, temporary paralysis, rapid heart rate, aggression and psychosis, demand an immediate response and may require transfer to hospital. The adverse effects of SC use can be long lasting, and custody and healthcare staff may have to manage the consequences for months following the initial presentation (i.e. long-term challenging behaviour).

As the drug market is fast-changing and very dynamic, close monitoring, early detection and timely responses to counter such emerging drug threats are required. Therefore, to rapidly detect, assess and respond to health and social threats caused by NPS, the European Union Early Warning System on New Psychoactive Substances has been established. It is composed of a multi-agency and multidisciplinary network, which includes the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 29 national early warning systems (NEWS), Europol and its law enforcement networks, the European Medicines Agency, the European Commission and other partners. Most new substances are identified for the first time following the chemical analysis of a seizure made by law enforcement. When a substance is suspected of being an NPS, the national early warning system reports this to the EMCDDA. If confirmed as a new substance, then a formal notification is issued on behalf of the reporting member state. As of December 2021, the EMCDDA was monitoring more than 860 NPS that have been formally notified since 1997. SC represent the largest group of substances currently monitored in Europe by the EMCDDA through the European Union Early Warning System on New Psychoactive Substances.

The trainer summarises key points and highlights the next session.

Session 8

Dual diagnosis

Duration	45 minutes
Learning outcomes	Participants will explore the complex interplay between substance use and other mental health disorders and understand the importance of providing simultaneous treatment services, recognising that treating these issues concurrently is essential for effective intervention (if you do not treat them together, you cannot beat either).
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.8 ► **Discussion topics**; Annex 1.8 ► **Case study**; Annex 1.8
Proposed references	Ministry of Justice/Department of Health (2009), "A guide for the management of dual diagnosis for prisons", available at https://lx.iriss.org.uk/content/guide-management-dual-diagnosis-prisons.html, accessed 17 November 2024. EMCDDA (2016), "Comorbidity of substance use and mental health disorders in Europe (Perspective on drugs)", European Monitoring Centre for Drugs and Drug Addiction, available at www.emcdda.europa.eu/publications/pods/comorbidity-substance-use-mental-health_en, accessed 17 November 2024.

WHO defines "dual diagnosis" as "the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder".[22] The EMCDDA uses the term "comorbidity of substance use and mental health disorders" for dual diagnosis and defines this as the "temporal coexistence of two or more psychiatric disorders as defined by the International Classification of Diseases, one of which is problematic substance use". Therefore, "dual diagnosis" *itself* is not a diagnosis, but rather a specific combination of diagnoses.

Dual diagnosis is not a new phenomenon. Psychiatric services have had longstanding challenges in helping patients with mental health problems who drink to excess. Similarly, drug and alcohol services have always worked with a number of clients with substance misuse problems who also suffer from a variety of mental health problems, including depression, anxiety states and psychosis. What has changed over the past two decades is a dramatic increase in the range and availability of street drugs.[23]

The interplay between SUD and other mental disorders is very complex and can change over time. Pathways to co-morbidity may be different.[24]

1. The SUD and the other mental health disorder may represent two or more independent conditions. In this case, the combination may occur through chance alone or as a consequence of the same predisposing factors (e.g. stress, personality, childhood environment, genetic influences) that affect the risk for multiple conditions. That is, SUD and other psychiatric disorders would represent different symptomatic expressions of similar pre-existing neurobiological abnormalities.
2. The psychiatric disorder other than the SUD is a risk factor for drug use and the development of a co-morbid SUD. According to "self-medication hypothesis", patients may use substances to deal with problems associated with the mental health disorder (e.g. social phobia, post-traumatic stress disorder, psychosis). The excessive use of substances may abate when the pre-existing mental health disorder is addressed appropriately. However, the psychiatric disorder could increase the risk of heavy and repetitive use of substances, leading to the development of an SUD that may continue even when the pre-existing psychiatric condition is appropriately treated.

22. WHO (1994), *Lexicon of alcohol and drug terms*, 65pp, Sw fr 17, Paperback, available at www.who.int/publications/i/item/9241544686, accessed 4 December 2024.
23. EMCDDA (2007), *Cocaine and crack cocaine: a growing public health issue*, Lisbon.
24. Ibid.

3. The SUD could trigger the development of a psychiatric disorder in such a way that the additional disorder then runs an independent course. Drug use can function as a trigger for an underlying long-term disorder. This is probably the most important mechanism underlying the association between cannabis use and schizophrenia. It is well known that cannabis use in vulnerable adolescents can facilitate the development of a psychosis that runs as an independent illness.
4. The temporary psychiatric disorder is produced as a consequence of intoxication with, or withdrawal from, a specific type of substance, also called a substance-induced disorder. Temporary psychiatric conditions (e.g. psychosis with features resembling schizophrenia) may be produced as a consequence of intoxication with specific types of substances (e.g. stimulants, such as amphetamines and cocaine) or withdrawal conditions (e.g. depressive syndromes associated with the cessation of stimulant use). There are some studies showing that, in some cases, previous induced disorders have been diagnosed as independent disorders after a follow-up period.

The trainer should ask: "In your opinion, what is the approximate number of patients with dual diagnosis in your prison? How is their treatment organised?"

There is a relatively high prevalence of co-morbidity in people who use substances, with about 50% having both a substance use and mental health disorder.[25] The most common co-morbidity is an SUD and depression, anxiety, bipolar disorder, schizophrenia or trauma-related disorders.

While mental health disorders and SUD have their own independent challenges, there can be additional issues when they occur together, such as:

- difficulty pinpointing whether specific issues came from substance use, mental disorder or both;
- a domino effect of relapse, where a step back in one treatment may cause a step back in both;
- adverse interactions with routinely prescribed medication for each disorder doubles the stigma.

Different treatment models

Sequential

In this model, the psychiatric and substance disorders are treated consecutively and there is little communication between services. Patients usually receive treatment for the most serious problems first and, once this treatment is completed, they are treated for their other problems. In this model, the patient may be passed between services, increasing the risk of dropout and relapse from both services. For that reason, evidence suggests that this model should be avoided when dealing with patients with dual diagnoses.[26]

Parallel

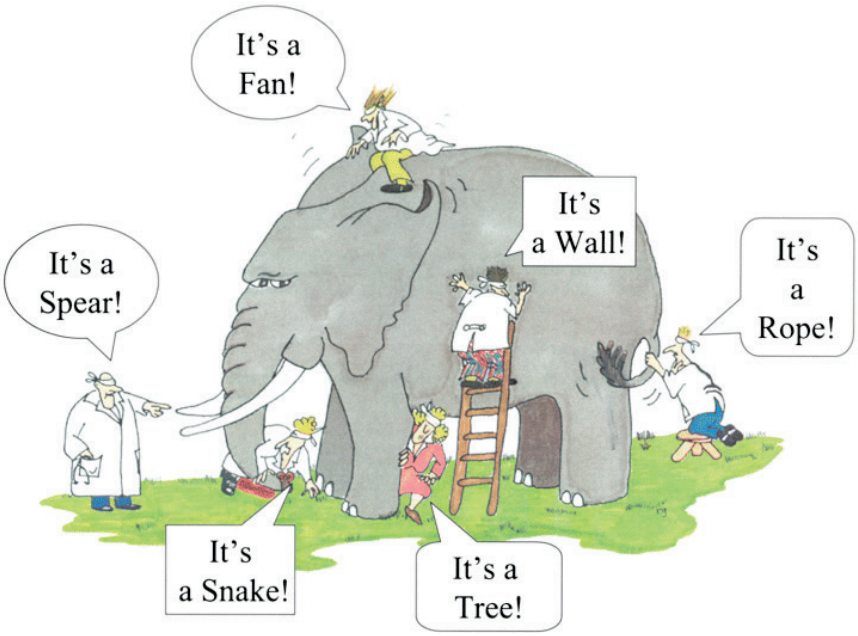
Treatment of the two different disorders is undertaken at the same time, with drug and mental health services liaising to provide services concurrently. Although some level of co-ordination between the two systems may be achieved, the two treatment needs are often met with different therapeutic approaches and the medical model of psychiatry may conflict with the psychosocial orientation of drug services. A potential negative consequence of this model is the lack of overall coherence of the treatment plan, which is often at the expense of the patient.

Integrated model (recommended)

In this model, treatment is provided within a psychiatric or drug treatment service or a special co-morbidity programme or service (e.g. some prisons in the UK have established specialist dual diagnosis teams comprised of professionals with a background in psychiatry, psychology, social care and substance use; cross-referral to other agencies is avoided). Treatments should include mental health treatment, motivational and behavioural interventions, relapse prevention, pharmacotherapy and social approaches.

The following illustration should be discussed in light of the treatment of persons with dual diagnosis.

25. EMCDDA (2015), *Comorbidity of substance use and mental disorders in Europe*, www.euda.europa.eu/publications/insights/comorbidity-substance-use-mental-disorders-europe_en, accessed 9 December 2024.
26. Substance Abuse and Mental Health Services Administration (2020), "Substance use disorder treatment for people with co-occurring disorders: updated 2020", Treatment Improvement Protocol (TIP), www.ncbi.nlm.nih.gov/books/NBK571020/, accessed 9 December 2024.



The most important elements of good practice in the care of patients with dual diagnosis are early identification of needs, continuity, specialist skills and flexibility. The therapeutic approach to tackle dual diagnosis, whether pharmacological, psychological or both, has to take into account both disorders and treat them simultaneously.

Upon admission to a prison, during the first medical examination, the medical team should be alert to any history of mental health problems as well as current mental health issues that might worsen if detoxification of a newcomer is undertaken. These conditions include any mental disorders, behavioural problems or any symptoms that a patient states have worsened when they stopped taking drugs in the past.

Patients with opioid dependence with serious mental health problems should be stabilised rather than detoxified. In cases of co-existent serious mental health problems and opioid dependence, long-term maintenance may be indicated.

Withdrawal from stimulants can cause a brief but sometimes profound depression. This may take anything from one week to several months to resolve as the central nervous system adapts physiologically to the changed chemical environment. During this time, a person may be at enhanced risk of suicide or self-harm.

Benzodiazepine withdrawal may cause the emergence of symptoms of psychosis; patients with a previous history of thought disorder may have a greater vulnerability to this effect. A period of stabilisation may be required before any further reduction in benzodiazepines is considered. Anxiety and self-harm can emerge as a result of withdrawal of benzodiazepines.

The trainer presents the case study.

The trainer summarises key points and highlights the next session.

Session 9

Management of withdrawal syndrome and overdose

Duration	60 minutes
Learning outcomes	Participants will enhance their knowledge of withdrawal syndromes associated with opioids, stimulants and benzodiazepines, and learn appropriate management strategies. Additionally, participants will acquire the skills to recognise opioid overdoses and apply first aid techniques.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.9 ► **Demonstration** Video: "Take-home naloxone programmes in Europe – overdose prevention", European Union Drugs Agency, available at www.euda.europa.eu/media-library/video-take-home-naloxone-programmes-europe-%E2%80%94-overdose-prevention_en, accessed 18 November 2024. ► **Discussion topics**; Annex 1.9 ► **Case study**; Annex 1.9
Proposed references	WHO (2009), *Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings*, World Health Organization, Geneva, available at www.ncbi.nlm.nih.gov/books/NBK310654, accessed 18 November 2024. WHO (2023), "Opioid overdose", available at www.who.int/news-room/fact-sheets/detail/opioid-overdose, accessed 18 November 2024.

Withdrawal syndrome

Withdrawal syndrome is defined as a group of symptoms of variable clustering and degree of severity that occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. These symptoms can last anywhere from a few days to a couple of weeks. However, some substances can lead to a protracted withdrawal phase, defined as substance-specific and non-substance-specific signs and symptoms common to acute withdrawal, but persisting, evolving or appearing well past the general acute withdrawal timeframes, lasting for several months and sometimes a few years.[27]

Withdrawal syndrome occurs in individuals who have developed physiological dependence on a substance and who reduce/cease their use of it.

Withdrawal management

Withdrawal management refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their substance of dependence.

Prison medical staff are obliged to manage withdrawal syndrome that may appear upon admission to a prison, as well as at any time during imprisonment.

According to the European Prison Rules, the medical practitioner or a qualified nurse reporting to such a medical practitioner shall see every prisoner as soon as possible after admission and shall pay particular attention to, *inter alia*, dealing with withdrawal symptoms resulting from the use of drugs, medication or alcohol (rule 42.3).

27. American Addiction Centers, "Post-acute withdrawal syndrome (PAWS): what is PAWS?", available at https://americanaddictioncenters.org/withdrawal-timelines-treatments/post-acute-withdrawal-syndrome, accessed 18 November 2024.

After encountering a situation where newly arrived inmates with acute opioid withdrawal signs including vomiting, shivering, agitation, abdominal cramps, piloerection and pain were left unattended, without receiving painkillers or other symptomatic treatment, the CPT concluded that "such a state of affairs is not acceptable" and recommended that the authorities take the necessary steps to ensure that, in all prisons, newly arrived prisoners with drug addiction problems are systematically identified and that those suffering from withdrawal signs are promptly provided with adequate treatment (i.e. substitution treatment or treatment relieving the symptoms).[28]

The trainer should ask: "Can a person die from opioid withdrawal?"

Opioid withdrawal syndrome

With short-acting opioids (e.g. heroin), the onset of opioid withdrawal symptoms is 8-24 hours after last use; duration is 4-10 days. With long-acting opioids (e.g. methadone), onset of opioid withdrawal symptoms is 12-48 hours after last use; duration is 10-20 days.

Symptoms of opioid withdrawal syndrome include:

- nausea and vomiting;
- anxiety;
- insomnia;
- hot and cold flushes;
- increased perspiration;
- muscle cramps;
- watery discharge from eyes and nose;
- diarrhoea.

Patients should be monitored regularly (3-4 times daily) for symptoms and complications. Clinical staff may use the Clinical Opiate Withdrawal Scale.

Whatever the clinical decision, medically supervised opioid withdrawal (detoxification) or maintenance methadone treatment, the absolute precondition for an effective start is to provide the patient with relevant information, particularly on the risk of overdose.

Benzodiazepine withdrawal syndrome

Benzodiazepines can have short or long durations of action. This affects the onset and course of withdrawal. Withdrawal (i.e. acute symptoms) on short-acting benzodiazepines, such as alprazolam, typically begins 1-2 days after the last dose and continues for 2-4 weeks or longer. Withdrawal from long-acting benzodiazepines, such as diazepam, typically begins 2-7 days after the last dose, and continues for 2-8 weeks or longer.

Symptoms include:

- anxiety;
- insomnia;
- restlessness;
- agitation and irritability;
- poor concentration and memory;
- muscle tension and aches;
- possible seizures.

These symptoms tend to be subjective, with few observable signs.

Patients in benzodiazepine withdrawal should be monitored regularly for symptoms and complications.

The severity of benzodiazepine withdrawal symptoms can fluctuate markedly, and withdrawal scales are not recommended for monitoring withdrawal. Rather, the healthcare worker should regularly (every 3-4 hours) speak with the patient and ask about physical and psychological symptoms. Provide reassurance and explanation of symptoms as necessary.

28. CPT (2020), "Report to the Turkish Government on the visit to Turkey carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 6 to 17 May 2019", CPT/Inf (2020) 24, available at https://rm.coe.int/16809f20a1, accessed 18 November 2024.

The safest way to manage benzodiazepine withdrawal is to administer benzodiazepines in gradually decreasing amounts. This helps to relieve withdrawal symptoms and prevent the development of seizures. First, the patient should be stabilised on an appropriate dose, for example of diazepam.

The length of time between each dose reduction should be based on the presence and severity of withdrawal symptoms. The longer the interval between reductions, the safer and more comfortable the withdrawal. Generally, there should be at least one week between dose reductions.

Generally, benzodiazepine withdrawal symptoms fluctuate; the intensity of the symptoms does not decrease in a steady fashion as is the case with most other drug withdrawal syndromes. It is not recommended to increase the dose when symptoms worsen; instead, persist with the current dose until symptoms abate, then continue with the dose reduction schedule.

Withdrawal management alone is unlikely to lead to sustained abstinence from benzodiazepines. The patient should commence psychosocial treatment.

Stimulant withdrawal syndrome

Stimulants are drugs such as methamphetamine, amphetamine and cocaine. Although these drugs vary in their effects, they have similar withdrawal syndromes. Symptoms begin within 24 hours of last use of stimulants and last for 3-5 days.

Symptoms include:

- agitation and irritability;
- depression;
- increased sleeping and appetite;
- muscle aches.

People who use large amounts of stimulants, particularly methamphetamine, can develop psychotic symptoms such as paranoia, disordered thoughts and hallucinations. The patient may be distressed and agitated. They may be at risk of harming themselves or others. These symptoms can be managed using anti-psychotic medications and will usually resolve within a week of ceasing stimulant use.

Patients withdrawing from stimulants should be monitored regularly. The mainstay of treatment for stimulant withdrawal is symptomatic medication and supportive care.

During withdrawal, the patient's mental state should be monitored to detect complications such as psychosis, depression and anxiety. Patients who exhibit severe psychiatric symptoms should be referred to a hospital for appropriate assessment and treatment.

Symptomatic medications should be offered as required for aches, anxiety and other symptoms. Patients should drink at least 2-3 litres of water per day during stimulant withdrawal.

Acute stimulant withdrawal may be followed by a protracted withdrawal phase of 1-2 months, characterised by lethargy, anxiety, unstable emotions, erratic sleep patterns and strong cravings for stimulant drugs. These symptoms may complicate the patient's involvement in treatment and should be taken into account when planning treatment. The preferred treatment for stimulant dependence is psychological therapy that focuses on providing patients with skills to reduce the risk of relapse.

Substance intoxication

Substance intoxication is transient and clinically significant alteration – for example in behaviour, consciousness or co-ordination – that appears during or shortly after substance use. Intoxication can last from only a few minutes to several days after the episode of use. The effects of intoxication are limited in time and fade away as the substance is eliminated from the body.

The ICD-11 allows for specification of severity of intoxication that can be classified as mild, moderate or severe and depends on a variety of factors, such as the amount of substance used, its half-life and the route of administration and, of course, individual susceptibility that can be influenced by body weight, tolerance or concurrent conditions, such as kidney or liver impairment.

Substance intoxication is considered mild if disturbances in psychophysiological functions and responses (for instance attention, judgment or motor co-ordination) are clinically recognisable but there is no – or little – disturbance in the level of consciousness.

In moderate intoxication, however, the above-mentioned disturbances are evident and tasks that require psychophysiological functioning and response are substantially impaired. There is also some disturbance in the level of consciousness.

Severe substance intoxication is a state in which motor co-ordination, attention and judgment are obviously impaired, as well as the level of consciousness. The person may not be capable of self-care or self-protection and may not be capable of communicating or co-operating with assessment and intervention. The intensity of intoxication decreases after reaching a peak of absorption of the substance, and the effects eventually disappear if there is no further use of the substance.

Overdose

"Overdose" is the term used when someone enters a critical state from ingesting too much of a substance or blend of substances.

There are a number of risk factors for opioid overdose (WHO). These include:[29]

- having an OUD;
- taking opioids by injection;
- resumption of opioid use after an extended period of abstinence (e.g. following detoxification, release from incarceration, cessation of treatment);
- using prescription opioids without medical supervision;
- high prescribed dosage of opioids (more than 100 mg of morphine or equivalent daily);
- using opioids in combination with alcohol and/or other substances or medicines that suppress respiratory function such as benzodiazepines, barbiturates, anaesthetics or some pain medications;
- having concurrent medical conditions such as HIV, liver or lung diseases, or mental health conditions.

The trainer presents a case study.

An opioid overdose can be identified by a combination of three signs and symptoms:

- pinpoint pupils;
- unconsciousness;
- slow or no breathing (respiratory depression).

Within 3-5 minutes without oxygen, brain damage begins to occur. With opioid overdoses, surviving or dying wholly depends on breathing and oxygen, and thus ventilation is a crucial part of its treatment.

Any respiratory failure should be managed by using mechanical ventilation and oxygen, while administrating naloxone. Opioid overdose is reversible through the immediate administration of naloxone, which blocks the action of the opioid. Its administration typically results in return to consciousness, resumption of breathing and, in cases of opioid dependence, onset of opioid withdrawal symptoms.

The trainer should ask: "Is your prison equipped with naloxone? Have you ever used it?"

Naloxone should be available within prisons to reverse opioid overdoses. There should be an internal policy (i.e. protocol) in place to allow uniformed correctional staff as first responders in many situations, who encounter unresponsive individuals, to initiate necessary first aid, cardiopulmonary resuscitation if required, use of an automatic external defibrillator, and administration of naloxone.

The trainer should ask: "How do staff feel about the statement above?"

In its new guidelines on community management of opioid overdose, WHO also recommends that people likely to witness an opioid overdose should have access to naloxone and should be instructed in its administration. Evidence shows that THN, complemented by educational and training interventions for peers and family members, helps decrease overdose-related mortality. With evidence on its effectiveness growing, THN provision has gained increasing attention in recent years.

29. WHO (2023), "Opioid overdose", available at www.who.int/news-room/fact-sheets/detail/opioid-overdose, accessed 9 December 2024.

Good practices include:

- since June 2019, naloxone for intramuscular injection in a pre-filled syringe has been available from pharmacies without prescription in France;
- in Scotland, in October 2015, the regulations regarding the supply of naloxone were changed to allow anyone working in a drug service to provide THN (previously this had been restricted to nurses/pharmacists/doctors), which has allowed for greater distribution via third sector organisations. It also allows family members to access THN without consent from the "person at risk".

The trainer summarises key points and highlights the next session.

Session 10

Infectious diseases associated with injection drug use

Duration	45 minutes
Learning outcomes	Participants will familiarise themselves with the United Nations' key interventions designed to create an effective response to human immunodeficiency virus (HIV) and related infections in custodial settings and learn the connection between medication-assisted treatment (MAT) and the treatment of infectious disorders.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.10 ► **Discussion topics**; Annex 1.10
Proposed references	UNODC/WHO/UNAIDS/UNDP/ILO (2012), "Policy brief – HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions", available at www.ilo.org/publications/hiv-prevention-treatment-and-care-prisons-and-other-closed-settings, accessed 18 November 2024. WHO (2023), "Creating supportive conditions to reduce infectious diseases in prison populations", World Health Organization, European Region, available at www.who.int/europe/publications/i/item/WHO-EURO-2023-8182-47950-70944, accessed 18 November 2024.

People who inject drugs are at increased risk of HIV, HBV and HCV through the sharing of drug use equipment.

HIV is an infection that attacks the body's immune system. Aids is the most advanced stage of the disease. HIV targets the body's white blood cells, weakening the immune system. This makes it easier to get sick with diseases like tuberculosis (TB), infections and some cancers. HIV is spread from the body fluids of an infected person, including blood, breast milk, semen and vaginal fluids. It is not spread by kisses, hugs or sharing food. It can also spread from a mother to her baby. HIV can be treated and prevented with antiretroviral therapy (ART). Early access to ART and support to remain on treatment is critical not only to improve the health of people living with HIV but also to prevent HIV transmission. Antiretroviral drugs given to people without HIV can prevent the disease; when given after an exposure, it is called post-exposure prophylaxis.

HBV and HCV infections affect the liver, and the acute infection may become chronic hepatitis disease, with very serious potential consequences for the liver, such as cirrhosis or liver cancer, which can be challenging to treat and may require a liver transplant, or lead to death. HBV is largely transmitted through bodily fluids. It can be passed at birth from a hepatitis B-infected mother. The key risk factors for HCV are also intranasal and injection drug use, tattoos and body piercings, and high-risk sexual contact. Hepatitis B is a vaccine-preventable disease. There is no vaccine for hepatitis C.

These infections can cause chronic diseases that may result in severe health-related harms, including death. While long-term trends in new HIV infections associated with drug injection have been falling in Europe, the risk of HIV transmission among people who inject drugs remains higher than for the general population, and transmission rates attributable to injecting are also still elevated in some countries.[30]

In addition to the above-mentioned diseases, prisons have consistently been recognised as high-risk environments for TB transmission. TB spreads through the air when infected people cough, sneeze or spit; the risk is higher where people live in crowded conditions. TB is caused by a bacteria that usually attacks the lungs, but can attack any part of the body such as the kidney, spine and brain. If not treated properly, it can be fatal. People with HIV/Aids and other people with weakened immune systems have a higher risk of catching TB than people with typical immune systems.

30. EUDA (2023), Drug-related infectious diseases – the current situation in Europe (European Drug Report 2023), European Union Drugs Agency, available at www.euda.europa.eu/publications/european-drug-report/2023/drug-related-infectious-diseases_en, accessed 19 November 2024.

The trainer should ask: "How many are receiving HIV and HCV treatment, and do the numbers reflect the real situation?"

According to the CPT, the act of depriving a person of their liberty always entails a duty of care that calls for effective methods of prevention, screening and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life-threatening diseases.[31]

The trainer should ask about practices on offering voluntary testing for HIV and hepatitis upon admission as well as TB screening.

United Nations package of 15 key interventions

Risk behaviour related to infectious diseases pose a threat to people in prison, prison staff, families and the community. Therefore, it is essential to provide integrated interventions in these settings, both for people held in prison and for those employed in prisons and closed settings. In order to support countries in creating an effective response to HIV and related infections in custodial settings, the UN has designed a comprehensive package of 15 key interventions. Each of these interventions in itself is useful in addressing HIV, but when delivered together they have the greatest impact.

The trainer should ask participants, in relation to each intervention: "Is this implemented in your prison?"

1. Information, education and communication

Information and education on HIV, HBV, HCV and TB; sexual and reproductive health; mental health; and drug use and overdose prevention and management should be provided.

2. Condom and lubricant provision

Male and female condoms and condom-compatible lubricants should be provided free of charge; access should be free and confidential; these should be provided also for intimate visits.

3. Prevention of sexual violence

Men and women, including young persons, should be accommodated separately.

Policies and strategies on placement of persons of all sexual orientations and gender identities should be developed to avoid further marginalisation and risk of violence, ill-treatment or physical, mental or sexual abuse.[32] Appropriate measures should be established concerning reporting and addressing instances of violence.

People who have experienced violence should be provided protection, psychological support and healthcare, including HIV testing, post-exposure prophylaxis for HIV[33] and other sexually transmitted infections, HBV vaccination and emergency contraception, with consent and as appropriate.

4. Needle and syringe programmes and overdose prevention and management

Easy and confidential access to sterile drug-injecting equipment, needles, syringes and paraphernalia should be provided as well as information on available NSPs.

Prisoners should be informed about overdose risks, prevention and management.

Naloxone should be made available to people held in prison, prison staff and other people who might witness an opioid overdose. It should be given to people upon release from prison to prevent post-release overdose death.

5. Medication-assisted treatment and other evidence-based drug dependence treatment

MAT should be available as the most effective treatment for reducing HIV/HCV risk behaviours and opioid overdoses.

A range of other evidence-based drug dependence treatment options should be provided.

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31. Extract from a 2001 monitoring report by the CPT on a European country; more information on specific reports available at www.coe.int/en/web/cpt/states, accessed 19 November 2024.
32. Yogyakarta Principles – Principles on the application of international human rights law in relation to sexual orientation and gender identity, available at https://yogyakartaprinciples.org/principles-en/about-the-yogyakarta-principles/, accessed 19 November 2024.
33. Anti-retroviral therapy (ART) within 72 hours (maximum) after a possible exposure to HIV.

6. Prevention of transmission through medical and dental services

As HIV and hepatitis can be easily spread through contaminated medical and dental equipment, there should be strict adherence to infection control and safe injection protocols.

7. Hepatitis B vaccination and prevention of transmission through tattooing, piercing and other forms of skin penetration

A comprehensive hepatitis prevention programme (including the provision of free HBV vaccination for all people in prisons, and free hepatitis A-B vaccination for those at risk) should be established.

Initiatives such as the provision of sterile equipment and training to reduce risks of transmission of HIV and viral hepatitis through the sharing and reuse of equipment for tattooing, piercing and other forms of skin penetration should be implemented.

Information on the risks of sharing shavers, scissors, clippers and toothbrushes should be provided.

8. Post-exposure prophylaxis

Post-exposure prophylaxis for people who have experienced sexual assault and for other people in prison potentially exposed to HIV through blood or sexual exposure should be provided.

Clear guidelines should be developed and communicated to people held in prison, healthcare staff, and other professionals and employees in prison.

9. HIV testing and counselling

Easy access to voluntary HIV testing services at any time during detention should be provided, including HIV testing and counselling for all people in prison during medical examinations.

HIV testing should be offered to individuals with signs or symptoms suggesting HIV, TB infection or other opportunistic infections, including abnormal cervical cytology.

HIV testing should be offered to pregnant and nursing women in prison.

All forms of coercion should be avoided.

Testing with informed consent, pre-test information, post-test counselling, protection of confidentiality and access to services should be carried out that includes appropriate follow-up, ART including prevention of mother-to-child transmission for pregnant or nursing women, and other treatment as needed.

Testing for HBV, HCV and other sexually transmitted infections should be considered when offering HIV testing.

10. HIV treatment, care and support

HIV treatment, care and support should be provided and be at least equivalent to that available to people living with HIV in the community and in line with national HIV guidelines for the community and international guidelines.

Access to ART for all people living with HIV should be provided as soon as possible.

Nutritional supplements, therapeutic education and support for treatment adherence to patients under treatment should be provided.

11. Diagnosis and treatment of viral hepatitis

A comprehensive hepatitis programme to prevent, diagnose and treat HBV and HCV should be developed that is equivalent to those available in the community.

HCV testing for people at risk should be offered; when a test is RNA[34] positive, immediate treatment in line with national guidelines and international guidance should be provided.

12. Prevention, diagnosis and treatment of tuberculosis

Active case-finding should be intensified.

Effective TB control measures should be introduced.

34. Genetic material of the HCV or its ribonucleic acid (RNA).

Newly admitted persons and those living with HIV should be screened for TB.

All people diagnosed with TB should be advised to have an HIV test.

All people living with HIV without symptoms of active TB (no current cough, fever, weight loss or night sweats) should be offered isoniazid preventive therapy.

Ventilation of cells, good access to natural light and adequate space per person should be ensured.

Those who have been confirmed to have active TB should be medically isolated until they are no longer infectious.

13. Sexual and reproductive health

Screening, early diagnosis and treatment of sexually transmitted infections as part of HIV prevention programmes, in combination with the provision of condoms and lubricants, should be provided.

A full range of sexual and reproductive healthcare should be provided, including free, voluntary and non-coercive contraceptive services and family planning, as well as screening for breast, cervical and anal cancer for women, men and transgender people.

Pregnant and nursing women should be provided the same access to antenatal and postnatal care and adequate diet as those in the community.

14. Prevention of mother-to-child transmission of HIV, syphilis and HBV

A comprehensive range of interventions for prevention of mother-to-child transmission of HIV, syphilis and HBV should be provided, including primary prevention of HIV, family planning and ART.

15. Protecting staff from occupational hazards

Education and training by labour inspectors and specialists in medicine and public health should be provided to all prison staff to enable them to perform their duties in a healthy and safe manner.

Occupational safety and health procedures in prisons that are at least at the same level as in the community should be implemented.

Prison staff should not be subject to mandatory testing, but should be offered confidential HIV and hepatitis testing as well as TB screening.

Employees should be provided with free access to HBV vaccination as well as easy access to protective equipment, such as gloves, mouth-to-mouth resuscitation masks, protective eyewear, soap, search and inspection mirrors, and post-exposure prophylaxis in case of occupational exposure.

World Health Organization conditions to reduce infectious diseases in prison populations

1. Prepare

Contingency planning is essential to ensure an adequate health response and to maintain secure, safe and humane prisons. Robust emergency preparedness plans are necessary, with working protocols for managing infectious disease outbreaks. Partnerships in planning among public health agencies, healthcare services and places of detention are essential.

2. Prevent

Measures to reduce prison overcrowding are an essential component of infection prevention and control, and adoption of criminal justice reform should be considered, such as non-custodial incarceration for some offences and shorter pre-trial detention. Furthermore, harm reduction intervention should be scaled up in prisons.

3. Detect

Systematic screening of people when they enter custody is recommended to ensure early detection of disease and prevention and care.

4. Respond

Access to treatment should be facilitated.

5. Build

Systems, sectors and partnerships should be optimised in planning services.

Link between medication-assisted treatment and treatment of infectious disorders

MAT enables people with OUD to stabilise their lives and avoid or manage many of the complications of injecting drug use. It is, therefore, seen as an essential component in strategies for retaining people who inject drugs in treatment.

The optimal way to manage HIV infection in people who inject drugs is to link ART with stable methadone maintenance therapy. Administration of ART in conjunction with directly observed methadone maintenance therapy will optimise adherence with drug treatment. Prescription of methadone should be carried out in co-operation with HIV professionals so as to avoid possible interaction in combining methadone with HIV medication and, if necessary, to adjust treatment schemes and dosages of methadone.

People under stable treatment with methadone respond well to HCV treatment. Direct-acting antivirals are recommended for the treatment of HCV infection in patients treated with methadone.

As several medications used for the treatment of TB can interact with methadone (in particular, rifampicin), methadone dose optimisation is vital when treating people for TB.

The trainer summarises key points and highlights the next session.

Session 11

Harm reduction measures

Duration	45 minutes
Learning outcomes	Participants will recognise that some level of drug use is expected both in prisons and in society and learn that harm reduction measures focus on preventing drug-related harm without necessarily requiring abstinence from those who use drugs. Additionally, participants will be motivated to implement a range of harm reduction measures to achieve greater benefits on both personal and societal levels.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.11 ► **Demonstration** Video: "Drug consumption rooms", European Union Drugs Agency, available at www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en, accessed 19 November 2024. ► **Debate**; Annex 1.11
Proposed references	Harm Reduction International (n.d.), "What is harm reduction?", available at https://hri.global/what-is-harm-reduction, accessed 19 November 2024. EUDA (2023), *Harm reduction – The current situation in Europe (European Drug Report 2023)*, European Union Drugs Agency, available at www.euda.europa.eu/publications/european-drug-report/2023/harm-reduction_en, accessed 19 November 2024. TCJP (2010), *Prison staff and harm reduction: a training manual,* Training Criminal Justice Professionals in Harm Reduction Services, available at www.drugsandalcohol.ie/14160/, accessed 19 November 2024.

Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.

Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgment, coercion or discrimination, or requiring that people stop using drugs as a precondition of support. It encompasses a range of health and social services and practices that apply to drugs, some of which are described in the following subsections.

Information on safer drug use

Using drugs brings risks but there are ways to make it safer. People can reduce their risk of HIV, hepatitis, overdose and other drug-related harms by applying evidence-based harm reduction strategies around safer drug use such as avoiding the mixing of drugs; using new needles and supplies; rotating injection sites; using sterile water; and using naloxone as the only way to stop an opioid overdose, and so on.

Needle and syringe programmes

NSPs prevent, control and ultimately reduce the prevalence of HIV and other blood-borne infections among people who inject drugs.

NSPs supply sterile needles and syringes for people who inject drugs. In addition, they often supply other equipment used to prepare and take drugs (e.g. filters, mixing containers and sterile water). The majority of NSPs are run by pharmacies and drug services. They may operate from fixed, mobile or outreach sites.

Switzerland was the first country to start an NSP in a prison in 1992.

Models of distribution vary: hand-to-hand by prison health staff; hand-to-hand by trained peers (i.e. prisoners); hand-to-hand by external personnel or non-governmental organisations; and automated dispensing machines. Each method has advantages and challenges in terms of greater or lesser anonymity, confidentiality, supervision, monitoring and costs.

Persons in prison may be reluctant to participate in an NSP due to the fear of being discriminated against or facing negative consequences with regard to their penal situation. They may also fear lack of confidentiality and do not want to declare themselves to be using drugs. All these should be taken into account when planning and implementing an NSP in prisons.

Evaluations of NSPs in prisons have consistently found that the availability of sterile needles and syringes does not result in an increased number of people who inject drugs, an increase in overall drug use or an increase in the amount of drugs in the institutions. The provision of sterile needles in prisons has not resulted in prison officials condoning or otherwise permitting the use, possession or sale of drugs. In every prison where NSPs are in place, drugs remain prohibited. Security staff members are instructed to locate and confiscate all illicit drugs and any needles or syringes that are not part of the programme.

The potential for the misuse of needles and syringes as weapons among persons in prison or against prison staff remains one of the most controversial issues facing NSP. However, in no research evaluation of NSPs has such misuse been recorded. There have also been no recorded safety problems with the disposal of syringes. Exchange rates within NSPs are very high (almost 1:1).

Inmates participating in NSPs are generally required to keep their kit in a pre-determined location within their cells. As an NSP is an approved programme, there is no need for the offender to conceal the equipment in their cells. This reduces the risk of accidental punctures with used needles for staff and for persons in prison.[35]

Overdose prevention and reversal

Overdose prevention includes taking steps to reduce the risk of overdose in the first place and responding to an overdose by administering naloxone. Naloxone can reverse an overdose from opioids, including heroin, fentanyl and prescription opioid medications. Access and use of naloxone, a non-addictive, life-saving drug that can reverse the effects of an opioid overdose when administered in time, should be expanded.

Medication-assisted treatment

Methadone and buprenorphine are therapeutic drugs used for the management of opioid dependence. In clinical practice, they are used for maintenance therapy or withdrawal management. Methadone and buprenorphine have a strong evidence base for their use and have been placed on the WHO model list of essential medicines. Pharmacological therapy is accompanied by other psychosocial interventions in MAT.

Drug consumption rooms

Drug consumption rooms, sometimes known as supervised injecting facilities, are fixed or mobile spaces in which people who inject drugs are provided with sterile injection equipment and can use illicit drugs under the supervision of trained staff. In some countries, consumption rooms also provide a space and equipment to allow non-injecting routes of administration, such as for crack cocaine smokers. Drug consumption rooms exist in several European countries and are usually located in areas where there is an open drug scene and injecting in public places is common. Their primary goal is to reduce morbidity and mortality by providing a safer environment for drug use and training clients in safer forms of drug use. Providing a conduit to other care services and reducing public nuisance may also be an explicit objective.

The trainer presents the video on drug consumption rooms.

Drug checking services

These services aim to prevent harm by allowing people to find out what chemicals are in the illicit substances they have bought and, in some cases, provide access to counselling or brief interventions.

The trainer manages a debate.

The trainer summarises key points and highlights the next session.

35. UNODC (2021), "A handbook for starting and managing needle and syringe programmes in prisons and other closed settings", advance copy, United Nations Office on Drugs and Crime, available at www.unodc.org/unodc/en/hiv-aids/new/publications_prisons.html, accessed 19 November 2024.

Session 12

Preparation for release of persons with substance use disorders

Duration	30 minutes
Learning outcomes	Participants will learn about the risks for persons with substance use disorders (SUD) upon discharge, particularly the risk of overdose for persons who use opioids, and recognise the paramount importance of timely discharge planning.
Teaching techniques	► **Lecturing** (PowerPoint presentation); Annex 2.12 ► **Discussion topics**; Annex 1.12
Proposed references	Hopkin G. et al. (2018), "Interventions at the transition from prison to the community for prisoners with mental illness: a systematic review", *Administration and Policy on Mental Health* Vol. 45(4), pp. 623-34.

The transition from prison to community appears to be problematic, even in cases when highly developed services are in place to identify and treat PWDUD in a custodial setting. The vast majority of persons released from prison, including PWDUD, typically face anxiety and stress associated with the need to find employment and lodging, to repair damaged relationships, and to face social stigma and potential isolation.

Upon being released into the community, PWDUD are likely to encounter some unique risks. For people who use opioids, the risk of dying from drug overdose greatly increases in the period after release from prison due to high rates of relapse and lower opioid tolerance. People who are incarcerated are 100 times more likely to die by overdose in their first two weeks after release compared to the general public. Even a prison sentence of just a few weeks, during which no drugs (i.e. opioids) are consumed, poses a considerable risk to released persons with OUD because of reduced tolerance for opioids; even small quantities can be life-threatening.

Respondents in a multi-country research project funded by the European Commission (2017-19), "'My first 48 hours out' – Comprehensive approaches to pre and post prison release interventions for drug users in the criminal justice system", made it clear that handling the first days outside is very hard. Some have the feeling that they have to learn again how to live and to organise their new daily routine, especially how to behave in interactions with others in society. Most participants recalled having used drugs in the two weeks following their last release. Using drugs at release can be considered a strategy to cope with the uncertainty and stress caused by the fact that their release was not well prepared.

What should be done in prisons

First of all, the relevant staff should be made aware of the date of release of PWDUD (i.e. it may be problematic for those on remand). This is a critical time for action, when ensuring continuity of care and targeted interventions can both support recovery and save lives.

Drug use, related risk behaviour and overdose risks need to be discussed with persons who use drugs or have a history of drug use before release. While still in prison, they should be provided an opportunity to verbalise and discuss their feelings about leaving the prison environment and re-entering the community.

Prevention programmes, especially inside prison, need to improve knowledge and support among PWDUD to cope with factors that lead to drug use in prison or relapse/overdose upon release. Realistic information about the risks of relapse after release should be provided.

Functional connections should exist between health and social services inside as well as outside prison. The perspectives of the respondents in the above-mentioned project clearly showed that psychosocial support is regarded as a crucial element to prevent drug use and relapse upon release.

Continuity of MAT (MOUD) for discharged persons with OUD is of paramount importance. Available studies and guidelines show that such treatment can reduce the risks of relapse and overdose at release and should be a core element of healthcare services for persons who use opioids.

The provision of naloxone, in addition to training on overdose management, is also an important measure to prevent opioid-related deaths due to overdose.

PWDUD should be referred in a timely manner to the services related to their gender, age, health and risk behaviours. Successful linkage to community resources is considered crucial for attending these services after release. To further support recovery, a wide range of social interventions should be made available in the community.

While medical care can be provided to PWDUD in a rather standardised way, psychosocial support needs to be tailor-made, taking into account the specific needs or situation of the individual. Preparation for release (including family, financial, housing and employment issues) as part of a throughcare or continuing care approach can be a key factor to successful reintegration.

Those requiring ongoing psychiatric medication (i.e. persons with dual diagnosis) should be provided with a sufficient amount of medication until they can reasonably be expected to obtain community mental health services. Be aware that any person on regular psychiatric medication should be referred as soon as possible to a psychiatric clinic, as they should not be furnished with large amounts of psychoactive substances.

Different prison services should have clear communication channels, as the preparation for release needs a multidisciplinary approach.

Without good discharge planning and post-release programmes, PWDUD are likely to cycle endlessly between prison and the community, or eventually die.

The trainer should ask: "How is preparation for release organised in your prison? What are the obstacles encountered and what are the practices in need of improvement?"

The European Prison Rules stress that "the enforcement of custodial sentences and the treatment of prisoners necessitate taking account of the requirements of safety, security and discipline while also ensuring prison conditions which do not infringe human dignity and which offer meaningful occupational activities and treatment programmes to inmates, thus preparing them for their reintegration into society".

The Mandela Rules stress that "the duty of society does not end with a prisoner's release".

The trainer summarises key points of the session as well as the whole programme.

Glossary

Abstinence is voluntary refraining from meeting certain physiological needs (such as eating) or from satisfying certain pleasures (such as psychoactive drug use, drinking alcoholic beverages, smoking).

Agonists are chemical substances that act on a neuronal receptor to produce effects similar to those of a reference drug; for example, methadone is a morphine-like agonist at the opioid receptors.

Antagonists are substances that counteract the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor. For example, naloxone is an opioid antagonist that rapidly blocks the opioid receptors and rapidly cancels the effects of an opiate overdose such as heroin.

Buprenorphine is a medication designed to treat OUD. It suppresses and reduces cravings for opioids. Buprenorphine can be prescribed or dispensed in physician offices/MAT sites, significantly increasing access to treatment.

Dependence is defined by WHO as a cluster of cognitive, behavioural and physiological symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance to feel its psychic effects and to mitigate pain/suffering. Substance dependence is a pattern of repeated or continuous use of a substance with evidence of impaired regulation of use of that substance that is manifested by two or more of the following: impaired control over substance use; increasing precedence of substance use over other aspects of life; and physiological features indicative of neuroadaptation to the substance.

Detoxification is the physiological removal of toxic substances from a living organism.

Disorders due to substance use and **addictive behaviours** are mental and behavioural disorders that develop as a result of the use of predominantly psychoactive substances, including medications, or specific repetitive rewarding and reinforcing behaviours.

Drugs are any substances that, when absorbed into a living organism, may modify one or more of its functions; in a pharmacological sense, a drug is any substance used or not in healthcare, the abusive use of which may create physical or psychic dependence or severe disorders in mental activity, perception and behaviour.

Dual diagnosis or **co-occurring conditions and disorders** refer to a person suffering from one or more mental health conditions and one or more SUD at the same time. The disorders need to be determined as independent of one another and not simply symptoms resulting from a single disorder.

Harmful patterns of psychoactive substance use are patterns of continuous, recurrent or sporadic use of a substance that have caused clinically significant damage to a person's physical health or mental health or have resulted in behaviour leading to harm to the health of others.

Medically supervised withdrawal is the use of an opioid agonist in tapering doses or other medications to help an individual who is dependent to safely discontinue illicit or prescription opioids. Formerly called detoxification (physiological removal of toxic substances from a living organism).

Medication-assisted treatment is the use of medications, in combination with counselling and behavioural therapies, to provide a "whole-patient" approach to the treatment of OUD. It is also important to address other health conditions during treatment.

Medication for opioid use disorder is a term sometimes used instead of MAT. However, MOUD refers primarily to the medications used to treat OUD, and not to the complementary counselling and behavioural therapies included in MAT.

Methadone is a medication that has been placed on the WHO model list of essential medicines to treat OUD. Methadone is a long-acting opioid agonist that, when taken daily, reduces opioid cravings and withdrawal and blunts or blocks the effects of opioids.

Naloxone is a medication designed to reverse the toxic effects of overdose of opioids. By blocking opioid receptor sites, naloxone helps to counteract life-threatening depression of the central nervous system and respiratory system, allowing a person experiencing an overdose to breathe normally. Naloxone can be injected into a muscle or sprayed into the nose. It is non-addictive, safe and can be administered with minimal training.

Naltrexone is a medication designed to treat both alcohol use disorder and OUD. Naltrexone blocks the euphoric and sedative effects of opioids. Naltrexone binds and blocks opioid receptors and reduces and suppresses opioid cravings. For OUD treatment, naltrexone is usually given as an extended-release intramuscular injectable.

Opioids are natural, synthetic or semi-synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain and reduce the intensity of pain signals and feelings of pain. Opioids are a class of drug that includes heroin, synthetic opioids such as fentanyl and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine and morphine.

Overdose is the administration of a larger quantity of drug than the body can tolerate.

Psychoactive substances are substances that, when taken in or administered into a person's system, affect mental processes such as consciousness, cognition, perception, mood and emotions.

Recovery is a process of change through which people improve their health and wellness, live self-directed lives and strive to reach their full potential. Being in recovery is when positive changes and values become part of a voluntarily adopted lifestyle. While many people in recovery believe that abstinence from all substance use is a cardinal feature of a recovery lifestyle, others report that handling negative feelings without using substances and living a contributive life are more important parts of their recovery.

Relapse is defined as the worsening of a clinical condition that had previously improved. In SUD treatment, relapse is the resumption of substance use after an attempt to stop or a period of abstinence.

Stigma is defined as irrational or negative attitudes, beliefs and judgments towards people with a particular characteristic, circumstance or condition (e.g. socio-economic status, gender, race, sexual orientation, age, medical condition, health status). Stigma can diminish the health and well-being of people with SUD by discouraging individuals from sharing their history with providers, seeking and accessing treatment, or remaining in care. In many cases, people with SUD experience more than one type of stigma simultaneously, which compounds the effects on them.

Stigma occurs on many levels, including individual, interpersonal, organisational and structural/systemic. Stigma at the individual level pertains to personal beliefs, attitudes and the internalisation of stigma, including through shame. Interpersonal stigma is manifested in the interaction between individuals, such as health service staff/providers and clients. Stigma at the organisational level encompasses harmful norms and inequitable policies, procedures and practices. Structural/systemic stigma includes societal-level conditions, cultural norms and institutional policies that may result in discrimination against particular groups.

Tolerance is a physiological feature indicative of neuroadaptation to a substance. It is a decrease in response to a substance dose that occurs with continued use. Increased doses of a substance are required to achieve the effects originally produced by lower doses.

Withdrawal syndrome is defined as a group of symptoms of variable clustering and degree of severity that occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. A withdrawal syndrome is one of the indicators of a drug dependence syndrome and may include high blood pressure, palpitation, sweating, tremors, arthralgia, headaches, dizziness, vomiting, psychomotor excitation, convulsions, anxiety, insomnia, and psychological and physiological discomfort.

Annexes

Additional support material is available on the Pompidou Group's supporting web page:

- Annex 1 – Teaching methods (practical exercises handouts)
- Annex 2 – PowerPoint presentations
- Annex 3 – Pre- and post-training questionnaire and survey

Annexes can be accessed at the following QR code:

Prison authorities are increasingly facing challenges with drug use and related behaviours. People with substance use disorders (SUD) are over-represented in prisons and often experience stigma and discrimination. Continued substance use leads to complex health issues, including the transmission of communicable diseases. It also contributes to creating a high-risk environment for both incarcerated people and staff. Such issues highlight the need for a well-trained workforce to address the complex needs of people with SUD, while respecting their human rights.

The "Trainer's manual on care and treatment of persons with substance use disorders in prisons" was developed under the Criminal Justice and Health in Prison Programme of the Council of Europe International Co-operation Group on Drugs and Addictions (Pompidou Group). It provides support in developing evidence-based criminal justice policies and comprehensive drug-treatment systems in prisons. The various projects carried out under the programme have assisted governments, public administrations and civil society organisations in improving drug treatment programmes and the social reintegration of detained people, to reduce relapse and recidivism and improve the health and well-being of people.

The manual was developed to guide trainers in delivering cascade training to multidisciplinary prison staff, including medical, psychosocial and custodial personnel. The training programme aims to enhance understanding of the challenges individuals with SUD face, improve care and treatment in custodial settings, strengthen co-operation across disciplines in treatment provision and facilitate connections to services upon release. It also supports reducing stigma and discrimination related to drug use and disorders, in line with international human rights standards.

The training package consists of 12 topics covering key aspects on treatment and care of people with SUD in custodial settings, and guidance on contemporary communication approaches to reinforce learning. Trainers can adapt the content to suit specific professional groups, as well as national and prison contexts. Each session includes clear objectives and suggested activities, such as discussions, role plays and case studies, along with additional resources, such as model presentations and evaluation questionnaires.

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