STATES OF JERSEY

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RESPONDING TO DRUG USE (S.R.1/2004): RESPONSE OF THE HEALTH AND SOCIAL SERVICES AND HOME AFFAIRS COMMITTEES

Presented to the States on 26th April 2005
by the Health and Social Services Committee

STATES GREFFE

INTRODUCTION

The Health and Social Services and Home Affairs Committees have agreed to provide a joint response to the Shadow Scrutiny Report on Substance Misuse in recognition of their dual responsibility for the Island's Community Safety and Substance Misuse Strategy 'Building a Safer Society' which came into force on 1st January 2005.

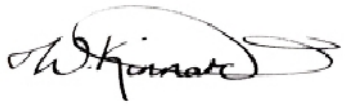
In responding to the Report, both the Home Affairs and Health and Social Services Committees recognise that the aim of the process was to enable Committees, Departments and the Scrutiny Panels themselves to gain a better understanding of how scrutiny will work in practice. With this in mind, we have tried to make our comments as constructive as possible.

It is fair to say that, in terms of raising our awareness of the practicalities of scrutiny, this has been an extremely valuable and educative process. Both politicians and officers agree that it has been a steep learning curve, but one that was extremely useful.

It has had a positive effect in that it has highlighted areas where perhaps we have not been pro-active enough, for example in building relationships with some voluntary agencies. It has given the public a platform upon which to air their views and it has made us reflect upon some of our practices in terms of service provision. The fact that we were already addressing the vast majority of the recommendations encourages us that we are moving in the right direction.

We have some concern that the assessment and weighting of evidence was not as rigorous as we would have hoped. The report seemingly placed a great deal of emphasis upon uncorroborated anecdotes and opinions rather than, published material or scientifically based research which had been subjected to objective assessments of reliability by means of 'peer-review', for example. We fully appreciate that it is important for the Panel to properly represent the views of the public. However, it is also incumbent upon them to present evidence in an impartial and ethically sound manner.

We hope that the following comments will be of use to future Scrutiny Reviews.



Senator W. Kinnard
President, Home Affairs Committee

Senator S. Syvret
President, Health and Social Services Committee

SECTION 1 – RESPONSE TO RECOMMENDATIONS

In responding to the Panel's recommendations, it is not our intention to be defensive or unduly critical. We recognise that their views represent a 'snapshot' and lay analysis of a complex health and social problem. The one thing that needs to be recognised is that there are no 'quick fixes' or easy solutions as far as tackling substance misuse is concerned. The main purpose of our response in this section is to examine the effectiveness and cost benefits of the key recommendations from the report.

Key Recommendation

1. The needle exchange scheme should be further developed to build on its initial success.

The Needle Exchange Scheme was established in 2002. Initially funded by the Substance Misuse Strategy, the Scheme is now funded centrally from Health and Social Services. It has shown great success in reducing the prevalence of needle sharing from 91% to 60% in the 2 years of its operation.

The Report identified a number of ways in which the scheme could be developed.

In order for the scheme to develop in line with current best-practice in the U.K., legislation needs to be put in place allowing additional drug paraphernalia, such as sterile water, spoons and filters, etc., to be supplied with fitpacks. The cost of providing the extra equipment is estimated at £13,000 – £20,000 p.a.

The provision of additional funding to enable the provision of fitpacks without charge from pharmacies. The estimated cost of provide free fitpacks from pharmacies is £7,000 p.a.

The provision of Sharps Disposal Bins on a trial basis in key selected areas to promote the safe return of needles.

Evidence from the Police would suggest that there has been an increase in the number of discarded needles reported to them. Sharps Bins have been used extensively in the U.K. The issue of placing Sharps Bins and posters in communal areas where discarded needles have been found has been raised, but has been resisted by residents.

The cost of introducing 12 Sharps Bins would be in the region of £1,500; this does not include the cost of collection and disposal.

Further work needs to be undertaken in order to ensure equity of access for the Portuguese and other ethnic communities. The needle exchange worker is currently developing an action plan.

The current office accommodation used by the needle exchange worker is inadequate. However, there are plans in place to improve accommodation once the Health Promotion Department moves to the Le Bas Centre.

The total cost for implementing this recommendation is –

Additional drug equipment	£13,000	(minimum)
Free Fitpacks	£7,000	
Sharps Bins	£1500	(approximately)
Total	**£21,500**	

2. A review of the opiate substitution programme should be carried out by an appropriate external medical body.

Jersey currently uses 2 forms of opiate substitute medication. The main form of medication is 'Methadone' which has been available since 1998. It is used as part of a reduction programme. More recently, following successful trials, 'Subutex' has been introduced as an alternative treatment. As with all programmes funded under the auspices of the Substance Misuse Strategy, the opiate substitution programme has been continuously monitored. The results show that the Jersey programme compares very favourably with similar programmes in the U.K. For instance, of the 347 people who have received methadone treatment, 1/3 completed the programme on their first attempt, almost twice the rate of completion than the U.K. Furthermore, the instance of Methadone finding its way onto the streets in Jersey is virtually nil. In the U.K., illicit Methadone is readily available.

An independent review by an external medical body of the Substitute Opiate Programme will be expensive. However, the Substitute Opiate Programme is due for evaluation in 2005 as part of the Building a Safer Society (BaSS) performance management process. The Monitoring and Evaluation Officer will conduct a 6-week review using the locally developed Rapid Evaluation Method (see Appendix 1). This process, which will be repeated every three years, provides both quantitative and qualitative information on the outputs and outcomes of the programme. Where possible, it benchmarks the programme against best practice elsewhere and makes recommendations on improving delivery of the programme.

3. Current detoxification practice should be reviewed within the context of the introduction of the proposed integrated care pathway system of assessment, treatment and aftercare.

The draft document on Substance Misuse Treatment Pathways, which will form a Joint Steering Group for Substance Misuse (see Appendix 2), provides the following statement on detoxification–

"*Many clients'/patients' first point of contact with the substance misuse care pathway will be through an identified need for detoxification.*

Detoxification needs will generally be met and delivered by the Alcohol and Drug Service, or the clients/patients General Practitioner, ideally in partnership.

Detoxification may also be undertaken by:-

- *Psychiatric or medical practitioners*
- *General Hospital/St Saviours Hospital*
- *Home Detox – A&D delivered*
  – General Practitioners
  – Residential Services (with A&D support)"

4. The Alcohol and Drug Service should seek to promote a more rapid and sensitive response to requests for assistance.

The average waiting time of 2-3 weeks is well within national guidelines. In Jersey, the Alcohol and Drug Service prioritises referrals according to need. There is a balance to be drawn between providing a timely intervention and value for money from the public purse. We believe that given the high level of client satisfaction with the service, as evidenced by the client satisfaction survey, the Alcohol and Drug Service attempts to provide a suitably responsive intervention within its current resources. However, the service regularly reviews its service provision and this recommendation will be discussed during the 2005 review.

5. Substance misusers wishing to access treatment should be made fully aware of the comprehensive range of options available in the island, including abstinence-based approaches, and the support available through Narcotics Anonymous and other agencies.

This recommendation will be partly addressed by circulating more widely the recently published Mental Health Resource Directory (2004), which contains information on the services provided by a wide range

of statutory and voluntary agencies.

User representation on the Joint Steering Group for Substance Misuse (see Recommendation 3) will also provide opportunity for raising awareness in respect of available services and the care pathways will capture individual need and outline service delivery.

Furthermore, the introduction of a Strategic Priority Co-ordinator for the substance misuse element of Building a Safer Society will ensure enhanced consultation with users and client groups.

6. The integrated care pathways approach should be developed as soon as possible following appropriate consultation.

The development of integrated services for substance misusers was being pursued prior to the Scrutiny Panel investigation. As already mentioned, the draft proposal for introducing an integrated care pathways approach is in the final stages of consultation. The care pathway will include statutory and non-statutory services with the aim of ensuring improved care for all service users.

7. Further research should be carried out into the operation of supervised injecting centres in Europe and reported in due course to the Health and Social Services Committee, with recommendations as to whether or not this practice might be implemented in Jersey.

This is an issue that has been raised a number of times in the past and has been extensively researched by the Senior Officer Group responsible for developing and implementing the Island's Substance Misuse Strategy.

The evidence shows that Supervised Injecting Centres (SICs) have typically been introduced in order to minimise the public nuisance associated with street injecting and to reduce the transmission of blood-borne viruses, risk of overdose and public disorder. They have also been typically introduced in inner-city locations and have a client base of 3,000 – 4,000 registered users.

There is some evidence that when implemented in the correct environment, SICs can have a positive impact on issues such as public disorder, needle sharing and fatal overdoses. However, Jersey does not have the same profile of street injecting or drug related public disorder problems as those countries where SICs have been introduced. Most people do not perceive drug taking as a problem in their own neighbourhood. Only 4% of respondents to the Jersey Crime Survey (2004) indicated that drug taking was a major problem in the area in which they lived. This is commensurate with the views of local drug workers who suggest that there is very little visible street drug taking or drug related public disorder locally.

As regards the health related benefits of SICs, we believe that there would be very little gained by introducing such as scheme. Building a Safer Society is implementing over 30 projects aimed at investing in children and young people in order to reduce the likelihood of future substance misuse; reducing the consumption of psychoactive substances; promoting health-enhancing behaviours; engaging and informing parents and families and extending the range of options for problematic drug users. Together with the introduction of the integrated care pathways approach we believe that we have a cost effective, balanced approach to harm reduction.

Therefore, given the profile of Injecting Drug Users (IDUs) in Jersey it would be inappropriate to introduce a Safe Injecting Centre at this point.

8. A pilot scheme, based on randomised anonymous testing, designed to monitor the spread/prevalence of blood-borne viruses should be instigated as soon as possible.

We understand from Dr. Muscat, Consultant Microbiologist, that a linked anonymous testing scheme will shortly be developed in conjunction with the Health Protection Agency to monitor the prevalence of blood-borne viruses within the wider population in Jersey. It is estimated that the cost will be in the

region of £5,000.

9. Whenever a Committee commissions a major report such as the Imperial College Study of Drug and Alcohol Use in Jersey, the implementation of its recommendations should be earmarked for an update report to the Committee on a regular basis.

We agree wholeheartedly with the sentiment of this recommendation. However, having had time to properly review the report, we would like to draw the panel's attention to the fact that the Imperial College Report was commissioned by the now defunct Crime and Drug Strategy Unit and not, as reported in the review, by the Health and Social Services Committee. The Presidents' Policy Group has, in fact, received regular updates on the implementation of the Imperial College Report as part of the annual report on the Substance Misuse Strategy. Furthermore, quarterly reports to the appropriate Committees are a feature of the performance management process for Building a Safer Society (BaSS) from 2005 onwards.

10. Further opportunities should be offered to raise awareness of the impact they (GPs) might have on the health of substance misusers.

We will continue to provide training opportunities for Island GPs. Funding will be provided through the Building a Safer Society Strategy.

11. A strategy should be developed as a matter of urgency, to promote the provision of good quality, accessible primary medical care and treatment in the community for substance-misusers, with a particular emphasis on targeting vulnerable young people.

It should be noted that the extent to which the Health and Social Services Committee can impose new working practices on GPs in Jersey is limited in view of their independent status. However, through the work of the BaSS Strategic Partnerships and the Drug Dependency Multi-Agency Committee, all GPs are actively encouraged to provide primary health care to substance misusers. In respect of targeting vulnerable young people, one of the strategic aims in BaSS is to invest in children and young people in order to reduce the likelihood of future substance misuse. This includes the work of the Children's Executive whose role is to focus on the most vulnerable young people.

12. Clear partnership funding arrangements should be established with voluntary bodies providing proven and effective rehabilitation and aftercare support for substance misusers.

We acknowledge that partnership agreements have not been as robust as perhaps they should have been. To a certain extent this will be addressed with the implementation of the integrated care pathways Joint Steering Group. The BaSS Strategic Partnership will ensure closer consultation with both the private and voluntary sector. In addition, the Health and Social Services Committee's Grants Panel are introducing new Service Level Agreements with all their voluntary and charitable partners. The Mental Health Directorate will prepare a business case for partnership funding in line with the Directorate business planning process.

13. Any well-founded new initiative to establish additional community support for substance misusers should be supported by the States with partnership funding.

The Community Grants Panel and the Drug Trafficking Confiscation Fund have been running for a number of years with the aim of providing worthwhile projects in the public, private and voluntary sectors with funds. Over £400,000 has been spent on 'pump-priming' numerous projects. They do not, normally, provide funding for recurring expenditure. Where funding for recurring expenditure is requested, for instance for salaries, it has been usual practice for this to be considered through the normal States procedures. Committees cannot give a guarantee to all well founded new initiatives within the current resource constraints.

14. A collaborative forum should be established, bringing together both statutory and voluntary agencies to monitor and promote service initiatives for substance misusers.

Since 1996 there has been a multi-agency forum responsible for delivering, first an illegal drug strategy, then a substance misuse strategy and more recently the joint community safety and substance misuse strategies. Since its inception it has striven to consult agencies within all sectors. It has held a number of multi-agency conferences, including the prestigious International Harm Reduction Conference in 2000, where all sectors were encouraged to attend.

Voluntary and charitable sector agencies were consulted during the development of Building a Safer Society, many of whom have initiatives included in the strategy. Having said that, it was recognised that more could be done to improve communication with other sectors and one of the principal roles of the BaSS Strategic Priority Co-ordinators is to meet with interested agencies more regularly.

15. The Panel supports a review of sentencing policy for drug-related offences, particularly in relation to young people.

We are pleased that the Panel supports a review of sentencing policy as highlighted in the draft Criminal Justice Policy.

16. The practice of compulsory detoxification of prisoners on remand should be reviewed.

This recommendation is misleading in that prisoners are not 'Compulsorily' detoxed either when on remand or when sentenced. They are given the option of a controlled detox using either Lofexidine or Dihydrocodeine syrup, but it is their choice.

A review of the protocols/guidelines on treatment for substance misusers in Prison was carried out in early 2003.

In 2004, the Health and Social Services and Home Affairs Committees jointly commissioned a review of the health needs of prisoners.

Where recommendations from the report were able to be implemented within current resources this has been done. A working group, jointly chaired by the Directorate Manager of Mental Health Services and the Prison Governor, has been set up to review the health needs of prisoners and the recommendations of the Wool Report. They are currently in the process of developing a substance misuse strategy for the prison.

17. The policy on harm reduction measures available to prisoners should be reviewed, in the light of best practice elsewhere. As a first stage, further research should be carried out into the introduction of a needle exchange scheme into H.M.P. La Moye.

As mentioned above, the working group is currently developing a substance misuse strategy for the prison. The Drug Counsellor, Ms. Rodriguez, has undertaken a study of the need for a needle exchange scheme in the prison, and concludes that the introduction of such a scheme may actually increase the numbers of prisoners injecting (see Appendix 3).

18. The implementation of the Wool Report on Health Needs in H.M.P. La Moye should be the subject of a review by a Scrutiny Panel once the full scrutiny function has been established after the elections in 2005.

Noted.

19. Funding should be made available for the establishment of a comprehensive statutory system of post-custodial supervision as soon as possible.

The Home Affairs Committee is pleased to confirm that funding for the introduction of post-custodial supervision has been supported by Committee Presidents during the ongoing revenue allocation process

for 2006 – 2008. This remains the Committees top priority for revenue growth funding.

20. A feasibility study should be carried out into the establishment of a half-way house for prisoners close to release.

A study had been conducted by the Probation and After-Care Service into the feasibility of introducing a half-way house type institution, which concluded that it was not a cost-effective option. However, we are working hard with a number of agencies both in the public and voluntary sector to help alleviate the problems that recently released prisoners face regarding accommodation.

We will review the situation once it has become clear exactly how the introduction of post-custodial supervision has impacted upon such problems.

21. A pilot scheme should be established, in conjunction with Silkworth Lodge, for selected prisoners who wish to access treatment and rehabilitation as part of an early release programme.

The President of Home Affairs has previously had informal talks with the Director of Silkworth Lodge as to the feasibility of this type of intervention. The Home Affairs Committee will request that the Joint Working Group considers this recommendation when developing the Prison Substance Misuse Strategy.

SECTION 2: COMMENT ON THE PROCESS

The Health and Social Services and Home Affairs Committees and their officers have co-operated with the Shadow Scrutiny Panel throughout and welcomed the opportunity to contribute to the process. We acknowledge the importance of scrutiny and the need for States funded services to be accountable to the public.

It is clear that the Shadow Scrutiny Panel has attempted to gain a wealth of information from a wide range of services and individuals; however, with such a complex subject, there were always going to be limitations in relation to the nature of information and how it was reported.

Scoping of the Review

The original scope of the review was intended to focus on the Needle Exchange Scheme. It was then decided to broaden the focus to include a review of the recommendations of the Imperial College Report. The discussion paper prepared by the Scrutiny Officer for the above mentioned meeting of officers states –

> *'Strictly speaking the ICR recommendations covered only needle exchange, arrest referral and assessing the spread of HIV and Hep C. However, as the review progressed, it became clear that services for substance misusers covered a wide range of issues which the Panel could not ignore, including a whole range of issues including the role of voluntary agencies, the role of medical services and the impact of the criminal justice system'.*

Had the focus remained on the Needle Exchange Scheme, it would have been appropriate for the Alcohol and Drug Service to provide the main comment. However, as the remit was expanded, as mentioned in the previous section, other services within both the Health and Social Services and Home Affairs Committees became more involved with the review. It could be argued that the panel may have benefited from requesting comment from the Presidents' Policy Group (PPG). We are pleased that the Committees are working in a cross-cutting way on this issue. Under the auspices of BaSS, there are eight committees represented on the PPG; 10 Chief Officers from Chief Officer Group and 13 departments represented at Senior Officer level, demonstrating good inter-agency working.

Terms of Reference

In our opinion, the process of formulating, following and reviewing the terms of reference for the review was unsatisfactory. The Panel departed radically from its defined remit at a comparatively early stage and without reviewing, revising and re-issuing the terms of reference to those Committees and departments that stood to be affected by its findings. Consequently, officers found it difficult to know what was relevant information for the purposes of answering questions or providing submissions.

The section of the Draft Guidelines (Projet P.186/2003) entitled 'Contact with States Departments and Other Witnesses' was noted to include the following provision –

> *'Panel members will not be permitted to question departmental officers directly other than as witnesses at a properly convened hearing, although direct requests for information will be progressed by the Scrutiny Officer.'*

Officers were questioned directly by members of the Panel on operational matters during the course of fact finding visits. However, departments and their officers considered this to be beneficial in terms of raising awareness of the relevant subject matter. In view of this, we recommend that the draft guidelines be amended in line with the above comment.

'Evidence'

We recognise that the Panel used a wide range of methods for collecting information and evidence but was somewhat constrained by the timescale of the review. However, in our opinion, Panels have a duty to ensure that, when making recommendations based upon opinion/hearsay, this evidence either clearly demonstrates a trend or

that there is corroborating scientific evidence. We would suggest that all future Scrutiny Reports include a section explaining the methodology used to gather evidence and the limitations of this evidence. For instance, the Panel stated that they considered it a priority to give due value to the views of the service-users themselves and their families. We agree that this is an absolutely essential ingredient in the scrutiny process. However, there needs to be explicit recognition that people are more likely to come forward when they have a grievance, and what amounts to submissions from a small number of witnesses cannot be claimed to be representative of all service users. Where Panels claim to represent the views of all service users, then they should utilise methodologies, such as client satisfaction surveys, to provide a more robust evidence base. Having said that, we felt that the public meetings and site visits were conducted in a courteous and diligent manner, for which the Panel are to be congratulated.

We found that some of the recommendations did not always reflect an impartial assessment of the evidence, in that criticisms highlighted in the report were either already being addressed or were purely opinions without appropriate evidence. For example, in Section 3.3 Opiate Substitution Programmes, there are anecdotal criticisms from witnesses that –

(a) taking their methadone prescription in full public view was degrading (3.3.3);

(b) being forced to undertake daily visits to chemists to take methadone means that they could be easily identified as addicts, possibly causing problems at work and making them a target for drug dealers (3.3.4);

(c) the methadone programme is expensive and ineffective, and is simply substituting one addictive substance for another. (3.3.7)

(d) it should be limited to those who demonstrate their commitment to abstinence and should be distributed on the basis of effect rather than emotion (3.3.8);

(e) the Yellow/Red card warning system discouraged substance misusers from being totally honest with their counsellors.

The responses contained with the body of the report show that –

In response to points (a) and (b) –

> Methadone in Jersey is carefully controlled in order to prevent 'leakage' onto the streets. For this reason it is taken under strict supervision in registered pharmacies and clients have to present themselves on a daily basis (3.3.2).
>
> The policy of Health and Social Services is that appropriate, discreet accommodation should be provided by registered pharmacies for the purpose of clients taking methadone, and that pharmacies recognised the need for privacy. In cases where a separate consulting room was not currently available plans were in hand to modify premises to improve the situation (3.3.3).
>
> It was important to maintain strict daily supervision of the dispensing of methadone in order to prevent leakage of the medication onto the street market (3.3.4).

In response to point (c) –

> Only a very narrow view sees methadone as simply a replacement for heroin. Methadone is widely known by the drug using community and is effective in drawing users into treatment. It is in the best interests of substance misusers to get them started on a treatment programme which recognises that some will fail, but that the methadone programme offered many advantages compared to the health risks associated with the misuse of opiates such as, needle sharing, unknown purity of drug etc. It also has many advantages for the community at large, such as

helping prevent individuals from committing crime in order to feed their illicit drug use. It is a fundamental principle of 'harm reduction' that even sporadic intervention is better than none at all (3.3.11).

In response to point (d) –

> The Alcohol and Drug Service has a duty to work with substance misusers with different levels of motivation and try to reduce the harm they are causing themselves (3.3.9).
>
> Repeated relapses are a common experience among addicts. However, it is in the interest of addicts' health to get them started on a treatment programme, even if they fail time and time again (3.3.10).

In response to point (e) –

> Dr. Bailey said that he would not be comfortable in continuing to prescribe without some form of control in place. Using heroin whilst on methadone is potentially risky (3.3.12).

The report concludes in paragraph 3.3.14 that the Panel: *'...believes that the criticisms expressed by the many witnesses should be addressed in the light of best practice elsewhere.'* We believe that (as evidenced above) the criticisms expressed have already been addressed in the body of the report itself.

Furthermore, we would argue that evidence was presented to the Panel that showed that Jersey was far more successful in the completion rate for the programme, in restricting the amount of Methadone leaking onto the streets and, consequently, in preventing Methadone-related overdoses and deaths than the U.K. Unfortunately, the Panel chose not to include this evidence in the report. If they had done so, we believe that rather than suggesting we look at best practice elsewhere, the local programme should have been hailed as a model of best practice.

We do not wish to sound unduly critical of the Panel and indeed recognise their right to publish any evidence they receive as per the guidelines. However, we do feel that in some instances the Panel's assessment and use of evidence was somewhat less than impartial. A report prepared for the Privileges and Procedures Committee on the effectiveness of the scrutiny process in this review states –

> *'...paragraph 3.5.4 of the final report refers briefly to an anonymous questionnaire completed by 45 respondents, concerning the service offered by the Alcohol and Drugs Service. It states that results obtained from those questionnaires indicated high levels of satisfaction. However, the report then highlights a number of complaints from witnesses in connexion with the Alcohol and Drugs Service, using detailed quotations, over much of the next six pages. The reader is left with few immediate clues as to the total number of complainants interviewed by the Panel and how that number compares with the number of respondents to the anonymous survey. Although the Director, Alcohol and Drugs Service is afforded a right of reply, it could be argued that, in terms of coverage and impact,* ***the negative view presented regarding the Alcohol and Drugs Service appears to predominate.'*** (our emphasis)

We recognise that it is important to get the views of the public across; however, we feel that there needs to be acknowledgment that States departments and Committees are unable to challenge the accuracy of individual accounts due to the requirement to maintain client confidentiality.

As far as we are aware, there are no guidelines with regard to the use of individual cases. However, Hampshire County Council scrutiny guidelines include the following advice on dealing with individual cases.

> *'It should be noted that individual cases cannot be included in Scrutiny Inquiries unless they are included along with other evidence which demonstrates a trend, pattern or policy of Hampshire which requires investigation.*
>
> *Individual cases which have caused concern should be dealt with via the appropriate channels.'*

We would argue that despite the qualification that the Panel *'...approached the review with a 'layman's knowledge' of the issues involved...'* it is still bound to conduct ethically sound research and give due weight to scientifically based evidence as against uncorroborated opinion and hearsay.

For instance, in paragraph 3.5.7 the Director of Alcohol and Drugs substantiated his opinion that the curren balance of response time in Jersey was about right by reporting evidence from a study he had conducted in Oxford on drop out rates from the point of referral. The findings were that those who were seen promptly were more likely to drop out of counselling and treatment than those who had to wait for two weeks.

In the next paragraph, the Panel offers the view that the Director's line of thinking is flawed and that in their opinion a period of waiting was likely to have a detrimental effect on the motivation of those wanting to enter treatment or counselling. They offer no scientific or corroborating evidence to support this opinion and yet recommend that the Alcohol and Drug Service should seek to promote a more rapid and sensitive service.

We are very concerned with some of the correspondence that has been published on the Scrutiny website. In 3 of the documents, (Confidential Notes (1) (Mrs. G); Confidential Notes (2) (Mrs. E) and Testimony of the Mother o an Addict), there are, what amount to, complaints regarding an officer. Although the name of the officer has been removed in most cases, the officer can easily be identified through the use of the job title.

We could not find any reference in the guidelines as to the protocol to be followed in respect of complaints or criticisms of individual officers; however, it does state in Section 6.1 that *'...Scrutiny should not used as an alternative to normal appeals procedures, nor should it become involved in what would amount to a disciplinary investigation against officials.'*

We believe that where members of the public have made allegations, complaints or criticisms against individual officers, then these should be passed on to the appropriate body, in order to allow the States complaints and grievance procedures to be invoked.

Value for money

We accept that there are strong arguments for the need for Committees and Departments to allocate sufficient time and resources to enable quality written submissions to Panels. This review has highlighted to us just how labour intensive this process can be. We estimate that the 3 principal officers who have been involved in this review have spent approximately 300 hours, at a cost of£12,700, working on submissions and responses to the review. This does not include the time from officers who have played a more peripheral role, nor does it include the opportunity costs. When taking these into account, it is likely that the true cost to Committees has been in the region of £30,000. As this was the first scrutiny review that many of our officers had participated in, there has been a steep learning curve. It is fair to say that neither Committees nor Departments were prepared for the commitment in time that was required. In consequence, some officers have had to work evenings and weekends in order to fulfil their obligations both to the panel and to their core work. We would recommend that in future, where possible, Committees are given sufficient notice of the intention to conduct a scrutiny review, in order to allow key officers the opportunity of re-prioritising their workload. We would also like to recommend that, where possible, the 3-month period allowed for response avoids the end of year period from December to February where departments are often at their busiest.

When considering topics for investigation we feel it is important that panels consider the likely impact that their review will have. For instance, in the case of this review, the States had agreed to adopt Building a Safer Society as the Island's response to substance misuse, a matter of only weeks before the Scrutiny review began. The Senior and Chief Officer Groups had spent the previous 2 years developing this strategy in consultation with a wide range of agencies and, as the table below shows, the vast majority of the recommendations contained with the Scrutiny Panels Report were being addressed already.

Table 1. Recommendations

Recommendation from Report	Response
1. Needle exchange scheme should	Law drafting instructions had been

be further developed to build on its initial success.	agreed enabling the provision of additional drug paraphernalia in 2003. It is included in the Mental Health Business Plan for 2006-08.
2. A review of the opiate substitution programme should be carried out by an appropriate medical body.	A review of the opiate substitution programme in 2005 had already been scheduled as part of the Building a Safer Society performance management process.
3. Current Detoxification practice should be reviewed within the context of the introduction of the proposed integrated care pathway system of assessment, treatment and aftercare.	Work on developing the care pathways system had begun in November 2003.
4. The Alcohol and Drug Service should seek to promote a more rapid and sensitive response to requests for assistance.	The Alcohol and Drug Service regularly reviewed their service provision as evidenced by the fact that they carried out regular client satisfaction surveys.
5. Substance misusers wishing to access treatment should be made fully aware of the comprehensive range of options available in the Island, including abstinence-based approaches, and the support available through Narcotics Anonymous and other agencies.	Steps were already being taken to address this problem through strategies for raising awareness such as the development of the Mental Health Resource Directory, User representation on the Joint Steering Group for Substance Misuse and the introduction of Strategic Priority Co-ordinators in BaSS.
6. The integrated care pathways approach should be developed as soon as possible following appropriate consultation.	Work on developing the care pathways system had begun in November 2003.
7. Further research should be carried out into the operation of supervised injecting centres in Europe and reported in due course to the Health and Social Services Committee, with recommendations as to whether or not this practice might be implemented in Jersey.	The Senior Officer Group responsible for developing the Substance Misuse Strategy has discussed the need for SICs in Jersey on a number of occasions. It has always been the case that it was felt the culture of injecting use in Jersey does not warrant such intervention.
8. A pilot scheme, on randomised anonymous testing, designed to monitor the spread/prevalence of blood borne viruses should be instigated as soon as possible.	It is true to say that the review has raised renewed interest in this problem which has resulted in a commitment by the President of Health and Social Services to progress this recommendation.
9. Whenever a Committee commissions a major report, such	Quarterly reports will be provided to both the Health and Social Services and Home

as the Imperial College Study of Drug and Alcohol Use in Jersey, the implementation of its recommendations should be earmarked for an update report to the Committee on a regular basis.	Affairs Committees on the progress of BaSS and any recommendations which may come out of reports commissioned by BaSS. The Presidents' Policy Group will continue to receive annual reports on the implementation of the Strategy.
10. Further opportunities should be offered to GPs to raise awareness of the impact they might have on the health of substance misusers.	This is being addressed in a number of ways through BaSS and the Joint Steering Group on Substance Misuse.
11. A strategy should be developed as a matter of urgency, to promote the provision of good quality, accessible primary medical care and treatment in the community for substance-misusers, with a particular emphasis on targeting vulnerable young people.	This is being addressed through the pathways approach and through BaSS.
12. Clear partnership funding arrangements should be established with voluntary bodies providing proven and effective rehabilitation and aftercare support for substance misusers.	This has been recognised as an area of concern and steps have been taken to formalise arrangements.
13. Any well-founded new initiative to establish additional community support for substance misusers should be supported by the States with partnership funding.	The funding of charitable and voluntary agency initiatives is constantly under review.
14. A collaborative forum should be established, bringing together both statutory and voluntary agencies to monitor and promote service initiatives for substance misusers.	Initiatives introduced through BaSS such as the Strategic Priority Co-ordinators will ensure that this happens.
15. The panel supports a review of sentencing policy for drug-related offences, particularly in relation to young people.	The Home Affairs Department started a review of Criminal Justice Policy in early 2003. The resultant draft report recommended a review of sentencing policy.
16. The practice of compulsory detoxification of prisoners on remand should be reviewed.	A health needs analysis on the Prison was carried out in 2004.
17. The policy on harm reduction measures available to prisoners should be reviewed, in the light of best practice elsewhere. As a first stage, further research should be	A health needs analysis on the Prison was carried out in 2004. A joint Working Group has been set up to action the recommendations and develop a substance misuse strategy for the Prison.

carried out into the introduction of a needle exchange scheme into H.M.P. La Moye.	
18. The implementation of the Wool Report on Health Needs in the H.M.P. La Moye should be the subject of a review by a Scrutiny Panel once the full Scrutiny function has been established after the elections in 2005.	Noted.
19. Funding should be made available for the establishment of a comprehensive statutory system of post-custodial supervision as soon as possible.	The introduction of post-custodial supervision has been a priority for the Home Affairs Committee for a number of years. Funding has now been supported by Committee Presidents during the ongoing revenue allocation process for 2006 – 2008.
20. A feasibility study should be carried out into the establishment of a half-way house for prisoners close to release.	Once the impact of post-custodial supervision has been analysed we will revisit this recommendation.
21. A pilot scheme should be established, in conjunction with Silkworth Lodge, for selected prisoners who wish to access residential treatment and rehabilitation as part of an early release programme.	This will be discussed as part of the development of a substance misuse strategy for the prison.

It is pleasing to note that the majority of the issues highlighted within the report had been recognised and were being addressed by departments prior to the scrutiny review. The review has confirmed that we are 'going in the right direction' as well as highlighting some areas to address.

The process of being scrutinised is always going to be challenging and at times provocative. We are hopeful that this response has identified areas in which both the shadow scrutiny panel and our committees and their officers have had the opportunity to reflect on the process, embracing the positive and identifying any weaknesses.

Appendix 1

Rapid Evaluation Methodology

Pilot Evaluation

Whilst we may refer to practice standards and guidelines or to the words of wisdom from successful ……projects, it is more important to consider what works for this community and under what conditions. Jane Mulroney, 2003

Introduction:

The aim of the pilot evaluation was to assess the effectiveness of the evaluation model by examining how the Court Liaison Officer initiative contributes to "Building a Safer Society" Strategy and specifically to Strategic Priority 3, key objectives 1, 2, and 6.

Context

The states of Jersey strategy document "Building a Safer Society" outlined certain key objectives regarding crime, anti-social behaviour and substance misuse for the period 2005 – 2009. The need to monitor and evaluate the implementation of the strategy was identified as an action of that report.

Methodology

In order to generate the richest data it was decided to carry out a qualitative design. The model was generated around the need for both a wider understanding of the initiatives involved than purely statistical evidence could supply and an acknowledgement that those models in place for performance management in U.K. where not entirely suitable for transposing onto a smaller jurisdiction.

Literature searches revealed a methodology that has been developed for performance management situations. The Rapid Appraisal Method was adapted from Rapid Rural Appraisal and Participatory Rural Appraisal techniques used to involve local communities in their own decision making in the 1970s. In the U.S.A. the Rapid Appraisal Method has been used as a way to gather data for performance-monitoring (USAID, No. 5, 1996). It also has beer utilised in various health settings in the U.K. and overseas and in research on poverty and anti-poverty policy in Columbia (McGee, 1997) but not in the criminal justice system (as far as I can discover). The methodology entails using a variety of qualitative techniques which help to produce a comprehensive understanding for management needs. It has been recognised that transcribing paradigms from larger jurisdictions onto small islands is not necessarily successful or desirable (Baldacchino and Greenwood, 1998) and so the methodology used was tailored to the particular requirements of the Building a Safer Society strategy.

A template for a job shadowing format was suggested and piloted for 6 weeks. The design included–

1. Setting Evaluation Criteria

2. Obtaining informed consent for the evaluation to take place from the initiative holder and their managers.

3. Contacting the Initiative Holder to agree shadowing details, obtain lists of contacts for interview and agree terms of continued contact.

4. Contacting related parties to arrange interviews.

5. Job shadowing, which took place in 2 one-week blocks agreed with the initiative holder and manager.

6. A literature review to obtain comparable data.

7. Data collection – using semi-structured interviews and statistics.

The literature review yielded data from other jurisdictions which were useful as background, but the Court Liaison Officer initiative being reviewed has not been duplicated in its present format and so using details from other jurisdictions as benchmarks was difficult.

The questions for the interviews were based around 3 main themes –

1. Examining the value of the reports that are written by the CLO.

2. Assessing whether the agencies felt the CLO initiative met the needs of their clients.

3. Assessing the impact of the CLO initiative on other roles.

The sample was purposive in nature in that it was chosen from representatives of agencies who work with the CLO. These include Probation, ADS and the Magistrates. One interview was also carried out with a client.

Semi-structured interviews were used in order to aid ease of analysis. This technique enables themes to be covered but allows scope for the interviewee to talk around other related issues. The results were recorded on an excel spreadsheet.

Scope – Altogether 9 interviews were carried out with agencies and clients. Observation during job shadowing was carried out over a 2-week period.

Limitations –

Sampling: the interviews were of necessity purposive and so the possibility of stakeholder bias has to be recognized.

The interview with the client cannot be taken to be representative but is included as recognition of the value of client perceptions. It is recognized that their motivation is key to the success of any drug programme.

The project also necessitates some contact with voluntary services but unfortunately these were not incorporated into the evaluation due to time constraints .The value of their contributions should be recognised in future research.

Participant Observation is arguably "the most personally demanding and analytically difficult method of social research" (May 2001, p.153). It is focusing upon the processes of the situation but its success is often dependant on the personalities of the participants and so it is difficult to fulfil the positivist criteria for replication.

Research Design

Setting Evaluation Criteria

1. Linking to the Strategy – this is the fundamental reason for the evaluation.

2. Establishing the Aims of the Initiative – this will be obtained from the job description and is necessary for evaluating whether the aims of the initiative meet the aims of the strategy for the initiative. Obtaining the job description is essential for understanding the criteria for the initiative and for using as a benchmark to assessing whether the actual day to day processes are the same as the expectations. It is also useful to have in order to carry out a literature review to ensure that any comparisons with different roles are relevant.

3. Literature Review – The aim of this is to locate any other evaluations done of similar projects to provide comparisons, both geographically and historically, to investigate the rationale behind the commencement of the role and to provide background reading about the philosophies behind the initiatives to give as wide a knowledge base as possible.

Getting Agreement

1. Introduction – this is an important part of any evaluation. It needs to be done well before the first week of the evaluation cycle so that the post holder is aware that they will be rung to arrange a preliminary meeting during the first week. It is vital to the success of any evaluation research that subjects are kept informed about the process. If it is accepted that any aim for evaluations must include the participants gaining some positive effects, then there has to be transparency in the process. Otherwise the data collecting will be extremely difficult and of questionable value especially using this model.

2. Introduction to Managers – In order for the overall outcomes of the evaluation to be successful the department mangers must be informed of the process and given opportunities to understand what is happening, how it is going to relate to them and to be given an opportunity for negotiating terms of access.

3. Arranging a meeting – the purpose of the initial meeting with the project manager is to personally introduce the evaluator and to set the parameters for future contact. The initial meeting will include: a discussion of the contact list, feasibility of meeting any clients for their feedback, exchange of contact numbers, agreement of shadowing details, data collected at the moment and terms for continued contact. Also included will be an explanation of the aims of the evaluation and a chance for the project manager to ask any questions.

Contact Related Parties:

1. Obtaining Contact Details – Part of the process using this model is the input of people who have both regular and occasional contact with the project. This includes voluntary agencies, statutory agencies and clients. Inclusion of clients is in recognition of the accountability to individuals that is inherent in the strategy. How they feel about any intervention is an important area in assessing the overall impact. The aim of this is to ascertain whether the initiative impacts on others, in what way and how this contributes to the overall effectiveness of the strategy. *It is not the aim to comment on the individual post holder*. The request for contacts will be included in the letter to the initiative holder.

2. Contact List – will be kept with the aim of sending out as many letters in the first week as possible. This is envisaged as being an ongoing process as there will be ad hoc contacts which may come to light during the job shadowing.

3. Terms of Continued Contact – is something that needs to be agreed at the start of the process by all parties. The research process is probably not always understood as being organic and the fact that often, on analysis, further questions sometimes need addressing should be overtly stated.

4. Opportunity for comment – the aim of this is to ensure that the parties involved with the evaluation have an opportunity to comment on the report, to assess whether they feel the interviews are representative of what they said and to give the project manager a chance for feedback.

Job Shadowing:

The aim is to provide a comprehensive overview of the day-to-day processes involved with the project. It is important to understand the essence of the job, what the post holder really feels, how they work on a day to day basis, what their experience tells them about what is happening in any given situation. The areas that are difficult to quantify.

Data Collection

The aim is to collect qualitative data through interviews as well as empirical statistical data. The link to the strategy from these will be assessed.

Timeline for Research

Two months prior to research

Arrange a presentation for those involved in the next 3 evaluations to inform them of the process and provide opportunities for questions. This will also provide a chance for those involved to meet others being funded by the strategy.

Two weeks prior to research

Request Job Descriptions

Contact Project Manager – also request for contact list and details of any data that is collected

Contact line managers

One week prior to research

Arrange introductory meeting with project manager

Arrange introductory meeting with line manager

Week One

Establish aims of the post

Link to strategy

Set evaluation criteria

Introductory meeting:

Prepare meeting plan

- Agree shadowing details
- Terms of continued contact
- A request for a comprehensive list of contacts
- Data collected
- A discussion of the feasibility of meeting clients and a request to begin implementing that
- Exchange of contact numbers
- Agree shadowing details
- Terms of continued contact and feedback

Literature Review (majority done in first week but ongoing) will include –

- Previous evaluations of role
- Jurisdictional comparison
- Local statistics
- U.K. statistics
- Statistics pre-role
- Background reading

Arrange Interviews with contacts

Week Two

Job Shadowing –

- Define typical day
- Daily recap
- Core elements
- Working processes
- Fixed deadlines
- Regular inputs\outputs
- Ad hoc inputs\outputs
- Determine network
- Establish what data is collected
- Identify obstacles and constraints
- What does the job feel like
- How could role be enhanced?
- Extend data range if necessary

Week Three

- Interviews:

The questions for the interviews will be based around the following themes –

- Assessing the impact of the initiative on other roles
- Assessing whether the initiative is meeting the needs of the clients
- Assessing whether the initiative is meeting its aims and objectives

Collating data

Week Four

- Job Shadowing

Week Five

- Interviews

Collating Data

Week Six

- Collate Data

Write report

Distribute to those involved for feedback.

Feedback

- Overall the results from the evaluation were very positive. As expected there were a number of recommendations that followed from the report and a number of unexpected outcomes. Feedback from the project manager seemed to indicate some positive outcomes from the process in reflecting on his practice and being aware of what others would like. However evaluations are difficult to do sensitively and many people don't necessarily like the spotlight being on them and will find the process uncomfortable. A point noted by the project manager was the importance of being kept informed throughout the process. He felt at times that he was not initially aware all the time of what was going on. This has been noted and incorporated into the action plan for the next evaluation.

The key to the whole process seems to be good and effective communications both within the agencies and between the evaluators and those involved.

Appendix 2

Substance Misuse Treatment Pathways

FINAL DRAFT PROPOSAL

STATES OF JERSEY

HEALTH AND SOCIAL SERVICES

SUBSTANCE MISUSE TREATMENT PATHWAYS

SERVICE SPECIFICATION

January 2005.

States of Jersey Health & Social Services

Substance Misuse Treatment Pathways
Service Specification

Contents

1. Statement of Purpose

The States of Jersey acknowledges the high level of alcohol dependency and increasing problem of drug misuse among the population of Jersey and the associated negative impact on the community.

The Island is well provided in the availability of addiction treatment services through the Alcohol and Drug Service, Adult Mental Health, Social Services, the Jersey Addiction Group and supportive community, statutory and voluntary services.

This Service Specification outlines integrated care pathways which define the collaboration necessary between existing services to offer a client/patient led seamless service to provide a care continuum to meet the needs of the substance misuse population of Jersey.

This document identifies the "high level of alcohol dependency and increasing problem of drug misuse" on the island, but does not explicitly acknowledge that a substantial proportion of illegal drug users and the majority of alcohol users consider their own use recreational and non-problematic and are unlikely to access treatment services. Encouraging this group to reduce their consumption nevertheless represents the greatest potential for overall public health gain, particularly where alcohol is concerned.

2. Philosophy Statement

All sufferers of substance misuse are capable of achieving harm reduction or abstinence from their drug of choice for varying periods of time.

The care pathway proposals of the States of Jersey offers substance misusers the opportunity to access a continuum of care from the point of referral through assessment, treatment, education, support therapies to aftercare and follow-up.

With professional help, guidance and supportive interventions, substance misusers can be motivated to accept the responsibility to co-operate with the agencies involved to minimise or arrest their substance use and develop better quality lifestyles.

Guiding philosophy

All individuals can achieve change, given structured support.

All individuals can gain new knowledge, skills and strategies.

All individuals have personal responsibility for their own health needs.

Young people

The Treatment Pathways document uses the National Treatment Agency's "Models of Care" as its framework. This document focuses on treatment for *adult* substance misusers, acknowledging that the needs of young people are different and that treatment services for them should link to the existing generic frameworks for young people. The prevalence and severity of young people's alcohol and drug use in Jersey does not warrant a specialised service or facility for adolescent substance misusers on the island. Their needs will be best met by an effective inter-agency collaboration and substance misuse training for other professionals. This piece of work is being driven by the coordinator of the SEBD service. A care pathway for young people with substance misuse problems will be prepared and added to this document as an Appendix.

3. **Service Definition**

(a) The Care Pathway Team

The team will be led by the Directorate Manager Mental Health Service.

A medical practitioner will be involved with the shared care of all people requiring detoxification, substitute prescribing or residential rehabilitation. A Consultant Psychiatrist, with specialist knowledge of substance misuse, is available for advice and will take a lead with complex cases.

It is recommended that the application and evaluation of the care pathway protocol will be monitored by a **Substance Misuse Joint Steering Group**. This group will consist of senior representatives from a wide range of agencies who are involved with the care pathways and / or providing support to people with substance misuse problems. They will meet at regular intervals (to be decided) to ensure implementation, monitoring, evaluation and audit of the care pathways. The aims of the group are to provide a coordinated approach to providing services for people with substance misuse problems whilst recognising the diversity of models of care and social support on offer locally. The full terms of reference will be agreed by the group.

It is proposed the JSG will include representatives from –

Adult Mental Health
Alcohol and Drug Service
Social Services
Jersey Addiction Group
Probation Services
Prison Service
AA/NA
GP
Shelter Trust
Margaret House
Roseneath
Housing Department
Social Security
Jersey Employment Trust
Others

(b) Care Structure – Tier System

A 4-tier system will address the needs of all service users.

This will identify the acuity of the substance misuse problem and the level of care required. Below each of the Tier's are described using the narrative from the document "Models of Care; for substance misuse treatment" (Department of Health 2002), followed by a detailed overview of local provision for each Tier.

Tier 1: "Non-substance misuse specialist services" are general health, social care and criminal justice services accessed by substance misusers and includes referral to and from specialist services".

Local Provision

Current local services within this tier are services provided by **G.P.s** ranging from brief interventions to medical detox. The **Health Promotion Unit** provides information and education, examples of which include "The Mental Health resource directory" published June, 2004, "Substance" magazine, published in 2001 which is aimed at young people aged 16+. This magazine focuses on harm reduction, information, risks and first aid relating to substance abuse. The health promotion unit also provide sexual health advice.

The Brook Centre offer free confidential contraceptive and counselling services for under 25s.

Other services offering information and advice include the schools **educational counselling and psychology** service, and **Minden Base**. **Jersey FOCUS on mental health** offer housing and advocacy and **Jersey Council on Alcoholism** provide housing and support. **Roseneath** and **The shelter trust** provide accommodation, support and counselling.

Services designed for children and young people include the **Children's service** and **Child and Adolescent Mental Health service**, both of whom will come in to contact with young people who abuse substances, and are able to offer some treatment interventions.

Probation services locally work closely with the **Alcohol and drug service** and the **Adult Mental Health service**. The court liaison officer is a joint appointment working between the A&D service and probation. The aim is to identify people in the Magistrate's Court who have substance misuse problems and to either encourage voluntary access to services or, on occasions, to work with individuals through treatment orders. The AMH forensic team provide 2 sessions a week of nurse specialist time to the probation service for those clients who have a foot in both services. This may include someone with a dual diagnosis of a mental health problem and a substance misuse problem.

Vaccination and communicable diseases are provided from the **microbiology service** based at the general hospital. This service provides screening and treatment for people with diseases such as Hepatitis or HIV. The microbiologist visits the prison on a monthly basis providing treatment screening and pre and post screening counselling to inmates.

The **accident and emergency** department at the general hospital may identify someone with a substance misuse problem and can make direct referrals to the A&D service. For the past 18 months the Adult Mental Health Service has been providing an A&E liaison service aimed at identifying those who attend A&E who have mental health problems. A number of these clients may also have substance misuse issues and will be referred to the A&D service.

The adult mental health service in conjunction with the occupational therapy service provides vocational opportunities. These include the job scope service at Chez Marguerite where referrals can be made for assessment of vocational ability and support into appropriate employment. The organic farm, run by the AMH service, also offer a number of people with substance misuse problems the opportunity of employment.

The Shelter Trust provides an outreach service for rough sleepers, many of whom have substance misuse problems. The majority of full-time staff at the shelter have completed the alcohol and drug counselling certificate which is accredited to the university of London.

Alcoholics anonymous and Narcotics anonymous provide a number of groups throughout the Island for people wishing to recover from alcohol or drug related problems.

Tier 2: "Open access substance misuse services are low threshold specialist services that facilitate engagement with treatment services. They are less structured then tier 3 and 4 services".

Local Provision

Tier 2 includes advice and information from the specialist alcohol and drug service. The main philosophy of this service is to provide a harm reduction service. A duty counsellor provides a drop in service Monday to Friday. The clinical team from within the A&D service provide brief interventions and are skilled in motivational interviewing techniques.

Since 2002 a needle exchange worker has been appointed and offers intravenous drug users the opportunity to obtain sterile needles and syringes to reduce the likelihood of spread of infection.

Low threshold prescribing is offered from the alcohol and drug service. This may take the form of a community alcohol and drug detox and is carried out in conjunction with a G.P. who provides a service to the A&D team.

Outreach services include, for example, an alcohol and drug worker providing a weekly clinic to the shelter trust residents; this allows them to discuss, in confidence, any substance misuse issues they may

have. A similar service is provided to the shelter trust by a mental health professional; often the cross over of mental health issues and substance misuse can be identified at these clinics. Both clinics are self referral/drop in clinics.

Tier 3: "Structured community based substance misuse service. This tier aims to provide treatment solely for substance misusers in a structured programme of care. Substance misusers attending these services will have agreed to a structured programme of care, which places certain requirements on attendance and behaviour. In addition to care management, treatment packages for clients with multiple needs will be co-ordinated by a care co-ordinator on behalf of all agencies and services involved".

Local Provision

The alcohol and drug service offer structured counselling and therapeutic interventions to people with longer term substance misuse problems. They are able to refer on to the **psychology service** for specific treatment interventions or for clients who have more complex needs. The probation service, through the court liaison officer, offer specific treatment packages for substance abusers who have had contact with the criminal justice system.

Community based detoxification services are offered through the alcohol and drug service. This includes working with the G.P. or the **consultant psychiatrist** with a specialist responsibility to the A&D service. The nursing team within the A&D service will carry out initial assessment and implement the treatment package with clinical support and prescribing. They will then monitor the detox to ensure risks are kept to a minimum.

The methadone programme is managed from the A&D service. It aims to substitute illicit opiate use and then gradually reduce the dependence on methadone. Subutex is a newer alternative to methadone which has been successfully piloted locally and has become a treatment option in reducing the risk of opiate use.

The A&D service provides some structured aftercare for those who have completed a period of active treatment. There is also the facility of referring those people who are keen to remain abstinent to the **Jersey Addiction Group** who offer a programme of residential rehabilitation and aftercare (see Tier 4).

Tier 4a: "Residential substance misuse specific services include inpatient substance misuse treatment, including inpatient detoxification, residential rehabilitation and specialist residential crisis intervention centres. They are usually abstinence-orientated programmes, which require the substance misusers to stop taking drugs either before entry or as part of a planned residential detoxification programme".

Local Provision

The AMH service acute inpatient wards offer a hospital detoxification service. These are normally planned admissions in conjunction with the A&DS. On average the AMH service completes 2 in-patient detox a week. If the physical health of the client is assessed at being a high risk admission can be arranged within a **medical unit** at the general hospital.

Silkworth Lodge offers residential rehabilitation using the 12 step abstinence model of care. This service has demonstrated its ability and quality in providing abstinence based model of care and the ongoing audit suggests a growing evidence base for its efficacy.

Although we do not have a specific crisis management service for substance misusers within Jersey there are options available dependant on the risk assessment. The Shelter Trust provide a drunk and incapable unit at their Kensington Place accommodation. This can be accessed by the Police or from within the shelters and offers a safe environment for intoxicated individuals to recover. For someone who is identified as being at risk of self harm or experiencing acute mental health problems, they can be assessed at the A&E department and if appropriate the crisis will be managed within the acute mental health in-patient wards. For people who self harm due to intoxication assessment and treatment will be offered by the general hospital and an assessment from the mental health team can be requested. The AHS are

currently piloting a nurse lead psychiatric liaison service at the general hospital.

We do not offer a specific mother and child substance misuse services. However, our generic services which include children's social services, child and adolescent mental health services and the community perinatal mental health nurse will at times come into contact with mothers who have substance misuse problems. The alcohol and drug service provide training to the course run by the perinatal mental health nurse and delivered to midwives and health visitors.

Tier 4b: ***"Highly specialised non-substance misuse specific services*** *will have close links with services in other tiers, but are (like Tier 1) non-substance misuse specific. Tier 4b services are not substance misuse specialis services, but generally, a substantial proportion of their patients/clients are substance misusers. Many of these services tackle substance misuse related harm. These services include specialist liver disease units, specialist HIV units, vein clinics, forensic psychiatry services, specialist personality disorder or eating disorder units and so forth".*

Local Provision

The microbiology service provides specialist treatment for people with liver disease and HIV. If someone needs treatment off Island we work with Southampton in relation to Hepatitis C, with between 6 to 10 referrals annually and for HIV specialist treatment Guys and St Thomas's hospital is referred to, approximately 2 – 3 referrals are made each year. It should be noted that not all those treated locally or referred to specialist off-Island centres have developed hepatitis or HIV from illicit drug use.

The community forensic mental health team provide input to the prison, probation service, courts and police for anyone who has or needs assessment for a mental health problem and who has been in contact with the criminal justice system. We currently have a small number of people receiving treatment in specialist **secure mental health units** in England. Our forensic team are actively involved in their treatment planning and assessing for treatment outcomes and risk management. The majority of service users who have received secure care in England have a dual diagnosis of mental disorder and substance misuse problems. We offer treatment for people with personality disorder through the forensic team. On rare occasions we will refer people to **specialist personality disorder units** in England.

Within the AMH service we have a community **eating disorder team**. They offer treatment and support for people with a primary diagnosis of anorexia nervosa or bulimia nervosa. A small amount of this client group may also experience difficulties with substance abuse issues.

(c) Seamless Service

Close collaboration between health, treatment and social care agencies will be vital to ensure that client/patient care is needs led, co-ordinated and seamless between tiers.

(d) Integrated Care Pathways

The Service Specification includes the application of all elements required to interface service components and agencies to maximise positive intervention, outcomes and prognosis through joint working arrangements, integrated care pathways and the Care Programme Approach (CPA) to patient/client care.

As noted by the Department of Health (2002), the Integrated Care Pathway (ICP) approach needs the following which this Service Specification addresses.

Definition of the care provided
Aims and objectives
Referral pathway
Screening and assessment processes
Description of treatment/service

Care co-ordination
Departure planning/follow-up
Services with which the modality interfaces

Care Programme Approach

The care programme approach (CPA) was introduced in 1991 as the cornerstone of the Government Mental Health Policy. The CPA was developed to give a more systematic and effective way of providing care and treatment to all people referred to and accepted by health services.

The CPA aims to ensure no-one is discharged from hospital, or any treatment service unless it has been shown that their needs can be met in the community.

The identification of a care co-ordinator ensures that a named professional takes responsibility for both the co-ordination of the care plan, and its delivery.

The CPA lays down a clear process of assessment, planning and reviews. It identifies the professionals who would normally be expected to participate in this

Assessment: This is a needs led assessment.

Patient involved in Care Pathways and Planning

Disseminating Information The patient is informed to whom all information is being circulated (a need to know basis)

Level 1: This is for a person with limited or clearly defined needs which are likely to remain stable.

Review: This is the key to monitoring the effectiveness of the care plan and ensures that the *objectives* and *goals* of care are being met.

Level 2: This is for a person with more complex needs and who requires support from three or more professionals. Their needs are likely to change and vary.

4. Accessing the Service

4.1 Screening and Referral

The screening of substance misusers should take place from the first point of contact with any health or care professional or agency.

Levels 1 and 2 assessments will establish which intervention or service tier will best suit the individual and the level of urgency.

Should a Tier 4 service be identified (residential treatment and rehabilitation) and if appropriate, referral should be made direct to JAG for a level 3 assessment (see below).

Triage Assessment (Department of Health 2002)

Level 1: Basic assessment in identifying substance misuse problems.

Level 2: Filtering process to establish which intervention tier or service would best suit client/patient needs. Assessment should take place at the first point of contact with substance misuse services.

Level 3: Target substance misusers who require more complex and structured care programmes. Level 3 assessment of all 7 health domains. On-going assessment must be linked to care co-ordination and integrated care pathways.

4.2 Assessment Process

A level 3 assessment will generally be conducted by one of the primary services involved in the treatment of substance misusers, A&D Service and J.A.G., and as a minimum will address the following 7 domains –

Drug use
Alcohol use
Psychiatric/psychological problems
Physical problems
Social problems
Legal problems
Risk assessment

Patients/clients who seek detoxification, harm reduction, short or long term prescribing, advice, support and counselling should be referred in the first instance to the Alcohol and Drug Service.

Post-detox treatment, counselling or support mediums will be identified by a level 2 or 3 triage assessment.

Patients/clients may be referred directly to JAG if they meet 2 or more of the following criteria.

1. They have a goal of abstinence which requires residential rehabilitation treatment.

2. Are in need of intensive/structured intervention.

3. Are/have been in contact with other service providers.

4. Have a history of disengagement from other treatment services.

4.3 Admission to Silkworth Lodge

Patients may be admitted for residential treatment to Silkworth Lodge subsequent to assessment and the following criteria being met –

Clinical criteria for suitability met
Motivation and commitment established
Agreement of all involved agencies and G.P. established
Detoxification needs addressed
Funding in place

4.4 Inter-Agency Collaboration

When the client/patient has been assessed and engaged in any level of care, the key worker should inform all relevant agencies involved with the care continuum as soon as possible, or at the regular ICP team meeting.

5. Intervention Process

5.1 Detoxification

Many clients'/patients' first point of contact with the substance misuse care pathway will be through an identified need for detoxification.

Detoxification needs will generally be met and delivered by the Alcohol and Drug Service, or the clients/patients General Practitioner, ideally in partnership.

Detoxification may also be undertaken by –

Psychiatric or medical practitioners
General Hospital/St. Saviour's Hospital
Home detox – A&D delivered
– General practitioners
– Residential Services (With A&D support)

5.2 Other Treatment Interventions

Should the assessment or the wish of the client/patient identify a goal of harm reduction, treatments include substitute prescribing, psycho-education, counselling psycho-social support etc. and preclude the need for residential treatment. The Drug and Alcohol Service will be the primary care co-ordinator in collaboration with any other agencies required to meet the individual's needs.

Should the client/patient at any time during the A&D intervention seek to change to a goal of abstinence a level 3 assessment will take place and if they fulfil the criteria in 4.2 above they may be referred to J.A.G for assessment for suitability for the residential rehabilitation treatment programme.

5.3 Residential Treatment and Rehabilitation (J.A.G.)

Should the criteria for admission to Silkworth Lodge be established, the client/patient will be admitted with an estimated time frame of between 8-12 weeks proposed. This treatment period may change to mee individual needs.

At an appropriate stage of treatment, all other agencies involved in the care continuum will be invited to attend a CPA meeting to agree discharge planning and aftercare support. Individual cases will also be discussed at regular ICP team meetings.

Subsequent to the completion of the residential component of the treatment programme at Silkworth Lodge, it is expected the clients will attend for 2 weeks from 9-5 daily, attend evening AA/NA support groups with the residents, and attend the weekly support group at Silkworth Lodge. Regular attendance at aftercare and A/A N/A meetings will be on-going for an indefinite period on completion of treatment.

5.4 Funding for Admission to Silkworth Lodge

The majority of clients/patients who meet the criteria for admission to the residential substance misuse treatment programme at Silkworth Lodge will be unable to meet the weekly cost of £600 per week.

Those who are in need of public monies to fund the residential rehabilitation and where the criteria for admission to Silkworth Lodge has been met the link practitioner from the ADS or the Director of ADS will assess the need in line with available resources. Any funding queries should be directed to the Directorate Manager Mental health service.

This funding should be requested by the referring agency or via Silkworth Lodge if the client has self-

referred to JAG.

All efforts should be made for the client to self-fund or part-fund JAG treatment.

Financial restraints must be recognised, and all services will be expected to work within their annual budget.

The Substance Misuse Joint Steering Group will formulate a policy relating to public funding of residential rehabilitation.

6. Evidence-based Practice

Evaluation and audit should be on-going to monitor the effectiveness of the ICP process, all levels of treatment intervention, to determine user satisfaction with the service, and measure outcomes, prognosis and positive lifestyle changes.

Standards audited should include –

Staff qualifications, skill base and effectiveness

Integrated care pathways

CPA implementation

Detoxification protocols

Environmental and care standards

Therapeutic components and processes

Admission/assessment/discharge procedures

Record-keeping

User satisfaction questionnaires

Outcome studies

7. User involvement and representation

One of the best ways to achieve a truly client-centred service is through service user representation. Patient and public involvement is now high on the agenda in the U.K. as a result of recent legislation, making it a statutory duty of N.H.S. providers to consult and involve patients in the delivery of services. Effective service user representation on the Substance Misuse Joint Steering Group would provide them with a voice in shaping service delivery to address these and other concerns by ensuring that services take clients needs into account. In the first instance this will be achieved through A.A. and N.A. representation on the steering group, however, one of the main aims of the steering group is to support the development of active user involvement.

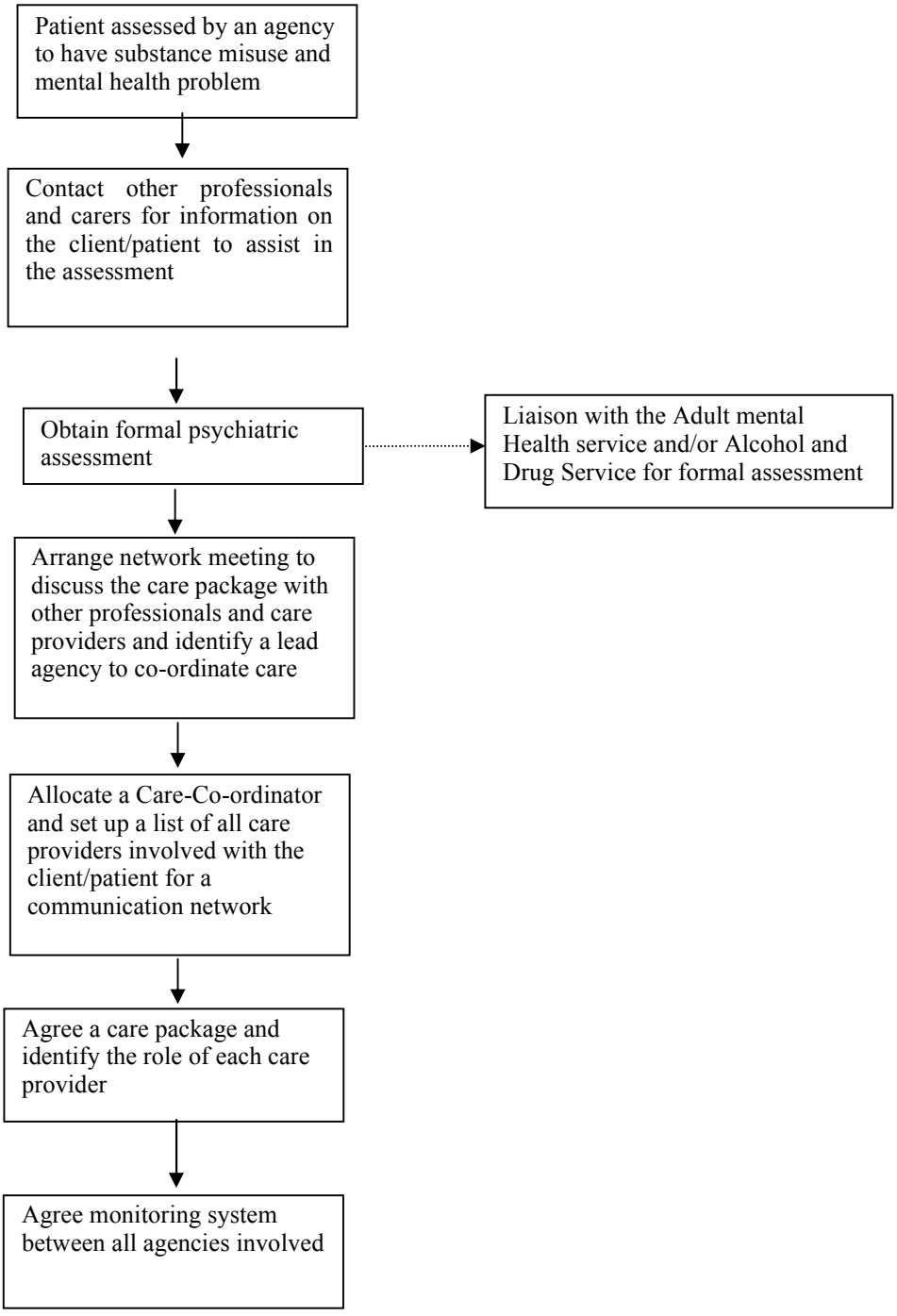
APPENDIX 1

The assessment system

	Content of assessment and outcome	Target group and professionals responsible
vel 1: reening and referral sessment	■ Identification of substance misuse problem ■ Identification of related or co-existent problems ■ Identification of immediate risks ■ Assessment of urgency of referral Outcome: Identification of an appropriate service for onward referral	All substance misusers presenting to Tier 1 and 4b services Carried out by all Tier 1 and 4b professionals
Level 2: Triage substance misuse assessment	▪ Risk assessment ▪ Assessment of urgency of referral ▪ Brief assessment of substance misuse problem ▪ Brief assessment of client motivation to engage in treatment ▪ Assessment of need for comprehensive assessment/Care Co-ordination Outcome: Identification of treatment/care needs. Need for comprehensive assessment	All substance misusers presenting to Tier 2, 3 and 4a services Carried out by all Tier 2, 3 and 4a professionals
Level 3: Comprehensive substance misuse assessment comprehensive	▪ Risk assessment ▪ Assessment of client motivation ▪ Drug use ▪ Alcohol use ▪ Psychological problems ▪ Physical problems ▪ Social problems ▪ Legal problems Outcome: Identification of treatment/care needs, based on comprehensive assessment Development of a comprehensive care plan	All substance misusers with one or more of the following: ▪ Significant substance misuse problems in two or more problem domains ▪ In need of structured and/or intensive intervention ▪ Significant psychiatric and/or physical comorbidity ▪ In contact with multiple service providers ▪ History of disengagement from SMS treatment All Tier 3 and 4 and some Tier 2 services

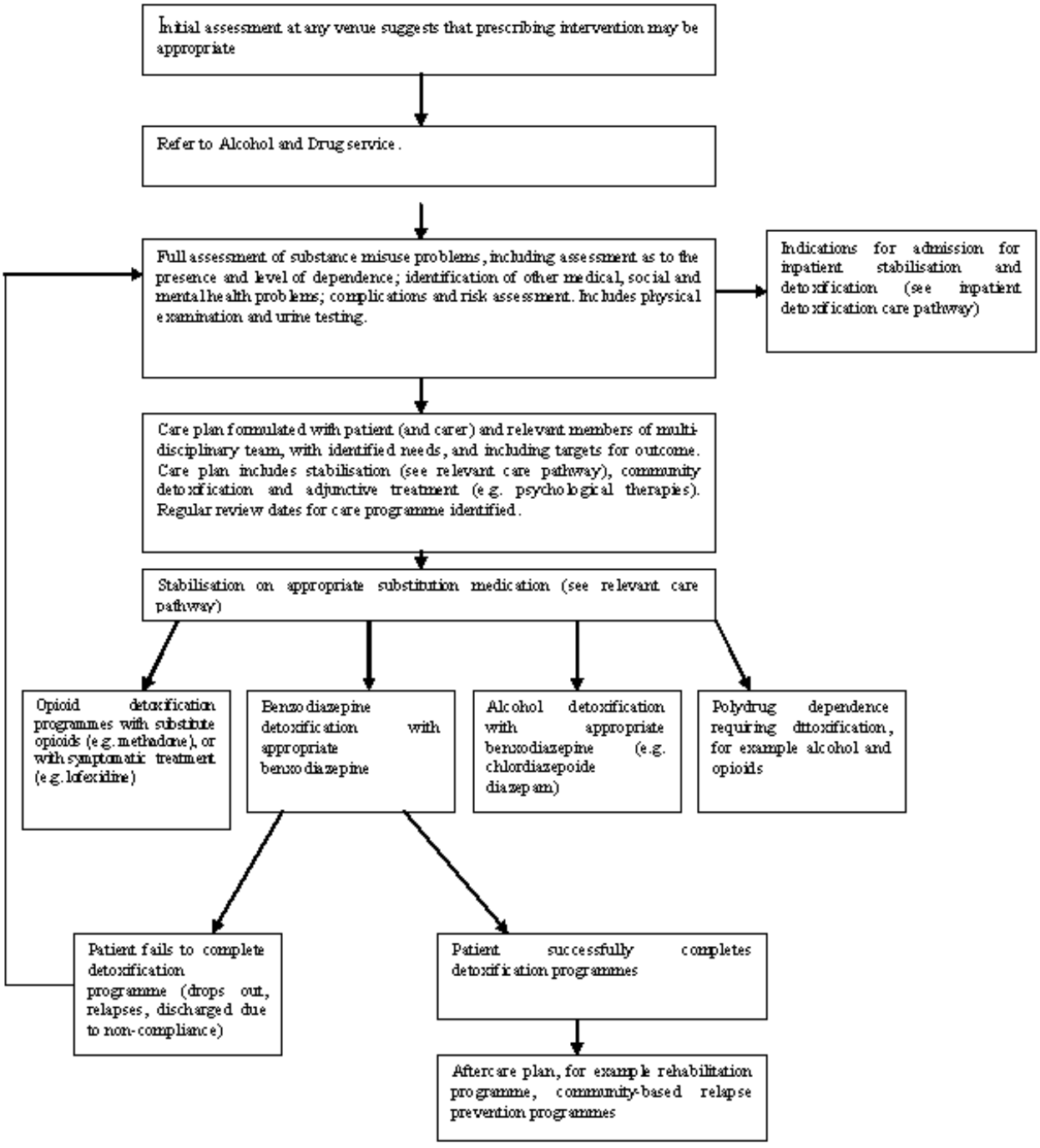
APPENDIX 2

Assessment care pathway



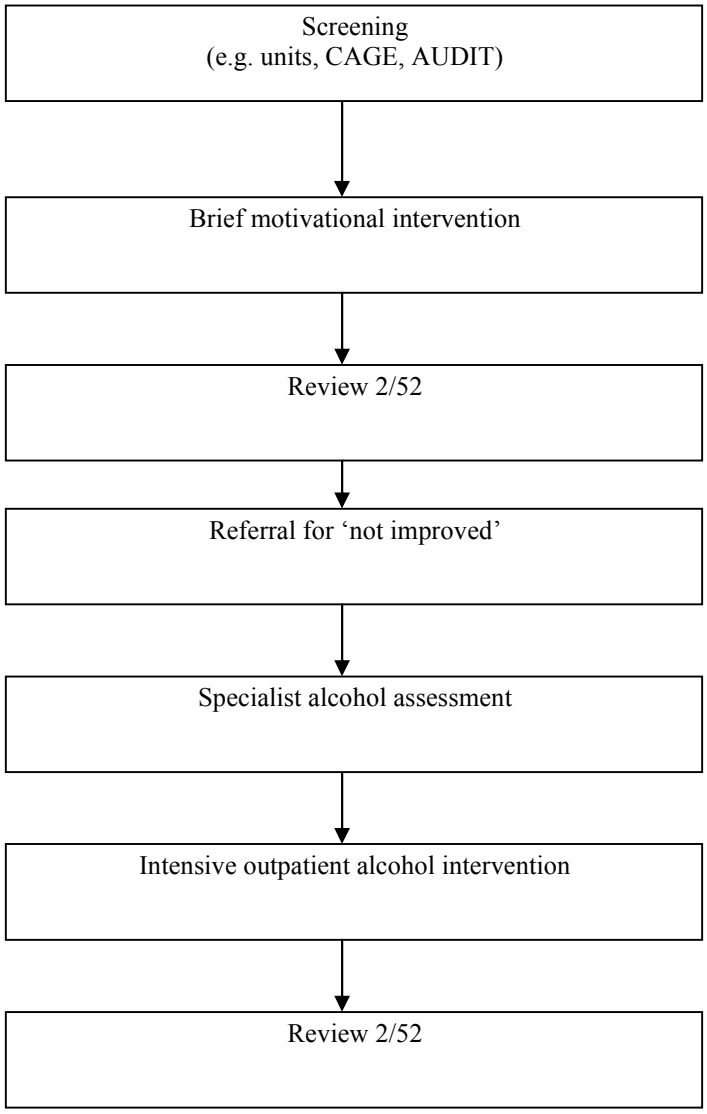
APPENDIX 3

Community detoxification



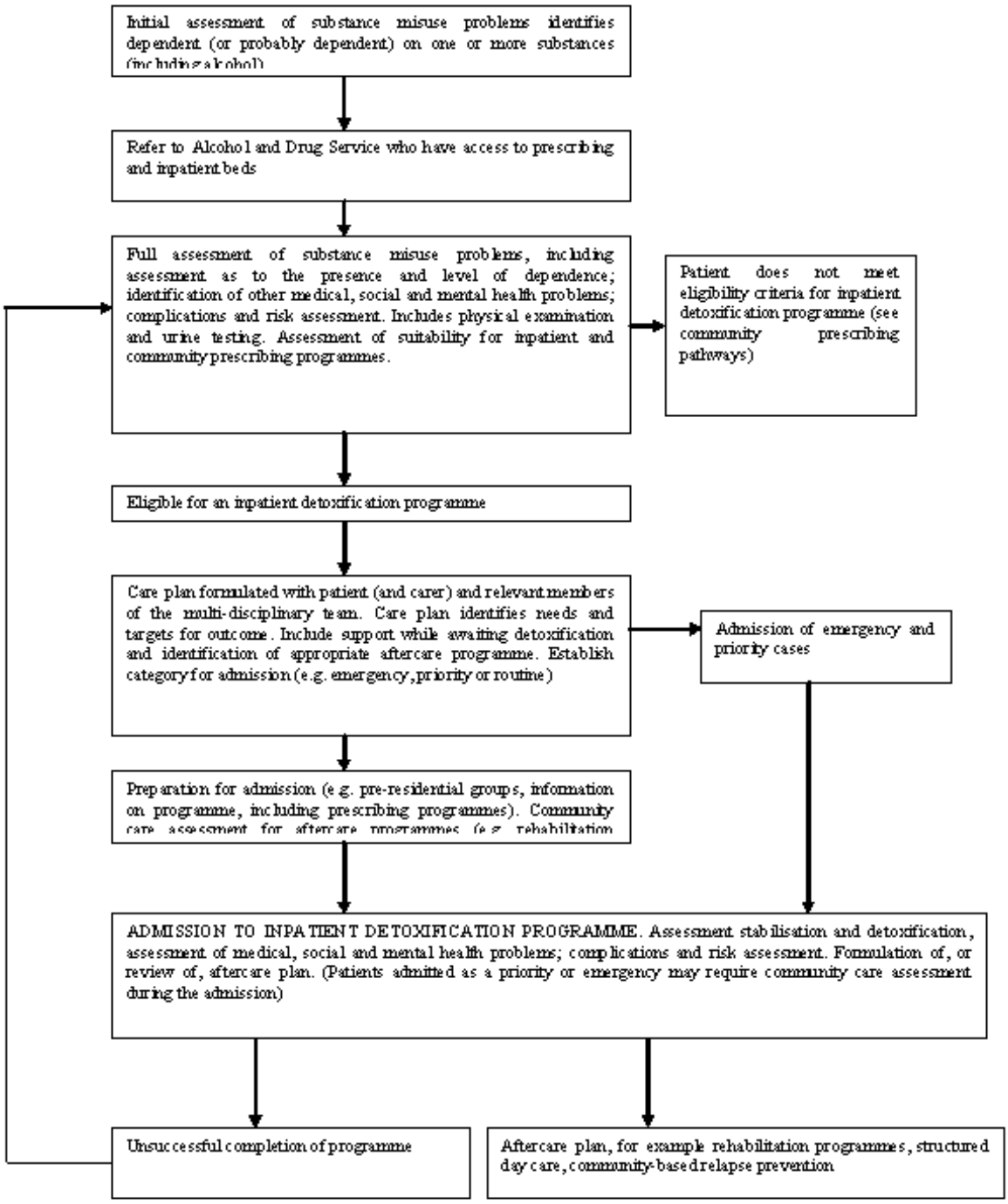
APPENDIX 4

Care pathway for brief alcohol interventions



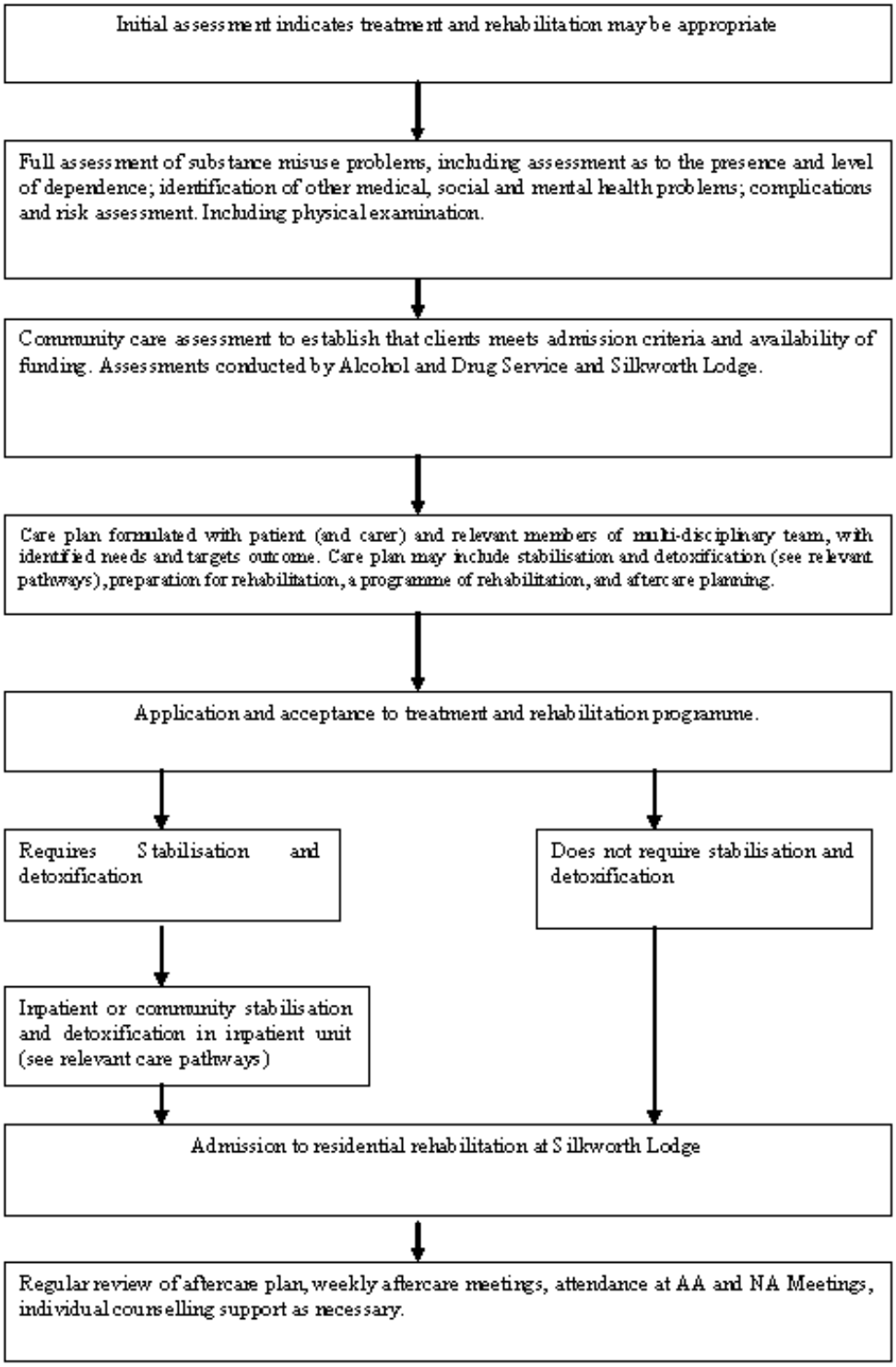
APPENDIX 5

Inpatient detoxification



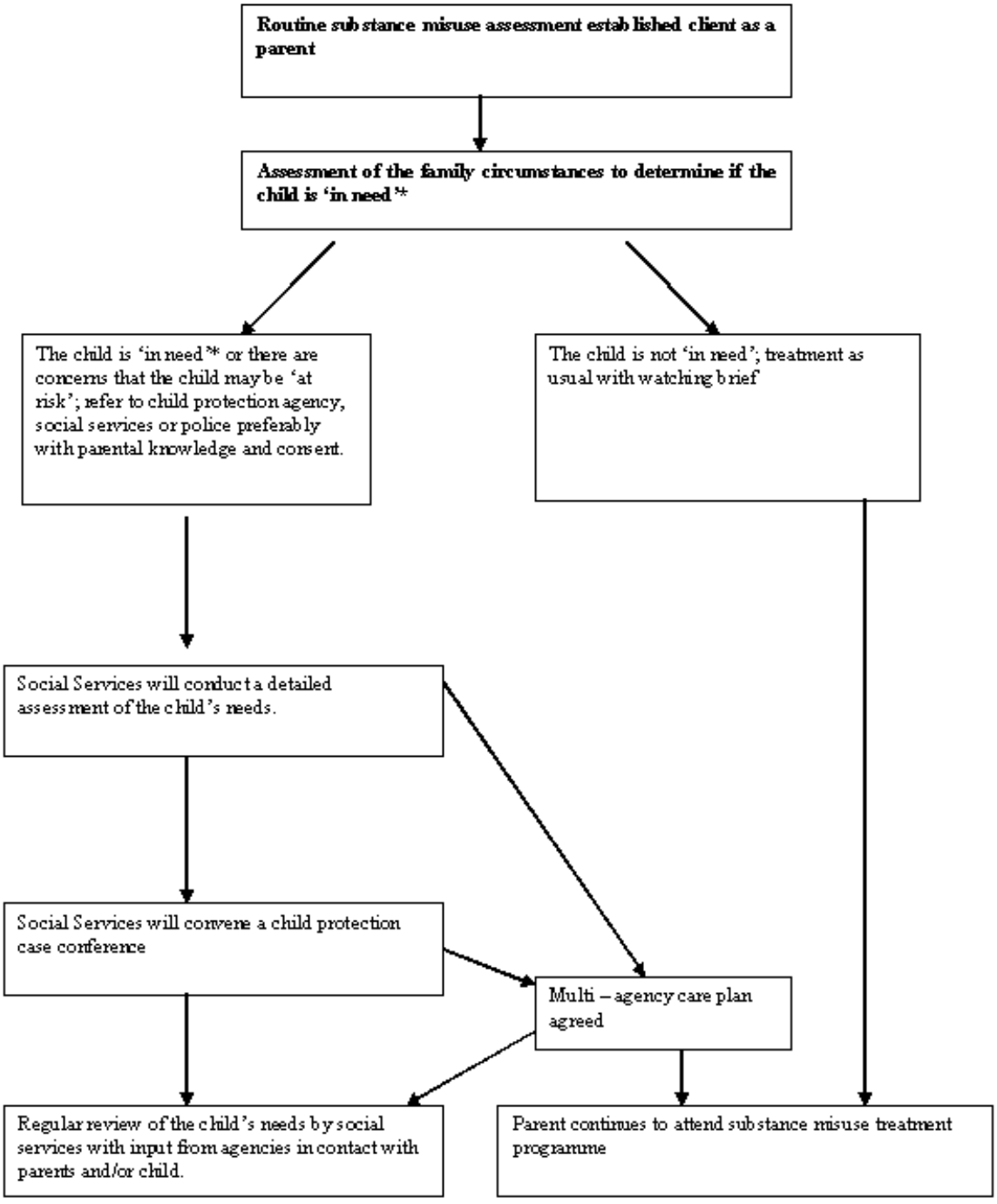
APPENDIX 6

Residential treatment and rehabilitation



APPENDIX 7

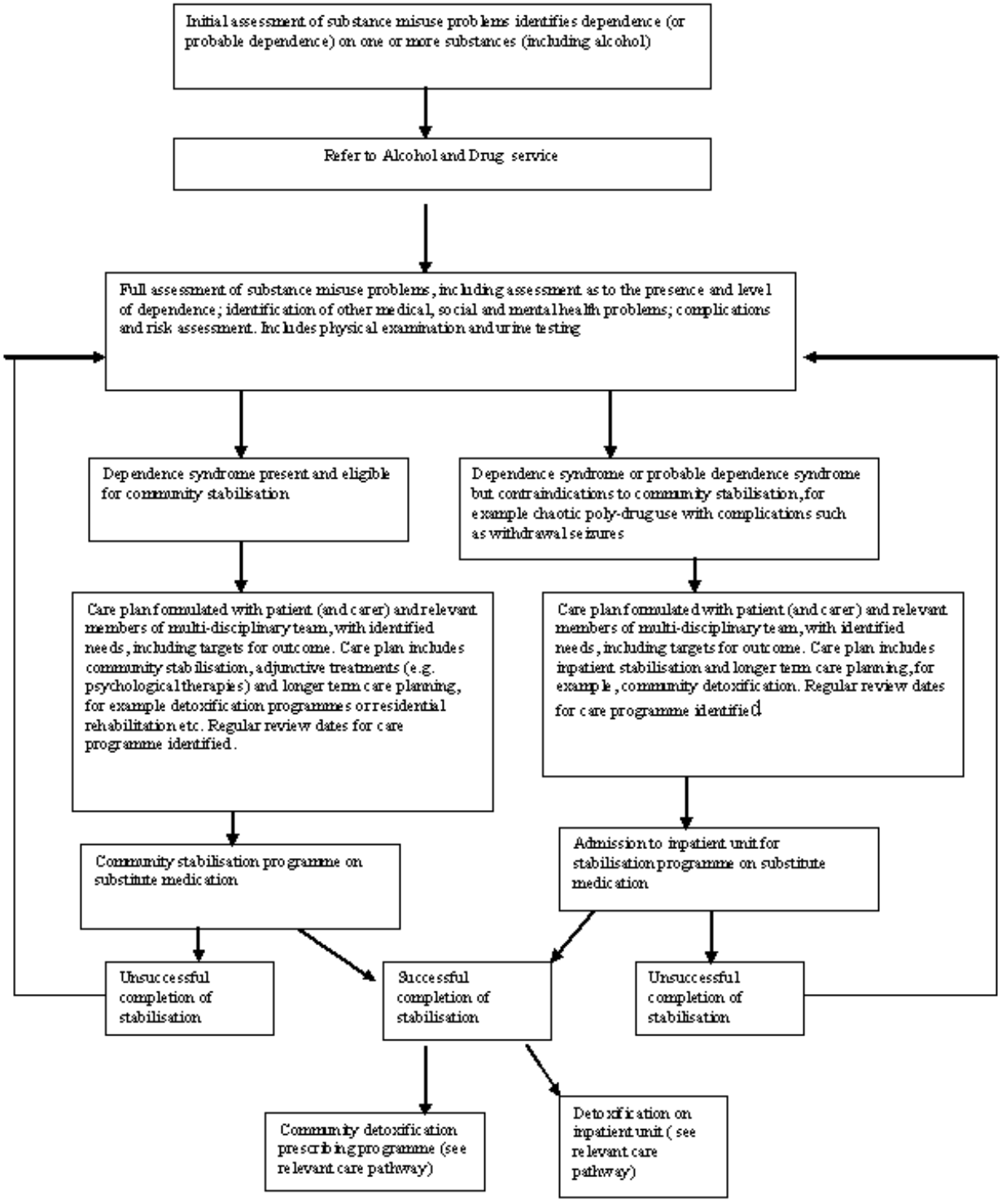
Care pathway for substance misusing parents



* Children in need are defined as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health and development or their health and development will be significantly impaired without the provision of services

APPENDIX 8

Stabilisation on substitute medication



Appendix 3

Needle Exchange
in H.M. Prison La Moye

INDEPENDENT RESEARCH

NEEDLE EXCHANGE IN H.M. PRISON LA MOYE - JERSEY

January 2005

BY TERESA RODRIGUES

In This Report

This report is an independent research carried out by Teresa Rodrigues, based in several articles, journals, reviews and reports from official sources.

The first part of this report is based on a researched by Canadian HIV/AIDS Legal Network in March 2004.

This chapter will give a brief history of the 6 countries that are using needle exchange programmes: Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus.

At the end of this I will report on the current situation of Jersey and include personal analysis and recommendations from these facts.

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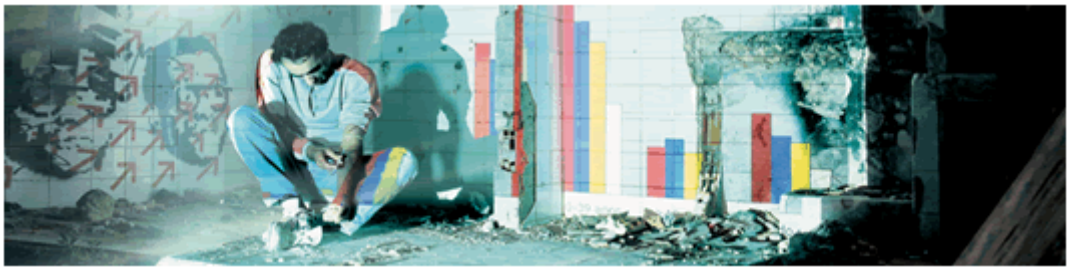
Brief History

In many countries, needle exchange programs in the community have become an integral part of a realistic public health response to the risk of HIV transmission among people who inject drugs and, ultimately, to the general public. Extensive studies on the effectiveness of these programs have been carried out, providing scientific evidence that syringe exchange is an appropriate and important preventive health measure. For example, a worldwide survey found that in cities with needle exchange or distribution programs the HIV prevalence rate decreased by 5.8% per year; in cities without such programs, it increased by 5.9% per year. A 1998 U.S. study analyzed the projected cost to the government of providing access to syringe exchange, pharmacy sales, and proper syringe disposal for all people who inject drugs in the country. The study found that "this policy would cost an estimated $34,278 U.S. per HIV infection averted, a figure well under the estimated lifetime costs of medical care for a person with HIV infection (Rick Lines, et al, 2004).

Because of the success of needle exchange programs in the community, calls to make sterile needles available to prisoners have been made in many countries. However, only 6 countries have established prison needle exchange programs – Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus. Some other countries, including Kazakhstan, Tajikistan, and Ukraine seem to be ready to establish such programs in the near future.

Since 1992, needle exchange programs have been implemented in prisons in these countries, and in each case needle exchange programs were introduced in response to significant evidence of the risk of HIV transmission within the institutions through the sharing of syringes.

Prison needle exchange programs have been implemented in both men's and women's prisons, in institutions of varying sizes, in both civilian and military systems, in institutions that house prisoners in individual cells and those that house prisoners in 'dorms', in institutions with different security ratings, and in different forms of custody (remand and sentenced, open and closed). Needle exchanges were typically implemented on a pilot basis, and later expanded based on the information learned during the pilot phase. Several different methods of syringe distribution are employed, based on the specific needs and the environment of the given institution. These methods include automatic dispensing machines; hand-to-hand distribution by prison physicians/health-care staff or by external community health workers; and programs using prisoners trained as peer outreach workers.'



Switzerland

Summary

Switzerland has 167 prisons spread across the 26 cantons that consist of the Swiss federation. Although the pena code is federal, the administration of the prisons is the responsibility of the government of the canton in whose territory the institution is located. There are 5,266 prisoners in Switzerland [at 1.9.2003 (National Prison Administration)].

In 1992 Switzerland became the first country to introduce a prison needle exchange program, at the Oberschöngrün men's prison. During this period needle exchange was not under prison regulations.

In the last 10 years, 7 other prisons in Switzerland are using this programme.

HIV/AIDS in Switzerland

The figures released by *UNAIDS and the WHO in Switzerland: epidemiological fact sheets on HIV/AIDS and sexually transmitted infections in 1/09/2004*, show that –

27.338 HIV cases;

7.815 AIDS cases;

5.420 AIDS deaths had been reported in Switzerland until 31st March 2004.

History of the response to HIV/AIDS, HCV, and IDU in Swiss prisons

Mid-80s, Harm-reduction initiatives were introduced in the prison system.

1985 – Distribution of condoms was approved within the prison system.

1989 – "hygiene kits" containing condoms, disinfectant, and instructions for cleaning syringes were distributed to prisoners on entry to Regensdorf penitentiary.

1889 – Methadone maintenance begun in a special section of Regensdorf.

1990 – disinfectants were made available in the remand prison in Geneva.

1991 – Methadone was expanded to several other remand prisons, in Basel, Berne, Geneva, and Zurich.

1992 – Discussions on prison needle exchange programs began.

2000 – Condoms were provided in one-third of Swiss prisons, and disinfectants in 8%. In addition to syringe exchange, 2 Swiss prisons (Oberschöngrün and Realta) have implemented heroin maintenance programs.

Brief history of needle exchange in Switzerland prisons

In 1992 the first prison needle exchange program in the world was started in the Oberschöngrün prison for men, located in the Swiss canton of Solothurn.

In 1994 was launched the Hindelbank needle exchange pilot project, syringes could be obtained via automatic dispensing units that were placed in 6 discreet locations around the institution.

In 1996 and 1997, needle exchange programs were established in Champ Dollon prison (Geneva) and Realta prison (Graubünden) respectively.

In 1998, prison needle exchange programs were started at the Witzwil and Thorberg prisons in Berne.

In 2000, the Saxerriet prison in Salez became the seventh Swiss prison to provide sterile needles.

Prison Brief for Switzerland

Country	**SWITZERLAND**
Ministry responsible	**Federal Department of Justice and Police**
Prison administration	**Section for the execution of sentences and measures**
Contact address	**Federal Office of Justice, Bundesrain 20, CH-3003 Berne, Switzerland**
Telephone/fax/website	tel: **+41 31 322 4171** fax: **+41 31 322 7873**
Head of prison administration (and title)	**Walter Troxler** Chef de la Section ExÃ(c)cution des Peines et Mesures
Prison population total (including pre-trial detainees/remand prisoners)	**5,266** at 1.9.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	**72** based on an estimated national population of 7.34 million at September 2003 (from Council of Europe figures)
Pre-trial detainees/remand prisoners (percentage of prison population)	**43.0%** (1.9.2003 untried, 10.0% convicted unsentenced)
Female prisoners (percentage of prison population)	**6.2%** (4.9.2002)
Juveniles/minors/young prisoners incl. definition (percentage of prison population)	**1.6%** (4.9.2002 18)
Foreign prisoners (percentage of prison population)	**70.8%** (1.9.2002)
Number of establishments / institutions	**167** (1997)
Official capacity of prison system	**6,513** (1.9.2003)
Occupancy level (based on official capacity)	**80.9%** (1.9.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 **5,400** **(79)** 1995 **5,655** **(80)** 1998 **6,041** **(85)** 2001 **5,160** **(72)**

(King's College London)

Europe statistics last modified: Thursday 21st October 2004

Germany

Summary

There are 222 prisons in Germany. Institutions are managed and administered by the state (Land) in which the institution is located.

In 1996, pilot needle exchange programs were established in 3German prisons. In the women's prison in Vechta, the men's prison in Lingen 1 Dept Groß-Hesepe, and the open prison Vierlande in Hamburg, syringes were distributed by an external organization, which also provided counselling as well as vocational training for prison personnel. Following a successful 2-year pilot phase and evaluation, the programs were continued in these three institutions and were expanded to four others. Over the last 2 years these programs have come under increasing attack from political leaders, 6 programs have been cancelled.

HIV/AIDS, HCV, in Germany

The figures released by *UNAIDS and the WHO in; Germany: epidemiological fact sheets on HIV/AIDS and sexually transmitted infections, 2004 Update*, show that –

21.063 HIV cases,

22.678 AIDS and

12.977 AIDS deaths had been reported in Germany by the end of 2003.

It's estimated that 40 to 45.000 people live with HIV/AIDS in Germany.

Several studies have estimated the HIV prevalence rate among German prisoners, with results ranging from 1.1% to 1.9%. These studies found that between 2.1% and 6.3% of prisoners who injected drugs was HIV-positive.

Rates of HCV infection among German prisoners are higher. A 1998 study in a Hamburg high-security prison for men found an HCV prevalence of 25% among all prisoners, and a 96% infection rate among people who inject drugs. A study at a women's prison in Lower Saxony found an HCV prevalence rate of 75%, and identified 20 women who had seroconverted while incarcerated. Other studies have found HCV prevalence rates of 77% among prisoners who inject drugs, and 18% for prisoners who did not inject drugs. A 2001 study of prisoners who had injected drugs only in prison found a 100% rate of HCV infection.

Introduction of needle exchange/distribution programs

The first programs

In 1995, the Minister of Justice in the northern German state of Lower Saxony approved a 2-year prison needle exchange pilot project in the women's prison in Vechta and the men's prison in Lingen 1 Dept Groß-Hesepe.

1996 – The pilot projects were initiated in the women and men's prisons in April and July respectively.

Expansion to other prisons

Based upon the success of the Vechta and Lingen projects, needle exchange programs were implemented in several other German prisons.

In 1996 – a program was started at the Vierlande prison in Hamburg, which houses over 300 men and approximately 20 women. This prison used both dispensing machines and staff to distribute sterile syringes.

In 1998 – needle exchange using dispensing machines was implemented in Lichtenberg prison for women and Lehrter Str. prison for men in Berlin.

In 2000 – needle exchange was made available through staff at the Hannöversand women's prison and the Am Hasenberge men's prison in Hamburg.

Current situation

Since 2001, prison syringe exchange programs in Germany have come under political attack.

2002 – Needle exchange programs operating in the Hannöversand women's prison, Am Hasenberge men's prison, and the Vierlande open prison (men and women) in Hamburg were terminated. The decision to terminate the programs was taken by a centre-right coalition government formed in September 2001.

2003 – (1st June) The needle exchanges in Vechta and in Lingen 1 Dept Groß-Hesepe were also terminated in similar circumstances by a new centre-liberal government in Lower Saxony.

In Berlin, the social-democratic and socialist coalition terminated one of its 2 needle exchange programs in early 2004. The stated reason for this action was an alleged lack of acceptance of the program among staff. The government also claimed that the prison did not exhibit a lower HIV infection rate than another prison without a needle exchange program. However, there is no epidemiological research to support this claim.

Prison Brief for Germany

Country	**GERMANY**
Ministry responsible	**Ministry of Justice (Bundesministerium der Justiz)**
Prison administration	**Prison and Probation Service (Das Referat Strafvollzug und BewÃ¤hrungshilfe)**
Contact address	**Mohrenstrasse 37, 10117 Berlin, Germany**
Telephone/fax/website	tel: **+49 30 20 25 92 22** fax: **+49 1888 10 580 92 22**
Head of prison administration (and title)	**Christian Lehmann** Ministerial dirigent
Prison population total (including pre-trial detainees/ remand prisoners)	**79,153** at 30.11.2003 (Federal Ministry of Justice)
Prison population rate (per 100,000 of national population)	**96** based on an estimated national population of 82.53 million at end of 2003 (Federal Statistical Office)
Pre-trial detainees /remand prisoners (percentage of prison population)	**21.2%** (30.11.2003)
Female prisoners (percentage of prison population)	**5.0%** (30.11.2003)
Juveniles/minors/ young prisoners incl. definition (percentage of prison population)	**4.4%** (adult prisoners only – under 18, 30.11.2003)
Foreign prisoners (percentage of prison population)	**29.9%** (31.12.2002 Council of Europe Annual Penal Statistics)
Number of establishments/ institutions	**222** (2002)
Official capacity of	**78,753**

prison system	(30.11.2003)
Occupancy level (based on official capacity)	**100.5%** (30.11.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 **57,448** **(71)** 1995 **66,146** **(81)** 1998 **78,584** **(96)** 2000 **78,707** **(96)**

International Centre for Prison Studies (King's College London)

Europe statistics last modified: Thursday 21st October 2004

Spain

Summary

There are 69 prisons in Spain falling under the jurisdiction of the Spanish Ministry of the Interior. There are also a further 11 prisons that are administered by the government in the autonomous region of Cataluña.

The first prison needle exchange program was introduced in July 1997 in Basauri prison, Bilbao, in the Basque region. This was followed by pilot programs in Pamplona prison (1998) and the Orense and Tenerif prisons (1999). In June 2001 the Directorate General for Prisons ordered that needle exchange programs be implemented in all prisons. By the end of 2001, syringe exchange was provided in 11 Spanish prisons. By the end of 2002 the number of prisons providing needle exchange had grown to 27; and by the end of 2003, to 30.

At present, the mandate to institute needle exchange programs exists for all 69 prisons under the jurisdiction of Spain's Ministry of the Interior**,** with the exception of psychiatric prisons and one high-security-level prison. There is also a pilot needle exchange program established in one of the prisons under the jurisdiction of the government of Cataluña.

HIV/AIDS, HCV, and IDU in Spain

The figures released by *UNAIDS and the WHO in, Spain: epidemiological fact sheets on HIV/AIDS and sexually transmitted infections, 2004 Update*, show there were approximately –

130,000 adults (aged 15 to 49) living with HIV/AIDS in Spain at the end of 2001,

66.344 AIDS and

34.871 AIDS deaths had been reported in Spain.

Spain has the largest cumulative total of AIDS cases, and of injection drug user amongst AIDS cases of any other European country.

Although declining in recent years due to the wide implementation of harm-reduction programs such as methadone and needle exchange, the HIV prevalence rate among people who inject drugs continues to be high at 33.5% in 2000, down from 37.1% in 1996. As of June 2001, the National AIDS Register had identified 39,681 cumulative cases of AIDS in Spain that were related to injection drug use, 65% of all AIDS cases identified up to that time.

Introduction of needle exchange/distribution programs

The first program

In December 1995 a Basque Parliament green paper recommended that the State Secretariat for Prison Affairs implement 3 pilot needle exchange programs in the Basque Autonomous Community. It was suggested that these pilots could be used to evaluate the feasibility of introducing syringe exchange programs more broadly within the prison system.

In January 1996 a planning committee was struck to examine the issue of prison needle exchange programs and make recommendations. The committee's primary finding was that needle exchange programs should be implemented in cooperation with the staff of an external, non-governmental organization that was already providing prison services.

1997 – the first pilot needle exchange was established in July in the Centro Penitenciario de Basauri in Bilbao, a men's institution with a population of 250. Of the 180 prisoners admitted in 1995, one-third regularly injected drugs, of which nearly half were HIV-positive.

Expansion to other prisons

1998 – In November a second prison needle exchange program was started in Pamplona.

1999 – Implemented projects in Tenerife, San Sebastián, and Orense.

Based upon the experience gained through these programs, the National Plan on AIDS and the Directorate General for Prisons jointly created the Working Group on Syringe Exchange Programs in Prisons. The Working Group's report, Key Elements for the Implementation of Syringe Exchange Programs in Prison, was published in April 2000. At that time, needle exchange programs were operating in nine prisons in the Basque region, Galicia, Canary Islands, and Navarra.

2001 – Syringe exchange programs had been established in 11 Spanish prisons.

2001 – In March the parliament approved a green paper recommending the implementation of needle exchange programs in all prisons.

2002 – In March the Ministry of the Interior and the Ministry of Health and Consumer Affairs jointly published the document *Needle Exchange in Prison: Framework Program*, which provides the prisons with guidelines, policies, and procedures, and training and evaluation materials for implementing needle exchange programs.

There are a number of features of the Spanish policy that are worth closer examination. First, the program guidelines do not mandate strict adherence to one-for-one exchange. While they advise that "the rule should be exchange, i.e., the previous syringe must be returned before a new kit is handed out," they do not practice this.

Second, prisoners participating in methadone maintenance are not disqualified from accessing the needle exchange program.

The guidelines also enable prisoners living in drug-free units or involved in abstinence-based programs to access sterile needles.

The only instances in which participation in the needle exchange program is restricted are in the cases of persons with mental health issues who pose a danger or those classified as particularly violent.

Involvement in the program can also be denied if an individual uses a needle as a weapon, or continually violates program rules.

Current situation

At present, the legislation and policy required for the implementation of needle exchange programs in all 69 prisons under the jurisdiction of Spain's Ministry of the Interior exists, with the exception of psychiatric prisons and one high-security-level prison. By the end of 2002, syringes had been distributed in 27 institutions increasing to 30 prisons by the end of 2003. A pilot needle exchange program has also been established in one of the 11 prisons under the autonomous jurisdiction of the government of Cataluña. Ongoing annual evaluation and assessment of the programs within the jurisdiction of the Spanish Ministry of the Interior will be conducted on a national base.

Prison Brief for Spain

Country	**SPAIN**
Ministry responsible	**Ministry of the Interior**
Prison administration	**General Directorate of Prison Administration**
Contact address	**Calle Alcala 38-40, E-28014 MADRID, Spain**
Telephone/fax/website	tel: **+34 91 335 48 81** fax: **+34 91 335 40 64** url: **www.mir.es/instpeni**
Head of prison administration (and title)	**Angel Yuste Castillejos** Director General
Prison population total (including pre-trial detainees/remand prisoners)	**59,398** at 24.9.2004 (national prison administration website)
Prison population rate (per 100,000 of national population)	**144** based on an estimated national population of 41.16 million at end September 2004 (from Council of Europe figures)
Pre-trial detainees/remand prisoners (percentage of prison population)	**22.4%** (24.9.2004)
Female prisoners (percentage of prison population)	**7.7%** (24.9.2004)
Juveniles/minors/young prisoners incl. definition (percentage of prison population)	**0.3%** (31.12.2003, Council of Europe Annual Penal Statistics)
Foreign prisoners (percentage of prison population)	**25.4%** (1.9.2002)
Number of establishments/institutions	**77** (2004)
Official capacity of prison system	**48,420** (1.9.2003)
Occupancy level (based on official capacity)	**114.1%** (1.9.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 **35,246** **(90)** 1995 **40,157** **(102)** 1998 **44,763** **(114)** 2001 **46,962** **(117)**

International Centre for Prison Studies (King's College London)

Europe statistics last modified: Thursday 21st October 2004

Moldova

Summary

The first prison needle exchange program in Moldova was initiated in May 1999 in Prison Colony 18 (PC18) in Branesti. Originally, sterile syringes were provided to prisoners through the prison health unit. However, after 4 to 5 months, the distribution method was changed to a peer model, which has been continued.

Based upon the success of the pilot project in PC18, a second syringe exchange program was initiated in May 2002 in Prison Colony 4 (PC4) in Cricova. The program in PC4 is also peer based. A third project, in the women's prison in Rusca, was opened in August 2003.

HIV/AIDS, in Moldova

The figures released by *UNAIDS and the WHO in; Republic of Moldova: epidemiological fact sheets on HIV/AIDS and sexually transmitted infections, 2004 Update*, show that –

1.945 HIV cases,

103 AIDS and

51 AIDS deaths had been reported in Moldova by the end of 2003.

HIV/AIDS, HCV, and IDU in Moldovan prisons

As of September 2002 there were 210 known prisoners living with HIV/AIDS in Moldovan prisons, which reflects an HIV/AIDS prevalence rate in the prison system approximately 100 times higher than in the general community. Twelve per cent of known cases of HIV infection in Moldovan prisons are among incarcerated women. However, these statistics under-represent the extent of HIV prevalence, since they only include prisoners whose HIV status is known. There is no universal HIV testing of the prison population, and it is assumed that the true prevalence of HIV in prisons is higher.

History of the response to HIV/AIDS, HCV, and IDU in Moldovan prisons

The development of harm-reduction initiatives in Moldovan prisons has been led by Health Reform in Prisons, a non-governmental organization of prison doctors established in 1997 by the former chief of the prison health department. Because the members of Health Reform in Prisons were themselves current or former prison physicians, the organization was in a unique position vis-à-vis the prison administration to be able to advocate for the implementation of harm-reduction measures.

Health Reform in Prisons, with the cooperation of the Moldovan Ministry of Prisons and financial assistance from the Open Society Institute of the Soros Foundation Network, began delivering HIV prevention programs in prisons in 1999. The organization went on to provide HIV and harm-reduction programs and services in all 19 prisons in Moldova. These activities include the provision of HIV prevention education for prisoners and staff peer education, the creation and dissemination of educational materials, the purchase of HIV-prevention and harm-reduction tools, the distribution of condoms and disinfectants, and the provision of sterile syringes in 2 prisons.

Up to September 2002, the project had reached approximately 14,000 prisoners (79% of all prisoners in Moldova) and 1,600 prison staff. The organization distributes condoms, disinfectant, and information in all Moldovan prisons. Since the project was started, over 30,000 items of information have been distributed.

Introduction of needle exchange/distribution programs

The first program

In May 1999 a pilot prison syringe exchange program was established. The site chosen was Prison Colony 18 in Branesti. There were several reasons why PC18 was chosen for the pilot. These included its proximity to the city of Chisinau (the capital of Moldova, where the NGO coordinating the project is based), the fact that it was the prison with the lowest average age of prisoners (24 to 26 years old), and because at that time it had the highest known number of prisoners known to be living with HIV/AIDS (18 people).

The pilot program in PC18 evolved through 2 stages. During stage one needles were distributed hand-to-hand to prisoners through the prison medical unit. During the 4 or 5 months that this distribution system was in place between 40 and 50 needles were exchanged.

Evolution of syringe exchange in Prison Colony 18: needles exchanged annually

YEAR	SYRINGES EXCHANGED
2000	115
2001	4350
2002	7150

In addition to one-for-one syringe exchange, peer volunteers also distribute condoms, disinfectants, antiseptic pads, and razors for shaving. They also provide harm-reduction and HIV-prevention information, including information on safer injecting and post-injection problems. The team of peer volunteers changes every year.

Expansion to other prisons

16th May 2002, Order 52 authorized the implementation of a second needle exchange project in Prison Colony 4, a men's institution in Cricova housing 1,200 prisoners.

Distribution of Harm-Reduction Tools in Moldovan Prisons: 2002 System-Wide Figures

BLEACH KITS	1,026
IODINE	211
SHAVING RAZORS	3,550
SYRINGES	14,705
CONDOMS	100,056

Evaluation and lessons learned

The Moldovan projects do not adhere to a strict one-for-one exchange policy. Unlike the programs in Western Europe, there are also no plastic storage cases provided for the syringes, nor are there regulations about where they may be stored. Initially, the decision against providing plastic cases was made on economic grounds. Later, it became clear that the programs were working well and safely without such storage cases and it was therefore decided they were unnecessary. The Moldovan projects have experienced no instances of syringes being used as weapons, and no problems with dirty needles.

Current situation

A third prison needle exchange was started in the women's prison in Rusca in August 2003. In 2003 there were 17 known prisoners living with HIV/AIDS in the women's institution, 12% of the total population in the institution.

Prison Brief for Moldova (Republic of)

Country	**MOLDOVA (REPUBLIC OF)**
Ministry responsible	**Ministry of Justice**
Prison administration	**Department of Penitentiary Institutions**
Contact address	**Str. Titulescu 35, MD-2032 CHISINAU, Moldova**
Telephone/fax/website	tel: **+373 2 55 90 68** fax: **+373 2 55 15 21** email: **penitenciare@araxinfo.com**
Head of prison administration (and title)	**Valentin Sereda** General Director
Prison population total (including pre-trial detainees/ remand prisoners)	**10,729** at 1.9.2003 (Council of Eur Annual Penal Statistics)
Prison population rate (per 100,000 of national population)	**297** based on an estimated national population of 3.61 million at September 2003 (from Council of Europe figures)
Pre-trial detainees/remand prisoners (percentage of prison population)	**24.4%** (1.9.2003 untried, 13.9% convicted unsentenced, 9.3% sentence unconfirmed)
Female prisoners (percentage of prison population)	**2.8%** (1.9.2002 Council of Europe Annual Penal Statistics)
Juveniles / minors / young prisoners incl. definition (percentage of prison populatio	**0.4%** (1 un2003 18), sentenced prisoners only
Foreign prisoners (percentage of prison population)	**1.0%** (1.9.2002)
Number of establishments / institutions	**20** (2003)
Official capacity of prison system	**12,105** (1.9.2003)
Occupancy level (based on official capacity)	**88.6%** (1.9.2003)
Recent prison population trend (year, prison population total, prison population rate)	1992 **10,258** **(273)** 1995 **9,781** **(261)** 1998 **10,521** **(288)** 2001 **10,037** **(276)**

International Centre for Prison Studies(King's College London)

Europe statistics last modified: Thursday 21st October 2004

Kyrgyzstan

Summary

Kyrgyzstan initiated a pilot prison needle exchange project in October 2002. In early 2003 approval was given to expand needle exchange into all 11 Kyrgyz prisons. Needle exchanges are now operating in all prisons.

HIV/AIDS, HCV, and IDU in Kyrgyzstan

The figures released by *UNAIDS and the WHO in;* Kyrgyzstan*: epidemiological fact sheets on HIV/AIDS and sexually transmitted infections, 2004 Update*, show that there are approximate –

3.900 HIV/AIDS reported in Kyrgyzstan by the end of 2003.

HIV/AIDS, HCV, and IDU in Kyrgyz prisons

In the 11 prisons in Kyrgyzstan, the number of identified prisoners living with HIV/AIDS has been steadily rising in recent years. In 2000 there were only 3 known cases of HIV in Kyrgyz prisons. In September 2001 this number had increased to 24, the majority being people who inject drugs. As of November 2002 there were more than 150 prisoners living with HIV/AIDS in Kyrgyzstan, 56% of all known cases in the country.

Injection drug use and needle sharing are highly prevalent in Kyrgyz prisons. A survey conducted by a Kyrgyz non-governmental organization found that 100% of prison staff agreed that drugs are being used in the prisons. The survey also found that 90% of drug users in prisons said they shared needles and did not disinfect them.

History of the response to HIV/AIDS, HCV, and IDU in Kyrgyz prisons

HIV prevention programs in prisons started in 1998 before the first case of HIV was identified. Initially, the response consisted of education programs for prisoners and prison staff.

In February 2001 the Main Directorate for Penalty Implementation (MDPI) and its Department of Correctional Institutions issued a “prikaz” (order) “on prevention of HIV/AIDS in the prison institutions of Kyrgyzstan” urging prisons to take steps to prevent the spread of HIV among prisoners. Based on this order, various HIV prevention and harm-reduction initiatives were implemented. These included the provision of condoms and disinfectants, HIV-prevention education for prisoners and staff, peer education, and voluntary HIV testing. Unofficial needle exchange was also initiated, specifically targeting those living with HIV/AIDS.

Introduction of needle exchange/distribution programs

The first program

In October 2002 a pilot needle exchange project was introduced in Prison IK-47, a maximum-security institution. The project provides services for approximately 50 prisoners who exchange needles on a daily basis (the project averages approximately 50 exchanges per day).

It was decided that exchanges should take place in a location where prisoners cannot be seen by guards; they therefore take place in the medical wards. A prisoner asks to come to the medical unit to receive medical service and while there he exchanges his syringe. The pilot also provides secondary exchange using prisoners as peer volunteers, as in the Moldovan model. The project coordinators found that both options for syringe exchange were needed.

Expansion to other prisons

September 2003 needle exchange programs were operating in six of the 11 prisons in Kyrgyzstan (5 men's prisons and one women's prison).

In February 2004 funding was obtained to expand the programs to all 11 prisons and by April 2004 sterile needles were available in all prisons.

In all 11 institutions, needle exchange is done using prisoners trained as peer outreach workers who work with the medical unit. This model was adopted following concerns that emerged when the medical unit was the sole point of exchange. Because needles could only be accessed from the medical unit during the day, and most drug trafficking took place in the evening, some non-drug-using prisoners were accessing sterile needles during the day that they would later sell at night to prisoners who injected drugs.

In September 2003 a total of approximately 470 drug users were accessing the six needle exchange programs then in operation on a daily basis.

April 2004, with programs established in all 11 prisons, this figure was approximately 1,000. Drug users are provided with one syringe and three extra needle tips. This allows prisoners who inject drugs to inject more – up to 3 times a day without having to reuse a syringe. This also reduces the cost of the syringe exchange program since tips cost less than complete needles.

There have been no instances of syringes being used as weapons, and prison medical staff have identified a reduction in injection-related health problems such as abscesses.

Current situation

Syringe exchange programs are currently operating in all 11 Kyrgyz prisons. There are plans to pilot test a methadone maintenance treatment program in 2004

Prison Brief for Kyrgyzstan

Country	**KYRGYZSTAN**
Ministry responsible	**Ministry of Internal Affairs**
Prison administration	**General Directorate of Penitentiary Institutions**
Contact address	**Ibraimova 106, Bishkek, Kyrgyzstan**
Telephone/fax/website	tel: **+ 996 312 223278 or 283911 or 293451**
Head of prison administration (and title)	**Grigory Y. Bubel** Director General
Prison population total (including pre-trial detainees/remand prisoners)	**19,500** at March 2002 (national prison administration)
Prison population rate (per 100,000 of national population)	**390** based on an estimated national population of 5.0 million at mid-2001 (United Nations)
Pre-trial detainees/remand prisoners (percentage of prison population)	**17.1%** (1.5.1997)
Female prisoners (percentage of prison population)	**3.6%** (31.12.1997)
Juveniles/minors/young prisoners incl. definition (percentage of prison population)	**1.2%** (31.12.1997 – under 18)
Foreign prisoners (percentage of prison population)	**1.3%** (31.12.1997)
Number of establishments/institutions	**40** (1996)
Official capacity of prison system	**18,869** (31.12.1997)
Occupancy level (based on official capacity)	**112.6%** (31.12.1997)
Recent prison population trend (year, prison population total, prison population rate)	1992 **9,707** **(216)** 1994 **13,775** **(298)** 1998 **21,254** **(462)**

International Centre for Prison Studies
(King's College London)

Asia statistics last modified: Thursday 21st October 2004

Belarus

Summary

The Republic of Belarus implemented a pilot syringe exchange program in one prison, Reformatory School 15/1 in Minsk, in April 2003.

HIV/AIDS, HCV, and IDU in Belarus

There were 5,165 people known to be living with HIV/AIDS in Belarus as of 1st September 2003. HIV and injection drug use are issues of significant concern. In April 2003 there were approximately 9,400 persons officially registered with drug treatment services. The number of people registered with drug treatment services has experienced an annual growth of 20% to 40%. However, these treatment figures are assumed to be a low estimate of the true circumstances, with the actual number of drug users estimated at 40,000 to 43,000. Ninety-one per cent of drug users in Belarus are people who inject drugs. Injection drug use is the primary mode of HIV transmission in Belarus, with 75.5% of people living with HIV/AIDS in the country being infected though IDU.

HIV/AIDS, HCV, and IDU in Belarus prisons

As of May 2003 there were 1,131 prisoners in Belarus known to be living with HIV. This represents 22.5% of all known HIV cases in the country.

History of the response to HIV/AIDS, HCV, and IDU in Belarus prisons

Prisoners in Belarus must undergo mandatory HIV testing when entering detention centres. The syringe exchange program is one component of a project that provides education for staff and prisoners, peer education, provision of information, voluntary HIV testing, and condom and bleach distribution. The project works with the support of the Committee on Execution of Penalties of the Ministry of Internal Affairs and with the prison administration.

Introduction of needle exchange/distribution programs

The pilot program was implemented in April 2003 at the Reformatory School 15/1 in Minsk, a prison with a population of 2000. This site was selected based on the availability of scientific and medical specialists and because the prison also houses the National Hospital, which provides primary HIV care for all known HIV-positive Belarussian prisoners.

The pilot is scheduled to run until 2004. There are 28 registered drug users in the prison, although it is estimated that the actual number of people who inject drugs is approximately 200. Fifteen prisoners are known to be HIV-positive. The program is open to all prisoners in the institution. The program follows the Moldovan model, and uses 20 volunteers from the prisoner population to distribute needles to their peers. During the first month over 100 needles were distributed.

Evaluation and lessons learned

A number of challenges were identified in establishing the program, including the reluctance of staff, the lack of a legal framework upon which to base a prison needle exchange program, the short duration of the pilot, and the fact that prisoners using drugs still face penalties if discovered. The program has yet to be evaluated.

Current situation

The pilot was originally scheduled to run until January 2004. This term was extended until June 2004. Concurrently, the needle exchange program was extended to two other prisons. The Ministry of Internal Affairs is prepared to expand prison syringe exchange throughout the country, although securing funding for such an initiative is a major barrier to realizing this goal.

Prison Brief for Belarus

Country	**BELARUS**
Ministry responsible	**Ministry of Internal Affairs**
Prison administration	**Committee for the Execution of Punishment**
Contact address	**Aranskaya Street 1, 220006 MINSK, Belarus**
Telephone/fax/website	tel: **+375 17 229 79 38** fax: **+375 17 226 18 06**
Head of prison administration (and title)	**V.A. Kovchur** Head of the Committee
Prison population total (including pre-trial detainees/remand prisoners)	**55,156** at 31.12.2001 (nation prison administration)
Prison population rate (per 100,000 of national population)	**554** based on an estimated national population of 9.95 million at end of 2001 (Council of Europe)
Pre-trial detainees/remand prisoners (percentage of prison population)	**17.5%** (31.12.2001)
Female prisoners (percentage of prison population)	**6.1%** (31.12.2001)
Juveniles/minors/young prisoners incl. definition (percentage of prison population	**3.1%** (31 December 2001 – under 18)
Foreign prisoners (percentage of prison population)	**2.6%** (31.12.2001)
Number of establishments/institutions	**37** (31.12.1997)
Official capacity of prison system	**43,400** (31.12.1997)
Occupancy level (based on official capacity)	**135.7%** (31.12.1997)
Recent prison population trend (year, prison population total, prison population rate)	1992 **33,641** **(327)** 1995 **54,869** **(535)** 1998 **63,157** **(620)**

International Centre for Prison Studies (King's College London)

Europe statistics last modified: Thursday 21st October 2004

Jersey

Summary

Jersey has one prison, which incorporates male, female, vulnerable persons unit and young offenders (15-21 years old). "The States of Jersey Home Affairs Committee has responsibility for the running of the Prison and the formulation of its policies. The Home Affairs Committee is accountable to the States of the Island of Jersey for its actions. The Prison Service retains the Royal Prefix H.M. thereby enabling us to maintain our traditional links with the Home Office of the U.K. Government". Currently there are 161 prisoners in La Moye Prison (at 09.01.2005).

HIV in Jersey

HIV (Since 1985 to April 2004) –

85 cases identified

64 male, 19 female and 2 unknown!

19 IVDU

26 MSM

25 Hetero

2 BP

2 Mat-Foe

7 unknown

HIV/AIDS in the Jersey Prison

Since the 80s to January 2005, two cases have been identified in the prison. Both have been infected previously to their arrest.

The response to HIV/AIDS, HCV, and IDU in Jersey prison

In the 90s, Harm-reduction initiatives were introduced in the prison system.

Healthcare Team

Many prisoners come from low income backgrounds, have low literacy levels, higher levels of substance misuse and have often had limited access to the healthcare system. These factors all contribute to reduced access to accurate information about health, risky behaviours and harm reduction. This explains, in part, the high incidence of undiagnosed infections that are evident among new prisoners.

The healthcare staff at La Moye Prison makes sure that all inmates from the moment of their reception receive a high standard of health care provision.

All members of the Healthcare team have been trained in Intravenous Blood Supplying. One member of the Team is currently studying blood-borne viruses in the U.K.

Pre and post-test counselling is available for prisoners undergoing blood tests for Hepatitis and HIV infections. The healthcare staff promotes this types of tests to all prisoners, and leaflets/posters advertise the scheme.

Hepatitis B vaccination is freely available.

Drug and alcohol workers

Counselling and education programmes within the prison may be the first opportunity prisoners have to consider how risky behaviours may impact on their health and what measures they may be able to take. Prison is considered a health promotion opportunity where, very often for the first time, it may be possible to engage with individuals and communities who would be otherwise extremely difficult to reach.

Current Situation

Currently the prison has a part time substance misuse counsellor. Professionals from Drug and Alcohol Services attend the prison on a weekly basis to see pre-release inmates, providing this way the link with community-based agencies.

Drug and Alcohol Awareness Course

Offers 12 weekly group sessions structured around a specific topic, including: understanding addiction, the process of recovery, relapse prevention, coping with high risk situations, anger management, blood borne viruses, sexual transmitted diseases, etc.
Certificate at the end of the course.

Auricular Acupuncture

Benefits of treatment are a decreased intensity of withdrawal symptoms like Headaches, body aches, sweat, sleep disturbances, tremors, anxiety and depression, decreases anger, and reduces cravings for alcohol and other drugs. It helps stabilize you physically and emotionally and increases mental clarity and your ability to focus Auricular Acupuncture is a quiet and relaxing treatment the treatment stimulates your body to heal itself.

One to One Sessions

Narcotics Anonymous Meetings

Alcoholics Anonymous Meetings

3 months Pre-release Counselling

Provision of sterilised tablets and condoms

Psychiatrist

Psychologist

A Consultant Microbiologist attends on a monthly basis

Samaritans

Referrals to agencies in the community are made for any inmate that requires, e.g. ACET, Brook, eating disorders, grief counsellors, etc.

Prison Brief for Jersey (United Kingdom)

Country	**JERSEY (UNITED KINGDOM)**
Ministry responsible	**States of Jersey Home Affairs Committee**
Prison administration	**H.M.Prison, La Moye**
Contact address	**Rue Baal, St Brelade, Jersey, JE3 8HQ**
Telephone/fax/website	tel: **+44 1534 744181** fax: **+44 1534 746875**
Head of prison administration (and title)	**Steve Guy-Gibbens** Governor
Prison population total (including pre-trial detainees/remand prisoners)	**170** at 19.11.2003 (national prison administration)
Prison population rate (per 100,000 of national population)	**188** based on an estimated national population of 90,200 at mid-2003
Pre-trial detainees/remand prisoners (percentage of prison population)	**32.9%** (19.11.2003)
Female prisoners (percentage of prison population)	**9.4%** (19.11.2003)
Juveniles/minors/young prisoners incl. definition (percentage of prison population)	**11.8%** (19 Jun 2003)
Foreign prisoners (percentage of prison population)	**14.0%** (14.10.2002)
Number of establishments/institutions	**1** (2003)
Official capacity of prison system	**149** (19.11.2003)
Occupancy level (based on official capacity)	**114.1%** (19.11.2003)
Recent prison population trend (year, prison population total, prison population rate)	1998 **108** **(125)** 2001 **134** **(149)**

International Centre for Prison Studies

(King's College London)

Europe statistics last modified: Thursday 21st October 2004

Different methods of needle distribution

Among the prison needle exchange programs reviewed above, different countries (and different prisons within a given country) have adopted different methods to distribute (or exchange) needles. There are important lessons to be learned from the experience of different countries employing different methods of needle distribution. These lessons are particularly important to jurisdictions and prisons planning the implementation of needle exchange programs in prison. The different methods used by the countries studied for needle distribution were –

distribution by prison nurses or physicians based in a medical unit or other areas(s) of the prison;

distribution by prisoners trained as peer outreach workers;

distribution by external non-governmental organizations or other health professionals who come into the prison for this purpose;

distribution by one-for-one automated needle-dispensing machines;

Each distribution method has its own unique opportunities and challenges. It is difficult to simply characterize these as "advantages" or "disadvantages" of a particular distribution method, since that would require a subjective assessment based on the philosophy, policies, or physical facility in a given prison system or prison. An "advantage" from the perspective of one jurisdiction or prison may be a "disadvantage" from the perspective of another, depending upon the nature and ethos of the programs themselves.

The issue of requiring a one-for-one needle exchange illustrates this point. While some of the jurisdictions examined for this report adhere to a strict one-for-one policy, others do not. Hindelbank, for example, uses dispensing machines that operate on a one-for-one basis, but also provides hand-to-hand up to five additional "points" or needle tips to program participants who have trouble finding veins to inject into. Spain has also shown flexibility in its approach. While Spanish guidelines acknowledge that "the rule should be exchange, i.e., the previous syringe must be returned before a new kit is handed out,".

Hand-to-hand distribution by prison nurse and/or physician

Provides personal contact with prisoners and an opportunity for counselling.

Can facilitate outreach to and contact with previously unknown drug users.

Prison maintains high degree of control over access to syringes.

One-for-one exchange or multiple syringe distribution possible (as necessary, and as reflects individual prison policy).

Lower degree of anonymity and confidentiality, which may reduce the participation rate (although high acceptance by prisoners is possible if confidentiality is maintained).

Access more limited, as syringes are available only during the established hours of the health service (this is particularly true if the prison follows a strict one-for-one exchange policy).

Creates possibility of proxy exchanges by prisoners obtaining syringes on behalf of those who do not want to participate in person due to lack of trust with staff.

Hand-to-hand distribution by peer outreach workers

High acceptance by prisoners.

High degree of anonymity.

High degree of accessibility (peer outreach workers live in the prison units, and are available at all hours).

No direct staff control over distribution, which can lead to increased fears of workplace safety among staff.

One-for-one exchange more difficult to ensure.

Hand-to-hand distribution by external non-governmental organizations or health professionals

Provides personal contact with prisoners and an opportunity for counselling.

Facilitates outreach to and contact with previously unknown drug users.

Prison has opportunity to maintain high degree of control over access to syringes.

One-for-one exchange or multiple syringe distribution possible (as necessary, and as reflects individual prison policy).

Provides a higher degree of anonymity and confidentiality, as there is no interaction with prison staff.

Access limited. Syringes available during set hours or set times of the week (this is particularly true if the program follows a strict one-for-one exchange policy).

Anonymity and confidentiality may be compromised by policies that require the external agency to provide information on participation to the prison.

There can be mistrust by prison staff of the external services providing syringes.

External workers may experience more barriers in dealing with the prison bureaucracy than internal prison health staff.

Turnover in staff of non-governmental organization may result in a lack of program continuity and lack of a consistent “face” for the program for prisoners and prison staff.

Automated dispensing machines

High degree of accessibility (often multiple machines are in various places in the institution, which can be accessed outside the established hours of the medical service).

High degree of anonymity, as there is no involvement with staff.

High acceptance by prisoners.

Strict one-for-one exchange.

Machines are vulnerable to vandalism and damage by prisoners and staff who are not in favour of this program.

Technical problems with functioning of the dispensing machines can mean syringes are unavailable for periods of time, which can decrease prisoner confidence in the program.

Some prisons are not architecturally suited for the use of dispensing machines (i.e., lack of discreet areas freely accessible to prisoners in which machines may be placed).

Because the machines must be custom designed and individually constructed, the expense of providing them in sufficient numbers in multiple prisons can be prohibitive for some prison systems.

My Personal Analysis

Needle exchange in prison is a highly controversial subject. Many agree that access to sterile needles implicates the right to health, given the great risk of HIV and HCV transmission associated with needle sharing. Numerous international laws provide that "Every person has a right to the highest attainable level of physical and mental health.(*see for example Universal Declaration of Human Rights, supra, note 86 at art. 25*). At an international level there is a general consensus that the standard of health care provided to prisoners must be equivalent to that available in the general community. Principle 9 of the Basic Principles for the Treatment of Prisoners states "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation." (*Basic Principals, supra, note 88*).

In 1991, the WHO Regional Office for Europe recommended the provision of sterile syringes in prisons as part of a comprehensive HIV prevention strategy *(H. Stöver, Drugs and HIV/AIDS Services in European Prisons Oldenburg, Germany: Carl von Ossietzky Universitat Oldenburg, 2002, at 127-128*).

Two years later, the WHO Guidelines published. Principle 1 of the WHO Guidelines says,"All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination … with respect to their legal status." (*WHO, Guidelines, supra, note 94 at 4*). Principle 2 further states, "general principles adopted by national AIDS programmes should apply equally to prisons and to the general community." (*Ibid.*)

The WHO Guidelines are clear that "In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injection equipment during detention and on release." (Ibid. at 6).

In another perspective, distributing equipment for illegal drug use in a prison to provide inmates, many of whom have been sentenced for drug related crimes, with syringes, seems paradoxical to many people. A number of objections have consistently been made against the implementation of needle exchange programs in prisons. The three principal objections to prison needle exchange programs are –

1. The implementation of prison needle exchange would lead to the use of syringes as weapons against prisoners and staff.

2. The implementation of prison needle exchange would lead to an increased consumption of drugs, and/or an increased use of injection drugs among those who were previously not injecting.

3. The implementation of prison needle exchange would be seen as condoning or promoting behaviour that the prison should be seeking to eradicate as part of the individual's "rehabilitation."

1. Use of syringes as weapons against prisoners and staff.

Through my research I could not find many cases where needles and syringes have been used as weapons, either against staff or other inmates. I could only find 2 examples–

"One of the prisoners was sentenced to three years and the other to two years for the 53-hour siege, during which prison officers had blood-filled syringes held to their throats". (The Examiner, http://ted.examiner.ie/archives/1999/february/3/opinion.htm).

"16/07/03 Indo: Three prison officers injured by prisoner-in-transit with blood filled syringe." (http://www.paddyshamrock.com/index-catalogue.html)

Even though, syringes are known, in many other countries, to be used as weapons between inmates, in our specific case, Prison La Moye, I could agree that this factor does not seem to be of major risk. For an inmate to use a syringe filled with blood against an inmate or officer they would have to disclose that they have a blood-borne viruses. This risk is very reduced due to the fact that inmates in Jersey very rarely assume between themselves, that they have Hepatitis or HIV. Bulling, threats, and fights do exist among inmates but they do tend to use other type of weapons, even when they have access to a syringe. BUT the risk of "stick injury" to officers and prisoners will be extremely higher then the current situation.

2. Increased consumption of drugs, and/or an increased use of injection drugs among those who were previously not injecting.

These next 2 points should be looked into carefully. In my view it is in here that lays the main risks of introducing needle exchange in the La Moye Prison. As it is the knowledge of many people, drugs in Jersey are very expensive (e.g. one gram of heroine in the U.K. can be bought on the streets for £60, in Jersey the street value is £200). Sustaining a habit on the 'outside' is already hard to make, but when incarcerated the ways of getting money are much reduced. In several conversations I have with inmates they all say that that a 'bag' (one dose of heroin), in prison is a very small portion compared with the doses in the community. Many have said that if they had access to proper and sterilised equipment, even though they never injected previously, they would start injecting.

I also question them (all heroin users) on their views of a needle exchange programme in La Moye Prison. At the moment they all said that they would not agree with such a scheme. None presented the reasons as fear of syringes becoming a weapon but all agreed that it would increase the number of people injecting. Some also think that because it's difficult to access drugs on a daily basis, the risks of developing low tolerance and overdose are much higher in the prison then in the community.

It is known that the majority of heroine users, started by smoking heroin and only after injecting. This is very common but the reverse unusual. Due to the price and quantity per dose in the prison, introducing a needle exchange can lead to an amazing increase of intravenous users. When released into the community rarely will be the cases of a drug addict to reverse their method of using from injecting to smoking.

3. Condoning or promoting behaviour that the prison should be seeking to eradicate as part of the individual's "rehabilitation."

My personal view as a professional is that starting a needle exchange programme in the prison may 'enable' drug use and keep people stuck from which they would otherwise escape. For many inmates being in prison is the 'rock bottom' and the tuning point on their lives. With more security approaches to reduce drugs in prison, the fact that they do not have access to paraphernalia and a comprehensive drug service counselling, education through courses, and other harm-reduction measures, it is the way to help inmates changing their lives.

Another possible effect is that, somehow, even though needle exchange in the community does prevent major health risk problems, in the prison due to several factors, needle exchange might encourage drug use. People who do not use drugs, but feel caught up by boredom, emotional problems, trapped or powerless to deal with personal situation, might start regarding drugs as safe and decide to start using drugs themselves. One of my fears is that we might be sending out the 'wrong signal'.

As a substance misuse counsellor I see the setting where I work, as one of the best places to reach addicts and helping them through the process of recovery. They normally arrived fearful of the new environment, many are desperate with broken families, no jobs or friends. This enables me to reach them in a crises situation and allows me to work with them towards a drug-free life.

Recommendation:

My personal recommendation is keeping developing programmes for drug and alcohol users in La Moye prison.

Encourage more prisoners to engage on voluntary tests scheme,

More programmes that focus on provision of information and education,

Reduce the supply of drugs into the prison,

Disinfecting tablets that can be used to clean a variety of things,

Provision of condoms, for inmates going on home leave and when released,

Continuation of a care plan based on prisoners' specific needs,

Ensure that links are made between the various departments within prison including healthcare, education and sentence planning,

Continuing the pre-release work and referral to Drug and Alcohol Services on release,

Creation of a new post for a social worker, to deal with pre-release inmates,

Implementation of Mandatory Drug Test.

Resources

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Drugscope – Chapter 12 – Interventions in the Criminal Justice System
http://www.drugscope.org.uk/druginfo/drugsearch/ds_report_results.asp?file=%5Cwip%5C11%5C3%5C014chapter12.html

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http://www.publications.parliament.uk/pa/cm199900/cmselect/cmhaff/271/27102.htm

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http://www.rapt.org.uk/

International Centre for Prison Studies (King's College London)
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