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Service Provision for Detainees with Problematic Drug and Alcohol Use in Police Detention:

A Comparative Study of Selected Countries in the European Union

Helsinki 2008

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Foreword

The European Commission under the framework of the AGIS project funded this comparative research on the provision of services for detainees with problematic drug and alcohol use in 8 European countries. The eight countries involved in the research were Bulgaria, England and Wales, Estonia, Germany Hungary, Italy, Lithuania and Romania.

The executive summary of the main report is also available in Bulgarian, Estonian, German, Hungarian, Italian, Lithuanian and Romanian. These summaries can be accessed from the CRQ Website: http://www.bcu.ac.uk/crq or from the HEUNI Website: http://www.heuni.fi/ In addition the executive summary has been translated into Russian by HEUNI and is available from the HEUNI Website: http://www.heuni.fi/

Executive Summary

Introduction

Over the last two decades drug use has substantially increased and as a result increasing numbers find themselves in police detention:

> most of these detainees are vulnerable individuals and the recognition of their substance misuse problem is now perceived [in the UK] as important and is receiving local and national attention. Accurate assessment of substance-misuse-associated morbidities, including the degree and severity of dependence, and of the need for medical intervention, is essential, because both intoxication and withdrawal can put detainees at risk of medical, psychiatric and even legal complications (Royal College of Psychiatrists and Association of Forensic Physicians 2006:ii).

Despite the expanding illicit drug industry and advances in law enforcement, which have lead to an increase in the proportion of problematic drug and alcohol users becoming entangled in the criminal justice systems throughout Europe, there is still little research about police detention (Van Horne and Farrell 1999), specifically in considering police forces' response to the problem and the treatment of problematic drug and alcohol users in police detention (MacDonald 2004).

Official statistics have shown an increase in the number of problematic drug and alcohol users across Europe and in Central and Eastern Europe. Recreational use and experimentation are becoming an integral part of youth culture. Problematic drug and alcohol users represent a small minority of the whole population, however, this sort of use is responsible for the vast majority of associated harm, in personal, economic and social costs.

This study explores legislation, policy and practice for problematic drug and alcohol users during police detention in eight countries in the EU.

The police and harm reduction

The roles of healthcare professionals and the police in addressing drugs and harm reduction have been discussed in several research studies (Spooner et al. 2002; Lough 1998; Beyer 2002). These studies raise issues about who is responsible for harm reduction and the conflicts for the police whether law enforcement and harm reduction can comfortably co-exist. As a general rule health professionals are more exposed to and have the responsibility for dealing with different drug-related harms experienced by drug users whereas

the police are responsible for dealing with crime and related issues experienced by the public. However, these different responsibilities are not mutually exclusive as policies and strategies implemented by health and police impact on each other:

> Police activities can influence health harms such as overdose, the spread of blood-borne diseases, the age of initiation of drug use. Similarly, health activities can influence crime and public amenity. For example, drug treatment programs can influence criminal activity among drug users (Spooner et al. 2002, 3).

It can be argued that many police identify their key role as reducing drug-related harm by placing the emphasis on the reduction of drug supply with the rationale that by reducing the supply of drugs one reduces the availability and thus the number of drug users (Martin 1999). The police face a contradiction in a situation where the use of alcohol and tobacco is accepted (despite the harm these cause) whereas the use of other forms of drugs are subject to an opposite set of legal values (Bradley and Cioccarelli 1989).

Research has demonstrated that the police can have a role in harm reduction provision, without necessarily compromising their legal and moral values. For example, they can encourage users to make use of local needle-exchange sites and provide information on their location, and they can use discretion in not arresting users at such sites, while consulting with the community on the need for such methods (Spooner et al. 2002).

Methodology

To provide an in-depth analysis of the policy and practices involved at the point of police detention and the response to people with problematic drug or alcohol use in the sample countries, an ethnographic approach was used. This involved semi-structured, in-depth interviews with key criminal-justice professionals, healthcare staff, government and NGO representatives and people with problematic drug or alcohol use who have experienced police detention.

The partners in the research played a key part in collecting data from their countries to inform the literature review and country reports. Data from a range of sources was used, including national policies that address problematic drug and alcohol use and official statistics demonstrating trends in use and associated problems, such as crime and public health problems.

Aims and objectives of the study

The key aim of the study was to investigate legislation, policy and practice in relation to treatment of people with problematic drug or alcohol use in police detention in eight countries in the European Union (Bulgaria, Estonia, England and Wales, Germany, Hungary, Italy, Lithuania and Romania). In order to achieve this, the objectives set for the research were as follows. For each country in the study to:

- explore trends in problematic drug and alcohol use;
- examine national legislation and strategies in place to address problematic drug and alcohol;
- investigate the provision of healthcare and treatment services for problematic drug and alcohol users in police detention and establish who is responsible for this;
- consider vulnerable groups relating to problematic drug and alcohol use;
- identify gaps in service provision for people with problematic drug or alcohol use in police detention;
- identify and disseminate good practice identified by partners involved in the study;
- consider the impact of joining the European Union, where appropriate, on strategies and service provision for people with problematic drug and alcohol use in police detention.

Participants came from a range of government and non-government organisations, including ministerial staff (responsible for criminal justice, policing and healthcare), the police, prosecution service, courts, prisons and probation, drug-treatment centres in the community, NGOs who provide services for problematic drug and alcohol users and also promoted the human rights of users in detention, and problematic drug and alcohol users who had experienced police detention. Access to the participants in each country was facilitated by the partners who also compiled the country profiles (see Chapter 3).

Conditions and impact of police detention

A key theme raised in the study was the physical condition of police detention regarding both the structure of the actual buildings and the facilities. It is important to distinguish between the conditions at the point of arrest at police stations and the conditions of police arrest houses. Estonia, Lithuania, Romania and Hungary have police arrest houses under the control of the Ministry of the Interior. In Bulgaria the police remand houses are under the Ministry of Justice.

Detention in police custody can be either a relatively short time in police stations (Italy, England and Wales, Germany) or for longer periods in police remand houses.

The conditions were not considered to be acceptable in police stations (England and Wales, Italy and Germany). Conditions in police remand houses, where detainees in some countries can be kept for up to nine months, were considered to be very poor and lacking in health care, services for drug users, overcrowded, unhygienic, in need of refurbishment and lacking facilities for exercise. Former detainees who had experienced police remand houses all said that they were glad when they were transferred to prison as the conditions and services improved dramatically compared to the police remand houses.

In some instances, the poor conditions in police detention were due to structural constraints (old buildings; listed buildings; lack of finance). Within countries there is a great deal of variation in the conditions in police establishments.

Treatment of detainees

In general interviewees in the sample countries felt that there was no difference in the treatment of those with problematic drug and or alcohol use, rather respondents suggested that all those arrested were treated as criminals. However, it is important to explore this view as problematic drug users are vulnerable at the point of arrest, often requiring drug services. Other groups are also vulnerable such as young people, foreign nationals and those with mental-health problems and with different cultural needs (e.g. the Roma community).

In the majority of the participating countries a lack of knowledge about those with problematic drug use led to negative attitudes towards them from the police. Detainees from most of the participating countries said that the police exploited them while they were withdrawing from drugs in order to secure confessions or to get information.

Physical violence towards detainees, though mentioned by some detainees, was on the whole considered to have significantly decreased in all of the participating countries.

Younger police officers were identified as having more sympathetic and positive attitudes towards those with problematic drug use.

The emphasis on strategies and policies regarding problematic drug use was identified as problematic as they tended to deflect attention away from other vulnerable groups such as those with mental-health problems, those with problematic alcohol use, foreign nationals, Roma and young drug users (under 18 years).

Access to drug and alcohol treatment

The availability of drug services for detainees with problematic drug or alcohol use is variable in the police forces included in this study.

Withdrawal

Doctors from the emergency service in some participating countries (Bulgaria, Italy, Lithuania, Hungary) are used in the assessment of both drug addiction and alcoholism and for providing help with withdrawal. The doctors from the emergency service administer pain killers or tranquillisers as necessary for detainees with problematic drug use. The Forensic Medical Service (England and Wales, Germany) provide assistance with withdrawal for detainees. In Estonia, felchers give drug users pills for withdrawal to reduce the pain. In Romania, the police use the prison hospital in Bucharest to provide help with withdrawal for some detainees.

However, detainees from most of the participating countries complained that often they received no help with withdrawal while in police custody.

Methadone

Methadone was available to some degree in the community in all of the participating countries. Only in England and Wales and Germany (if the detainee provides their own supply) was methadone available in police custody (but not in all police stations). Detainees who are on the methadone programme in the community with ID cards can have their methadone brought to the police station by their families in Bulgaria and this also used to be possible in Estonia. In Italy, in Rome, an NGO visits detainees with problematic drug use and will provide methadone.

In the majority of the participating countries, the general experience of those detainees who are on a methadone programme in the community, is disruption of their methadone when they are arrested due to the lack of liaison between community, police and prisons, which exacerbated by prisons and the police usually being under different Ministries.

Alcohol

Detainees with problematic alcohol use was identified as a key problem as there were a lack of services for alcoholism both in police detention and in the community. A key finding in Germany was the practice of using police detention for sobering up with respect to users of alcohol. Alcohol users were also identified to be the ones most likely to have psychiatric problems in most of the participating countries.

Access to healthcare

Access to health care was on the whole less available in police detention than in the prison systems of the sample countries.

The availability of health care was worse in those countries where the police had arrest houses (detention centres) under the control of the Ministry of the Interior than those where detainees went directly to pre-sentence prisons under the control of the Ministry of Justice.

There were various models of health care provision for detainees in police custody such as a dedicated forensic service (England and Wales, Germany); provision by the Ministry of Health (Lithuania and Hungary); reliance on emergency service at police stations (Italy, Estonia, Bulgaria) and provision by the Ministry of Interior (Romania). In the police remand houses health care is provided by felchers[1] (Bulgaria; Estonia) and normally treatment is not offered.

A lack of consistent provision in all police stations and in remand houses was raised in the participating countries, in particular concerning the difference in health care provision in urban and rural settings.

Lack of detainee confidentiality was raised as an issue in some of the participating countries due to a guard being present during the consultation between the detainee and the doctor, confidentiality being compromised due to a lack of facilities and a lack of training resulting in police officers feeling they needed to know a detainee's HIV or hepatitis status.

Harm reduction

Generally, police officers in most of the participating countries did not see the provision of harm reduction measures as an important part of their role. They felt it was something users could access in the community or in prisons.

Harm reduction was much more likely to be offered in relation to occupational safety for officers than in services for detainees with problematic drug or alcohol use.

The initiatives developed to address the need of problematic drug and alcohol users in police detention demonstrated the partnership between the police and community healthcare or NGOs providing treatment services. The majority of more innovative approaches to address the needs of problematic drug and alcohol users in police detention came from NGOs working in partnership with the police (for example, Villa Maraini in Italy) or providing services in the

1 A felcher is a paramedic with 3 years of training. They are able to prescribe some medicine governed by a series of restrictions.

community and promoting harm reduction (for example, the 'I Can Live' organisation and Open Society Fund in Lithuania).

Harm reduction training was provided for the police in a few of the participating countries. In most of the countries police officers were aware of how to search a detainee safely and how to use protective gloves. However, protective gloves were not always available to police officers in all of the participating countries. The need for more training for police officers on harm reduction was highlighted in all of the participating countries.

Interviewees from the police in most of the countries were on the whole positive about harm reduction both for their own practice and in provision for detainees but some police did not see harm reduction as part of their role. A key point made by a representative from a Human Rights NGO as an explanation for the lack of harm reduction provision both in the community and police detention was that due to the exclusion of harm reduction strategies in legal codes, they were seen as part of the remit of healthcare agencies or NGOs.

Provision of information or referral to drug or alcohol treatment services were generally accepted but not necessarily seen as the role of the police. A key finding was that internal documents for the police about harm reduction should be put in the form of a well-written leaflet rather than just in official communications (as these tend to be looked at quickly and then ignored).

Initiatives like needle replacement and substitution treatment were generally not accepted by the police officers interviewed.

Other members of the criminal justice system such as lawyers, prosecutors and magistrates were unlikely to have had any training about harm reduction.

Lack of joined up approach across the criminal justice system

During the course of the research a variety of service providers and service users were interviewed. A key theme that emerged was that there was often a lack of co-ordination and/or co-operation between different criminal justice agencies, government organisations and non-government organisations. This lack of a joined-up approach often reduced the potential impact that services could make on the lives of those with problematic drug or alcohol use.

The participating countries were at different stages of partnership working with a range of agencies to meet the needs of detainees with problematic drug or alcohol use. On the whole those interviewed thought that working in partnership and sharing best practice was the only way to respond to problematic drug and alcohol use.

Partnership, where it did exist, was not always easy to manage and problems were identified by responds both amongst police officers and service providers. In order for partnership to be successful there need to be well-developed social services and NGOs in the community.

The research has highlighted some good examples of partnership such as arrest referral workers in England, Villa Maraini in Italy and the case-management approach of problematic drug users in Romania.

Good practice and gaps in provision

In the participating countries a range of good practice was identified in the provision of services and treatment for those with problematic drug and alcohol use. Some examples of good practice are:

- the practice in the methadone treatment programme to provide withdrawal for clients before they go to prison (Bulgaria);
- arrest referral workers who provide information to detainees on treatment for problematic drug use and custody nurses who provide health care (England and Wales);
- provision of HIV medication to prisoners when they are transferred back to police arrest houses from prison for court appearances (Estonia);
- the development of detention facilities specifically for those with problematic alcohol use in some German cities;
- confidentiality of detainees' medical records as accessed by healthcare staff only (Hungary) as police officers only have access to general information such as gender, or if the detainee has used drugs;
- Villa Maraini, which is the only NGO in Italy able to prescribe methadone and which works in all of Rome's police stations although this is not underpinned by any protocol or agreement;
- that major cities in Lithuania have methadone maintenance programmes and centres and day-care facilities to help dependent users and many projects carried out by NGOs have received government support;
- that in future in Romania, according to ANA (Anti Drugs Agency) there will be no gaps between community, police detention and prison as methadone programmes will operate in all detention sites. All people with problematic drug use who are on a methadone programme will be recorded by ANA and if they are arrested then the ANA centre will manage their methadone substitution during their detention.

The gaps in provision for problematic drug and alcohol users in the participating countries bore some similarities:

- a lack of support for detainees during withdrawal was raised in most countries;

- poor condition of police cells and arrest houses;
- a poor understanding of harm reduction amongst police officers and a lack of training for police officers on drugs, basic health care and harm reduction;
- a lack of harm reduction information or services provided for detainees;
- methadone maintenance not generally being available in police detention;
- a lack of needle replacement schemes to replace injecting equipment removed during arrest when detainees are released;
- a lack of partnership with community drug agencies (governmental and non-governmental) and other criminal justice agencies (prisons, probation);
- other members of the criminal justice system such as lawyers, prosecutors and magistrates were unlikely to have had any training about harm reduction;
- a lack of alternatives to custodial sentences for those with problematic drug and alcohol use;
- the emphasis on strategies and policies regarding problematic drug use was identified as problematic as they tended to deflect attention away from other vulnerable groups such as those with mental health problems, those with problematic alcohol use, foreign nationals, Roma and young (under 18 years) problematic drug users;
- a lack of confidentiality for detainees' medical records while in police custody;
- in some countries, a lack of well developed social services and NGOs in the community for the police to refer those with problematic drug or alcohol use to.

Conclusion

This research has highlighted the needs of those with problematic drug and alcohol use in police detention and identified examples of best practice and gaps in provision of services for those with problematic drug or alcohol use.

The criminal justice system contributes much to the everyday lives of those with problematic drug and or alcohol use living at or beyond the margins of legality: from police practices on the streets, the operation of the courts and the conditions of police cells and arrest houses and prisons. This research focused mainly on the experiences of detainees at the point of arrest and during detention in police houses. There is a need for greater attention to police practice in their response to problematic drug users in the provision of drug services, harm reduction and health care. It is argued that the police and their practices are an important link between the initiatives in place for drug users and public health in the community and to some degree in prisons. The police

also have a role in reducing the spread of communicable disease and harm reduction among IDUs and for referring drug users to treatment interventions.

Drug policy

The existing drug strategies in the participating countries were considered to have positive and negative elements. Some of the positive elements were a focus on harm minimisation aiming to improve the basic health of those with problematic drug use and attracting them into treatment. However, engaging drug users with harm reduction is still very much seen as a route into treatment and abstinence from drug use (Hungary, England and Wales). In addition, in some of the participating countries the drug strategy was positive in encouraging a multidisciplinary, multifactor, integrated and comprehensive approach to drug users that aimed to improve the quality of the programmes (Romania) and to provide more services for those with problematic drug use in the community (Estonia).

The problems with the drug policy in the participating countries was discussed by interviewees who raised issues such as the lack of distinction between drug users and drug dealers (Bulgaria and Italy), the focus on prevention at the expense of harm reduction, that the law did not distinguish between the type of drug used (Italy, Romania, Bulgaria) that impacted on the provision of services for those with problematic drug or alcohol use.

Even when harm reduction is stressed as an important element and emphasised in the drug strategy, it is still difficult to implement, often due to a lack of resources and negative attitudes towards those with problematic drug and/or alcohol use.

In some countries, the theory behind the drug strategy was considered to be very good, but its implementation was problematic as many of the goals and targets were not being met (Hungary) or the focus on drugs led to gaps in provision for those with problematic alcohol use (England and Wales). The national drug policy may not be implemented in the same way in the individual states (e.g. Germany) within a country where the departments responsible for drug strategy create their own programmes and policies for drug users. The policies in each state can be very different from each other and are not always in complete harmony and, in addition, not all city-level initiatives have state-level support.

General comparison with prison

A lot of work has been and is currently being done in the prison systems of Europe to provide drug services and harm reduction for those with problematic drug use. The police are lagging behind: many detainees interviewed stated that

they were glad to leave police detention and get to prison where they were offered better facilities and services for problematic drug use.

Issues like throughcare are being tackled by many prison services. Seamless care for those with problematic drug use requires cooperation between community drug agencies, prisons and the police. Currently, the gap in the provision of drug services is during arrest and in police arrest houses. Many prisons, for example, offer substitution treatment or are considering the implementation of substitution treatment in the near future.

Providing continuing care requires multi-agency partnerships and a commitment to do it and as the research has shown there is often a major difference between the attitudes towards harm reduction initiatives, such as needle exchange provision and methadone treatment, in the community and among the police (and to a lesser degree prison administrations). In the participating countries it was rare to find a police service that considered the provision of drug services and treatment for those with problematic drug or alcohol use as being a key part of their job.

Culture change and training

There is a need for a culture change amongst some police officers to one where treatment and healthcare are also seen as part of the role of police and to reduce negative attitudes towards detainees with problematic drug or alcohol use. This can only be achieved by education and training. To some extent training that involves professionals from different agencies, both government and non-governmental, can impact positively on negative organisational cultures and encourage a change in attitudes. The appropriate training:

> can make great advances for harm reduction – when talking to the police it is important to educate them about HIV, about drug use, about their own professional safety, and showing them the human face of drug use. Many police simply regard a drug user as a criminal. We should ask the police for help, but we should also show them that it is an equal exchange and that we can provide them with valuable knowledge in return (IHRD 2004, 22).

Many detainees reported that there were occasions when they would be detained for more than the standard 24–48 hours. This may be due to being kept in detention over the weekend when courts were closed, or for a variety of reasons of which they were not always informed. Particular problems were highlighted in Lithuania, where detainees were often kept in detention for up to ten days without being charged. In England, instances of being kept in detention for five days or more were reported as a result of prisons using police cells to cope with overcrowding.

In all of the participating countries, examples of exploitation of detainees by police officers were reported. They claimed that police officers recognised when problematic drug and alcohol users were most vulnerable during withdrawal and would use this time to coerce them to confess or pass on information about dealers.

The conditions of police detention were described by many detainees as unhygienic, with lack of space and with no provisions for maintaining their personal hygiene. In England, one detainee stated:

> It's horrible, there was no mattress, I couldn't have a shower not even before court…something needs to be done about that.

Although detention in police custody can be for a relatively short period in police stations it can last for much longer in those countries where there are arrest houses usually under the Ministry of the Interior. The conditions in police detention can have a negative impact on detainees' health, drug treatment or harm reduction initiatives started in the community and breach human rights.

In England, particular problems were highlighted when detainees were transferred to court detention cells, often for a whole day, with up to six people sharing a small cell with benches, whilst waiting for their case.

Detainees who were interviewed in all of the participating countries emphasised the need for improvements to both the condition of detention and in relation to how they were treated by the police. Specifically, they stated that the most important measures that would improve their situation would be medical care when you need it, i.e., pain relief or methadone, clean clothes, better food, a private toilet and showers, and an exercise yard. Many also felt the attitudes of officers towards detainees' with problematic drug and/or alcohol use were generally more negative than towards other detainees.

Vulnerable detainees and human rights

In all the participating countries, certain groups among problematic drug and alcohol users were identified as presenting particular problems, for example, those with mental-health problems and foreign nationals or 'non-citizens' who are not eligible for state healthcare. In England, problems arose when mental healthcare providers refused clients who used drugs or alcohol, and drug-treatment agencies were often ill-equipped to deal with users who also had mental-health problems. Young people (i.e., under 18 years), although they had different (and usually better) conditions at the point of arrest in the majority of participating countries, were also often excluded from referral services, as community treatment services for young people were limited (England and Wales). Initiatives such as arrest referral workers in England were considered to overcome concerns about certain groups being excluded as detainees do not have to test positive for drugs or alcohol, nor do they have to commit a specific

offences to take up this service. However, both police officers and arrest referral workers felt there was still a general lack of resources in the community to address the needs of problematic drug and alcohol users from diverse groups.

The research has shown that detainees' human rights are often overlooked in matters relating to problematic drug and alcohol use. The Universal Declaration of Human Rights provides for the right of everyone to have the highest attainable standard of physical and mental health. These conventions also provide the legal basis for 'states to respect, protect and fulfil, equitably and in a non-discriminatory manner, all injecting drug users' human rights.' This includes comprehensive harm reduction programmes along with providing treatment, care and support, including anti-retroviral therapy for HIV-positive drug users as necessary (International Federation of Red Cross and Red Crescent Societies 2004, 24).

The police need to be aware that their need to progress the investigation of an offence must be balanced against the need to respect the detainees' human rights and not cause harm and distress to them. By causing harm and distress, police officers may find their methods are counter-productive and could lead to complaints (Kothari et al. 2002). Many detainees in this study reported examples of exploitation by officers whose primary goal was to proceed with the investigation of their case, and who would take advantage of users' vulnerable state during withdrawal.

The use of emetics (medication to induce vomiting) in Germany, for example, presents clear breaches of human rights, as identified by Amnesty International and the World Socialist Website. At the time of the research concerns were raised about the use of emetics in some German police forces. This strategy is targeted at those detainees suspected of transporting drugs inside their body, in order to enable officers to proceed with their investigation by getting the drugs out. In other countries, police officers monitor such cases to look for signs of drugs escaping into the body, and simply wait for detainees to expel the drug through natural means. The use of, and the concerns about, emetics raises serious issues around human rights and has led to several fatalities. As a result, this practice has now stopped in most of the German 'Länder'.

Access to drug and alcohol treatment

Access to drug and alcohol services and treatment for police detainees was on the whole limited. A key need for detainees with problematic drug and alcohol use was help during withdrawal and to continue with their methadone programme. The help available to most detainees during withdrawal in the participating countries was limited to tranquilizers and pain killers with methadone being available only to detainees in Germany and England and Wales. Detainees who are on the methadone programme in the community with ID cards (to identify their participation in the programme) can have their

methadone brought to the police station by their families in Bulgaria and this also used to be possible in Estonia. One project run by the Red Cross in Rome demonstrated that it was possible to provide professional help to problematic drug users in police custody (methadone treatment) that was beneficial to both the detainees and to the police. A common reason given by police in the participating countries for not providing drug services was a lack of resources and in some cases, particularly in the arrest houses, a lack of medical staff or reliance on the emergency health service or lack of relationship with community drug service providers. The reality for most of the detainees interviewed who were on a methadone programme in the community was that during their time in police custody their programme was disrupted.

Detainees with problematic alcohol use were identified as a key problem as there was a lack of services for problematic alcohol use both in police detention and in the community. A key finding in Germany was the practice of using police detention for sobering up with respect to users of alcohol. Alcohol users were often identified to be the ones who were homeless and with psychiatric problems as well. Key issues that were raised in Germany were that the criteria for releasing or transferring those with problematic alcohol use were not clear and that there were no well-defined approaches about dealing with those who had both problematic drug and alcohol use. The emphasis on strategies and policies regarding problematic drug use was identified as problematic as they tended to deflect attention away from other vulnerable groups such as those with mental health problems, those with problematic alcohol use, foreign nationals, Roma and young drug users (under 18 years). In addition, a lack of treatment facilities for problematic alcohol users in the community, despite the numerous and widespread harms caused by alcohol, meant that detainees were released from custody with nowhere to go for support. This is particularly important as often drug users will use alcohol as a substitute, and will need additional support because of this.

In England and Wales there was an emphasis on addressing the needs of problematic drug users at the point of arrest. Generally, among police officers in England, the point of arrest was seen as a prime opportunity to address the needs of problematic drug and alcohol users. It was viewed as part of the 'journey' of treatment, a starting point where users can begin to address their problems. The remit of the police was described by one officer as being to address the cause of the offending and look beyond investigative and legal procedures and follow up enforcement with treatment, or to make the episode of arrest a much richer event.

This was not a view that was shared by police officers interviewed in the other participating countries. Many police officers did not expect to provide treatment, (for example, pain relief or substitution treatment). Ministerial representatives in Italy emphasised that the main role of the police is the enforcement of the law and not referral to treatment or treatment provision. Officers primarily viewed their role as one of law enforcement, and felt the healthcare needs of detainees were met by doctors or nurses called to the

station, or through community or prison provision, which users would access on release or transfer from police custody. There were no protocols to implement referrals to treatment services for detainees and any such service would be dependent on the officers' discretion and knowledge of local services. Clear protocols for service provision with other agencies is important as these take the personality out of the decision making and help to overcome the loss of expertise and experience when personnel change and prolong organisational memory of good practice. In addition, these protocols need to be embedded in the structure of the police, laying out the agreements and with clear directives.

A key point that was raised by police officers and magistracy staff in England and Wales was a major difficulty associated with the treatment of problematic drug and alcohol users as being delays in court appearances, leading to delays in treatment provisions via criminal justice sentences. Concerns were raised by other criminal justice and healthcare participants in England about the feasibility of treatment through the criminal justice system. Users engaged in treatment through court orders can suffer more serious consequences (i.e., more severe sentences) if they experience a relapse compared to others accessing treatment through health services alone. In addition, the use of Anti-Social Behaviour Orders (ASBOs) in England, often leads to users being banned from city centres, which impacts on their access to treatment services.

Police officers in some of the participating countries held negative attitudes towards detainees with problematic drug or alcohol use, such as, a perception that drug users do not want to be treated (which is not true as a large proportion do); that drug users do not need treatment; and that when given treatment it is not effective. Views such as these need to be challenged in order to engage the police in playing a wider role in referral to treatment or in providing drug services for detainees with problematic drug or alcohol use especially in a situation where locking up those with drug or alcohol problems is not an effective response.

Health care

Detainees interviewed in the participating countries felt there was a lack of healthcare provision in police detention, in that often their requests were ignored and the medical staff would take a long time to get to them.

Medical care in police detention is regularly perceived as a subject of low importance with police detention often being seen as a period of transition that requires emergency care. For more general healthcare needs, police officers and other staff working in police stations in all the participating countries reported that detainees were able to access healthcare when they needed it. Some problems were identified by police officers when they had to detain prisoners when community healthcare, such as the Services for the Drug Addiction (SERT) (in Italy) was unavailable, for example over the weekend.

Who provides health care for police detainees is variable both within a country and between the participating countries. The medical care provided in police arrest houses was generally limited and not comparable to either that in the community or in prisons. The standard of health care available in police cells is inconsistent with inadequate training in relation to drugs, alcohol and mental health amongst police officers who have the responsibility for the care of detainees. There is a clear need for training about health care for police officers as without it they are less likely to be able to assess whether a detainee is intoxicated or to identify illness that may be masked by alcohol. The provision of medical care in police cells may be constrained by a lack of suitable consultation rooms, equipment and resources.

Healthcare in custody should be equal to that in the community and this needs to be rigorously enforced during the period of detention both in police cells and arrest houses. Some minimal level of qualified medical care should be accessible in police custody to enable the assessment of the risk that detainees pose to themselves, to identify those who need to be transferred to hospital and to provide regular medical care such as that provided by custody nurses in some police forces in England and Wales. Such initiatives like custody nurses were rare in the participating countries, more frequently there was a reliance on emergency services, or a doctor would be called for from the forensic medical service. A priority should be to provide officers with training in basic first-aid, in dealing with drug and alcohol addiction and mental health matters so that they are in a good position to know when they need to call for medical services. Training should not be a one-off event but be regularly updated.

The condition of police cells and police arrest houses and the available facilities raises the question whether they are suitable places to detain those with acute healthcare needs, mental-health problems and addiction. In Germany, there are special police detention facilities for those with alcohol problems where detainees could be more closely monitored. However, detainees interviewed who had experienced these centres were critical of the care they had received whilst there, which compared less favourably to the treatment they had received in the community hospital. The Police Complaints Agency (PCA) report in England and Wales concluded that:

> the police service is simply not equipped to deal with the complexity of extreme alcohol intoxication, and does not have the systems in place to offer adequate care to this population. Unless there are vast improvements in custody staff training, detainee risk assessment, the extent and quality of medical support and organisations' commitments to effective detainee management, there is no alternative but to conclude that drunken detainees should not be taken to police stations in other than the most extreme circumstances (Joint Committee On Human Rights 2005).

These conclusions from the England and Wales report are also relevant to the situation found in police detention in the participating countries.

Improving health care in police detention is important in itself and usually necessary to meet basic human rights requirements of detainees. Reforming the provision of health care can be a useful way of introducing wider reforms. Living conditions in police detention may be an abuse of human rights in themselves due to the shortage of space, air, light, ability to exercise and nutritious food. The conditions in police detention may be harmful to health so that change can be justified on health grounds even when the human rights argument might be less politically acceptable.

A key component in improving healthcare for detainees is education and staff training on health risks and infections. Some of the police officers interviewed were ignorant about transmission of infections and especially about the transmission of HIV. Although some officers in some of the countries had some training about occupational health they did not always have access to such things as protective gloves to use during searching.

Confidentiality of detainees' health status

The lack of training that police officers had about infectious diseases led in some cases to a breach of detainees' confidentiality where officers felt that they had a right to know of detainees' HIV status, or record books where such details were kept were accessible to a wide number of people. A balance is required where detainees are asked to declare any health problems in order for their welfare needs to be met while at the same time their right to confidentiality is respected. Police officers saw disclosure of health problems as necessary to ensure the health and safety of anyone coming into contact with detainees, so they would make sure colleagues were aware of the need for caution, without necessarily declaring the specific nature of the detainees' illness. However, among other staff who come into contact with detainees (magistrates, arrest referral workers) this was not considered necessary as all detainees should be treated with caution, thus police officers did not need to know specific details about detainees' health to protect themselves.

The lack of healthcare and treatment for detainees raises concerns about public health, in much the same way as the need for such provisions in prison (MacDonald 2005). Those with problematic drug and alcohol use who do not receive treatment or referral to treatment and are released in the community, are vulnerable. Without harm reduction measures, they are at risk of overdosing and contracting and spreading infectious diseases, and without substitution treatment or detoxification, they are likely to re-offend in order to continue using drugs and/or alcohol. There are clear implications for health services when considering injecting drug users, as they are more likely to be responsible for the spread of infectious diseases (HIV/AIDS, hepatitis, tuberculosis) and numerous studies have highlighted the growing problem of this spread among incarcerated populations (MacDonald 2001, 2005; Hammett et al. 1999). The detainees interviewed in this study reported specific problems

with time in police detention disrupting their treatment or access to harm reduction services, putting themselves and others at greater risk.

Harm reduction

The use of harm reduction measures in police detention is variable, both within and across all the participating countries, and yet, where it is available, there has been a willingness to adopt such measures and recognition of their effectiveness. The roles of the police and health professionals based in police detention centres are key in implementing such strategies. However, for many countries, the need for a shift from more punitive and coercive strategies is required in order to enable such policies to develop and be implemented effectively. Examples of best practice came primarily from community providers and NGOs, which are more experienced and open to using harm reduction techniques to minimise the health risks and other harms associated with problematic drug and alcohol use. However, such services are limited and in some cases non-existent, in some of the participating countries, especially in rural areas.

Generally, among police officers in all the participating countries, providing harm reduction measures was not seen as an important part of their role, and was something they considered that detainees with problematic drug use could access in the community, or in prisons. A key point made by a representative from a human rights NGO as an explanation for the lack of harm reduction provision both in the community and in police detention was due to the exclusion of harm reduction strategies in legal codes, that they were seen as part of the remit of healthcare agencies or NGOs.

Many police officers interviewed did not understand the importance of harm reduction measures and this highlighted the need for further training. The lack of understanding about such measures was emphasised by detainees who confirmed that officers in England would often remove clean injecting equipment from detainees and destroy it. For some detainees, when they were released back into the community, this resulted in sharing needles with others, if they could not access needle-exchange services in the community.

Police officers interviewed reported that harm reduction measures were seen as useful, as far as giving out leaflets and advice were concerned, but more practical measures such as providing condoms and clean needles were seen as unnecessary and potentially risky within the confines of police custody. Many felt that users knew more about the availability of clean needle provision or needle exchange programmes in the community than police officers and were well informed as to where to go. However, this was contradicted by one officer who felt that embracing the treatment agenda necessitated a more open mind to using innovative methods such as needle exchange programmes, particularly for more rural areas where such provisions are not readily accessible in the community.

Some magistracy staff, prosecutors, arrest referral and NGO staff thought that practical harm reduction measures should be available in police detention.

Securing committed and enduring support from important stakeholders, both in the community and in police detention, is crucial for harm reduction programmes that want to become established and sustainable. Police, politicians, public-health officials, doctors, lawyers and journalists play key roles in either hindering or promoting harm reduction programmes. A key task for harm reduction projects is to educate various stakeholder groups about the importance of harm reduction. In many countries harm reduction is still a new and controversial philosophy and a range of methods need to be used to convince stakeholders about the necessity and effectiveness of harm reduction measures. One such method that has been found to be effective in gaining stakeholder support is study tours, as abstract discussions and lectures have been found to be unlikely to convince stakeholders that harm reduction is an effective way to reduce HIV infection rates and improve occupational safety.

Lack of joined-up approach across the criminal justice system

Many criminal justice policy directives encourage organisations to work in partnership rather than in competition, which has led to a plethora of partnership groups dealing with a wide variety of issues particularly in England and Wales. In the participating countries where the police were working in partnership with other agencies this was considered to be a good thing. As mentioned previously the provision of health care in police detention can be very limited. The provision of health care is an area where partnership working with either the National Health Service or the prison health service would be beneficial. There tended to be very few links between prison health care and police detention health care. The reason given for this was that the police and prisons are usually under different ministries and subject to different budgetary constraints.

The lack of a joined-up approach across criminal justice agencies can have a detrimental effect on the healthcare or treatment programmes of those with problematic drug and alcohol use. Detainees who are on a methadone programme in the community are unlikely to be able to continue their methadone at the point of arrest but they may be able to continue their methadone in prison. However, by the time they have reached prison they may well have experienced a break in their programme. A lack of co-operation between the police and community drug agencies may result in detainees being released at times when they are unable to access clean needles or methadone. This can lead to detainees who find themselves in this situation sharing needles.

Working in partnership was not considered to be easy but respondents felt that when it worked it was of mutual benefit to the police and the community agency or prison. The process of establishing partnerships needs time to develop good relationships to be ready to deal with some of the more difficult issues that often come up, for example whether everyone has equal rights in decision making at multi-agency meetings. Concerns were raised about the lack of training for organisations in engaging in multi-agency working, and, among police officers, it was felt other agencies in one country expected the police to take the lead with initiatives and addressing local problems. A police officer in England and Wales said that:

> there are tensions sometimes in custody suites with multi-agency working and this can cause some frustration. There is very limited multi-agency working training and also there is the problem of who is going to deliver it and pay for it. It is not only resource issues that impede training but taking drugs workers off line to attend training when in a situation that is already under-resourced is not easy. Normally police work to performance indicators but in this area there are none but introduction of them would help.

Even when partnerships are in place problems dealing with those with problematic drug and alcohol use can arise in the evenings and at weekends when for example arrest referral workers in England and Wales are not working. However, in England and Wales and in Italy the police said that they appreciated the drug agencies who worked with them as they managed to calm the drug users down and made their life easier.

There were inconsistent responses among police officers interviewed in the participating countries in relation to the point of arrest being a realistic opportunity to address problematic drug and alcohol users' needs. A key issue was the lack of understanding that some demonstrated about harm reduction techniques and treatment provisions, and others, who felt that such strategies were not part of their role. This was reflected very much in the experience of detainees, many of whom reported on the lack of basic healthcare and services for those with problematic drug and alcohol use, and also identified negative attitudes and exploitation from police officers. The lack of facilities and treatment provision can be attributed to inadequate resources, but there were also cases where such resources do exist and where detainees reported receiving little or no assistance on request. Different views were expressed by other criminal justice staff and NGO representatives who emphasised the need for the police to engage with harm reduction measures, as they are a key contact point for many problematic drug and alcohol users and to establish stronger links with NGOs and other government agencies.

It is necessary to establish what works in what situations, to look beyond national policy at implementation of strategies and to bring together examples of best practice and identify where problems still exist. The study indicates both similarities and differences in the police response to problematic drug and

alcohol users across the participating countries. Differences in national approaches to the problem may be dependent on the extent of the problem, the resources available, cultural attitudes among the police and public and also historical and political changes occurring throughout the EU.

Recommendations

This research has identified a range of good practice in meeting the needs of detainees while in police custody but it has also shown a number of gaps in provision for detainees with problematic drug use. It is hoped that the following recommendations will promote discussion and change where appropriate in current practice.

Drug policy

The drug policy in the participating countries was considered to have both strengths and weaknesses and there were some problems with the implementation of some initiatives. National drug policy, to be effective, needs to distinguish between the type of drug used and reflect this in the criminal justice response to drug users and to stress the need for harm reduction and the development of programmes for those with problematic drug and alcohol use. It is recommended that:

- legislative and policy reforms be pursued to change criminal law and penalties with the objective of reducing the criminalisation of personal drug use and significantly reducing the use of arrest and imprisonment for drug users who are not involved with violence;
- the police in discussion with drug agencies in the community (NGO and Governmental) develop practice guidelines, for example providing harm reduction information to detainees;
- National Police Authorities should commission the development of guidelines for the management of those with problematic drug or alcohol use in police detention. Guidelines should include supportive care, harm reduction and treatment;
- links be established with prisons by the police to ensure continuity of treatment for those with problematic drug and or alcohol use while in police detention.

Staff and training

There is a need for a culture change amongst some police officers to one where harm reduction, treatment and healthcare are also seen as part of the role of the police and to reduce negative attitudes towards detainees with problematic drug or alcohol use. It is recommended that:

- police officers receive training so that they understand the human rights of problematic drug users and do not use the time of withdrawal to coerce them to confess or pass on information about dealers;
- regular staff training is provided to facilitate culture change amongst some police officers to one where treatment and healthcare are also seen as part of the role of police and to reduce negative attitudes towards detainees with problematic drug and/or alcohol use;
- police officers, as part of their training, gain sufficient awareness of the symptoms of key conditions, involving addiction (drugs and alcohol) and health conditions, and to be able to conduct risk assessments of detainees in their charge;
- regular update training is provided.

Access to drug and alcohol treatment

The reality for most of the detainees interviewed who were on a methadone programme in the community was that during their time in police custody their programme was disrupted. Detainees were also unlikely to receive harm reduction information or referral to treatment options. Maintenance programmes for opioid dependent prisoners are considered to be successful interventions with a positive impact on the health status of those in the community and during imprisonment. It is recommended that:

- maintenance therapy should be available during police detention to avoid detainees experiencing a gap in their treatment;
- relationship with community drug-service providers be created and developed;
- protocols to implement referrals to treatment services for detainees be established;
- training is provided that challenges the view that drug users don't want to be treated, don't need treatment and that when given treatment it is not effective.

Health care

The principle of equivalence means that health care interventions that are available in the community should be available to those in police detention. Detainees are entitled, without discrimination, to a standard of health care equivalent to that available in the community including prevention measures. However, the principle of equivalence is not being met in police detention, particularly in the areas of general health care and drug services. It is recommended that:

- police forces should guarantee the confidentiality of detainees' medical information and that it should not be shared with others without the

detainee's consent except in exceptional circumstances that are clearly defined and explained to the detainee;
- healthcare in custody should be equal to that in the community and this needs to be rigorously enforced during the period of detention both in police cells and arrest houses;
- training in relation to drugs, alcohol and mental health is increased amongst police officers who have the responsibility for the care of detainees;
- training about health care for police officers is provided so they are more likely to be able to assess whether a detainee is intoxicated or to identify illness that may be masked by alcohol.

Harm reduction

The use of harm reduction measures in police detention is variable, both within and across all the participating countries, and yet, where it is available, there has been a willingness to adopt such measures and recognition of their effectiveness. It is recommended that:

- harm reduction strategies be included in legal codes;
- consideration be given to implementing needle-replacement schemes in police stations;
- needle-exchange programmes be considered in police arrest houses;
- to promote acceptance of harm reduction methods by police officers' joint training events, study tours and site visits, conferences and communications materials and other literature be used.

Promoting a joined-up approach across the criminal justice system

Many criminal justice policy directives encourage organisations to work in partnership rather than in competition and in the participating countries where the police were working in partnership with other agencies this was considered to be a good thing. It is recommended that:

- national and local governments should allocate NGOs with sufficient funding to play an integrated and effective role in provision of drug services for detainees;
- training for organisations in engaging in multi-agency working be provided;
- links between prison health care and police detention health care be explored both at the operational and Ministerial level.

Introduction

In May 2004, ten countries joined the European Union (EU), bringing changes to policy affecting a wide range of issues, such as the economy, law and healthcare. In Eastern Europe there is already a sense of more explicit challenges to legal authorities (Mawby 1996), and, more generally, a greater sense of transparency regarding the extent of crime and the response to it. Previous studies comparing the way in which the criminal justice system works in different countries have focussed largely on victims' experience of crime and policing (Mawby 1996); official reports on specific cases of breaches of the Human Rights Act (1998), CPT Reports; the treatment of prisoners with drug/alcohol addiction (MacDonald 2001, 2004; MacDonald et al. 2006) and the performance of the police (Van den Broeck 2002; Holmberg 2002).

Over the last two decades the amount of drug use has substantially increased and with this, increasing numbers find themselves in police detention:

> most of these detainees are vulnerable individuals and the recognition of their substance misuse problem is now perceived [in the UK] as important and is receiving local and national attention. Accurate assessment of substance-misuse-associated morbidities, including the degree and severity of dependence, and of the need for medical intervention, is essential, because both intoxication and withdrawal can put detainees at risk of medical, psychiatric and even legal complications (Association of Forensic Physicians 2006:ii).

Despite the expanding illicit drug industry and advances in law enforcement which have led to an increase in the proportion of problematic drug and alcohol users becoming entangled in the criminal justice systems throughout Europe, there is still little research in police detention (Van Horne and Farrell 1999), specifically in considering police forces' response to the problem and the treatment of detainees with problematic drug and alcohol use in police detention (MacDonald 2004).

Research has been described as one of the 'four pillars' contributing to achieving effective policing, along with co-operation, education and training (Pagon 1996). It requires assistance and transparency from the police, and also an exploration of citizens' experience of policing, in order to discover the reality beyond the rhetoric. There are numerous differences in approach for police forces throughout the EU and even within countries, depending on the resources available to them, the type of offence and offender they are dealing with and the management style and organisational culture within the police. Despite these differences, inter-country and inter-agency communication is vital, at a global and local level to begin to fight some of the greatest threats that exist today, namely terrorism, organised crime, cyber crime, human trafficking and drug trafficking and the growing number of people with problematic drug use (Bottoms and Wiles 1996).

Official statistics have shown an increase in the number of people with problematic drug and alcohol use across Europe and in Central and Eastern Europe, recreational use and experimentation are becoming an integral part of youth culture. People with problematic drug and alcohol use represent a small minority of the whole population, however, this sort of use is responsible for the vast majority of associated harm in personal, economic and social costs. This includes health risks (exposure to infectious diseases and death) and addiction, which often leads to criminal behaviour and subsequently, arrest and detention by the police and potentially, a custodial sentence (EMCDDA[2] 2002). The way in which such offenders are dealt with in each of the EU member states varies in the length of time they may be detained without charge and the provision of services to deal with problems that arise. Harm reduction techniques at the point of arrest and detention can lessen the impact on individual and community health, by preventing the spread of infectious diseases (e.g. through needle-exchange programmes). Early interventions at the point of detention by the police have already been employed in England and Wales to reduce the negative consequences associated with binge drinking, which can include health problems for the individual concerned, along with violent behaviour and costs to the police, health service and the workplace. They attempt to control drinking and offending behaviour through brief motivational interventions, which differ from the sort of services heavy and dependent drinkers may require, where the goal required is complete abstinence (Sharp and Atherton 2006).

The point of arrest and detention also provides an opportunity for diversion from further involvement with criminal justice interventions, as well as identifying problematic drug and alcohol users, who have not yet taken up treatment, whether by choice or lack of availability and accessibility of services. There are concerns about the feasibility of integrating criminal-justice interventions with community-based treatment and services provided by non-governmental organisations (NGOs), which may be viewed as less cost effective than custodial sentences and are often perceived by the general public as 'soft options' that do not act as a deterrent to others (Terry-McElrath et al. 2002). Approaches for dealing with problematic drug and alcohol users are very much embedded in the stated goals of a country's criminal justice system, be it ensuring community safety, rehabilitation of offenders, punishing offenders or deterring and preventing others from committing crime. In response to increasing problematic drug and alcohol use, tensions have emerged in some countries in the EU between old government bodies favouring punitive methods and NGOs promoting new ideas and concepts, such as treatment and harm reduction measures (EMCDDA 2003). In addition, disparities exist between national policy and local delivery of services, often due to a conflict of ideas as to how best to deal with problematic drug and alcohol users, whether as criminals in need of punishment or as patients in need of healthcare.

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2 European Monitoring Centre for Drugs and Drug Addiction

The I-ADAM[3] report on comparative research into drug-related offending across eight countries goes some way towards exploring the different problems faced by different countries, how they deal with them and the challenges of doing comparative research (Taylor 2002). However, it does not fully explore the police response to and treatment of those with problematic drug and alcohol use at the point of arrest and detention. Reports from the Council of Europe (Pompidou Group) give comprehensive details on the legal codes and policies for various countries and how they apply to problematic drug and alcohol users, at different stages of the criminal justice system (Council of Europe 1998). However, there is still a need for further study to consider how policy is put into practice in order to begin to establish the reality of being a problematic drug and alcohol user in police detention throughout the EU. The time has come for a broad consensus to emerge, to establish what works in what situations, to examine how policy is implemented and to bring together examples of best practice.

This study explores legislation, policy and practice for those with problematic drug and alcohol use during police detention in eight countries in the EU.

Chapter 1 presents a general overview of the key issues surrounding problematic drug and alcohol use and the response by the police and other organisations. These include a review of trends in use throughout the EU, its links with crime and public-health problems, strategies to address use and associated problems in the community and within prisons and secure settings. It also examines criminal-justice interventions that specifically address problematic drug and alcohol use, the general response by the police and their role in dealing with users in detention and addressing crime related to problematic drug and alcohol use, partnership working between the various criminal justice agencies and other organisations and an overview of treatment and healthcare services for users in detention and in the community. There is an assessment of the current problems faced by detainees in police custody and the role played by harm reduction measures in addressing some of the healthcare needs presented by detainees, including more vulnerable groups identified among problematic drug and alcohol users. Finally, there is a discussion of barriers to implementing harm reduction services in general and within the arena of criminal justice, an exploration of human rights issues and international standards in place for the care of detainees and the role of NGOs and other government agencies.

Chapter 2 outlines the methodology, the procedural and ethical issues relating to researching the area of problematic drug and alcohol use and policing and highlights some of the issues identified in conducting the fieldwork.

Chapter 3 presents a profile of the eight sample countries involved in the study, with an overview of the criminal justice system, the organisation and

3 International Arrestee Drug Abuse Monitoring programme

role of the police, trends in problematic drug and alcohol use and related offending and health problems, policy and strategies in place to address this and the role of NGOs. These profiles were compiled and produced by the sample country partners who also facilitated the fieldwork for each country.

Chapter 4 discusses the similarities and differences identified in the profile of each of the sample countries, specifically the organisation and role of the police; trends in problematic drug and alcohol use and offending; the impact of problematic drug and alcohol use on public health in the sample countries and strategies to address problematic drug and alcohol use.

Chapter 5 presents the key themes identified from the fieldwork, some of which are apparent in all of the countries visited and others, which are more specific to one or more of them. The key themes discussed are *conditions and impact of police detention,* both the facilities available and the physical structure of the buildings. Both police cells and arrest houses that are under the control of the police are discussed. *Treatment of Detainees* and vulnerability of particular groups arrested are explored and the training issues that are raised for the police. The theme *access to drug and alcohol treatment* will, where data is available, explore the response to detainees who are withdrawing, the continuation of drug treatment started in the community and links with NGOs and community drug service providers. *Access to healthcare* considers the different models of health care provision in police detention. Harm reduction strategies and links with NGOs and other governmental agencies in the community are examined followed by a more detailed examination of the role of *harm reduction within the criminal justice system*, specifically in prisons and police detention and barriers to implementing such measures in this arena. The *lack of a joined up approach* in dealing with those with problematic drug or alcohol use across the criminal justice system is examined and the realities and success of partnership working is considered. Lastly examples of *good practice and gaps* in provision are briefly discussed.

Chapter 6 presents conclusions drawn from the overview of literature and policy, the profiles of the sample countries and the issues identified from the fieldwork.

Chapter 7 provides some examples of existing guidelines and presents recommendations for the police and other criminal justice agencies and organisations who deal with problematic drug and alcohol users to improve conditions, the treatment of detainees, and to raise awareness of the key issues.

Chapter 1: Overview of Key Issues

This chapter considers the key issues surrounding problematic drug and alcohol users at the point of arrest and detention. It explores trends in problematic drug and alcohol use in the EU, including poly-drug use and binge drinking, the links with offending and the impact on public health, strategies to address supply, demand and the harms caused by drug and alcohol use and the response by the police, including drug testing, provision of harm reduction, arrest referral schemes and working with other agencies. It then discusses current issues around the healthcare needs and services for detainees, the needs of more vulnerable groups in police detention, human rights issues, the role of NGOs, international standards in place for the care of detainees and barriers to implementation.

1.1 Problematic drug and alcohol use in the European Union

The extent of the drugs problem throughout the European Union (EU) is monitored by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), and statistics on alcohol use in the EU, ranging from low consumption to problematic, heavy use are compiled by Eurocare (European Alcohol Policy Alliance). Both provide a detailed profile of the EU member states, and also publish various thematic reports. In addition, there are national statistics collected within countries, which are presented in the country profiles of this report. Recent findings from the EMCDDA emphasise the rapidly changing political climate for many countries, which has led to a rise in unemployment and subsequently a decline in standards of living. There is also evidence of a spread of problematic drug and alcohol use beyond major urban centres, especially among young people, which has been further exacerbated by political and economic liberalism, leading to increased trafficking of drugs and also in expectations and demand by young people.

Problematic drug and alcohol use can be defined as 'that which involves dependency, regular excessive use, or use which creates serious health risks' (Edmunds et al. 1998). It also refers to use which contributes to or acts as a direct cause to committing crimes, and as well as the use of drugs being illegal, it is also stigmatised in society, making it difficult to uncover the true extent of the problem. In considering the scope of problematic drug and alcohol use in the EU, it is necessary to look at the economic changes that have occurred in the last 20 years, such as the break up of the Soviet Union and the inclusion of several Central and Eastern European countries in the EU. As a result of this, border controls were relaxed, and as formerly communist countries became 'western capitalist' there was a shift towards:

> ‘A market philosophy and more consumer oriented and individualistic perspectives’, particularly among young people in urban centres. The use of cannabis, alcohol, ecstasy and cocaine increased noticeably among this group, as they emulated the western lifestyles and cultures they had recently become exposed to (EMCDDA 2003).

The break up of the Soviet Union in 1989 represents a key historical point when data on problematic drug and alcohol use in the newly independent states became more readily available and problems, which were previously played down, came to the forefront (EMCDDA 2003). Among Eastern European countries and the Baltic States, where problematic drug and alcohol use was either associated with the ‘decadence of Western countries’ or simply not viewed as a problem, there was little demand for supply and demand reduction strategies. Existing criminal-justice policy was repressive and treatment often non-existent, as incarceration was a key response and the stigma associated with problematic drug use was more pronounced compared to Western European countries. However, governments and policy makers in Eastern European states are becoming increasingly aware of the extent of problematic drug and alcohol use, its impact on health and levels of crime and the need to think beyond imprisonment as a measure to address this.

1.1.1 Drug use

The misuse of drugs is spreading among broader segments of society, beyond major urban centres and in many countries, particularly among younger generations. In addition, communities in Central and Eastern Europe are becoming increasingly diverse, all of which needs to be taken into account when formulating policy to deal with drug misuse and supply. The response from the police needs to be targeted and culturally sensitive to accommodate the variety of citizens and circumstances they deal with, as well as being nationally and internationally co-ordinated. For many countries this need for co-operation is acknowledged at political level to deal with the supply of drugs but there remains a lack of consensus as how to best implement demand and harm reduction measures (EMCDDA 2002).

The latest figures from the EMCDDA *Annual Report* (2006) show that throughout the EU, cannabis is the most widely used illicit drug (after alcohol use), with a 20% lifetime prevalence rate [4] among adults. Amphetamine use has also increased, now with a lifetime prevalence rate of 3%, and both ecstasy and cocaine are at 2.6%, with more use among young people. Drugs are also reported to be cheaper than ever before and the transmission of drug-related

4 Lifetime prevalence (LTP) is the number of individuals in a statistical population that at some point in their life (up to the time of assessment) have experienced a "case" (e.g. a disorder), compared to the total number of individuals (i.e. it is expressed as a ratio or percentage).

infectious diseases continues to be a cause for concern. Throughout most of Europe, HIV-prevalence rates remain low at 5% but there has been an increase in injecting drug users contracting HIV and currently it is estimated that 60% of injecting drug users in Europe have hepatitis C. This is despite an expansion of needle exchange programmes, which is part of a broader approach to dealing with injecting drug use, including information and education for users. This approach also includes dealing with licit drugs such as alcohol, tobacco and some prescription medicines, as it is recognised that there is a lack of treatment services, especially for long-term dependent alcohol users (EMCDDA 2006).

Currently, research tends to focus on the problems in one country, as there are inherent difficulties in measuring the impact of problematic drug and alcohol use on crime levels across countries due to different police recording systems and different legislation relating to drug use and associated offending. However, it is possible to present an overview of trends identified in the EU, such as the overall increase in most EU countries between 1999–2004, particularly in Estonia, Lithuania, Hungary and Poland. In addition, cannabis has been identified as the predominant drug associated with offending, including use, possession and supply and there has also been an increase in cocaine-related offences (with the exception of Bulgaria (EMCDDA 2006).

1.1.2 Poly-drug use

Poly-drug use is defined as the use of two or more drugs in combination such as alcohol and cannabis, which is particularly prevalent among young people throughout the EU. There is also evidence of a lack of intervention and treatment for young people engaged in poly-drug use (Arria et al. 1993). The EMCDDA report (2005) highlights poly-drug use as 'central to the EU drug phenomenon' and in the latest report, emphasises the difficulties in monitoring such use, as the current systems have traditionally focused on single use of various drugs (EMCDDA 2006). This report also emphasises the need for better understanding of poly-drug use[5], in order to develop improved services and treatment. From looking at patterns of drug and alcohol use, especially among young people, it is possible to conclude that the majority of users are poly-drug users, particularly when considering the use of tobacco and other licit drugs (Olszewski and Griffiths 2003).

The traditional notions of dependency on a single substance that needs attention by health services are no longer appropriate. Poly-drug use has also been identified among those users undergoing substitution treatment using methadone, who engage in cocaine use, which has a detrimental impact on

5 No simple definition is available for what constitutes poly-drug use, nor is the term used in any consistent way. For an in-depth discussion see Olszewski and Griffiths (2003), POMPIDOU GROUP MINISTERIAL CONFERENCE Dublin, 16–17 October 2003, www.coe.int/t/dg3/pompidou/Source/MinConf/EMCDDA_en.pdf

their treatment outcomes (Leri et al. 2003). Concerns regarding poly-drug use have also been raised with regard to such use along with AIDS-related risk behaviours, where research has shown that among injecting drug users in the north west of England, 90% were poly-drug users. In addition, 'significant associations' were found with incidences of risky sexual practices among this group (Klee et al. 1990). The risk factors associated with poly-drug use have been identified by one study as being higher among young males, who are not in treatment, who engage in injecting drug use and share injecting equipment and who use amphetamines and opiates (Darke and Hall 1995). In addition incidences of poly-drug use may be of short duration and for these short periods,

> risks related to drug use may be especially elevated, suggesting the need for targeted prevention and harm reduction responses. This situation highlights the need to consider the context in which poly-drug use occurs when considering the relevant policy-related issues (Olszewski and Griffiths 2003, 8).

Generally, poly-drug use was found to be more frequent among older users among the groups studied, who also had a history of emotional problems (Martin et al. 1996).

1.1.3 Alcohol use

Alcohol continues to be the most problematic and widely used substance in the EU (EMCDDA 2003) and it is often overlooked as a 'socially acceptable' problem. Marketing of both alcohol and tobacco is viewed as playing an important role in the increase of consumption and yet this goes hand in hand with a decrease in the attention paid to it as a major concern among political parties and the public (EMCDDA 2003). Studies show that 5% of European adults are physically dependent on alcohol, with one in four men and one in ten women consuming hazardous levels of alcohol that are harmful to health, and one in four drinking on occasions where they consume more than six units of alcohol (Eurocare 2003).

Compared to the rest of the world, the European Region has the highest alcohol consumption, and among members of the EU, there is a wide spread of countries with a high level of alcohol consumption. There is a slight decrease in consumption in Austria, Belgium, France, Hungary, Poland, Slovakia, Sweden and Spain, with a greater decrease in Bulgaria, Estonia, Italy, Switzerland and Ukraine. However, it is important to note that in some countries, the level of unrecorded consumption may affect overall levels considerably. Those countries showing an increase in recorded consumption include Turkey (175%), the Russian Federation (79%), Belarus (67%), Ireland (56%), Latvia (45%), and the Czech Republic (26%). Problematic alcohol use differs widely in the EU, for example varying from 14% in Hungary to 27% in Ireland and 41% in Austria. Among males drinking more than 400g per week,

the figures are 7% in Germany and 6% in the United Kingdom, but 28% in Austria, with a similar situation for women in EU states (Rehn 2001).

1.1.4 Binge drinking among young people

Binge drinking, also known as heavy and episodic drinking, is most likely to involve those under the age of 25 years with a higher proportion of men, although women's drinking has been rising rapidly over the last ten years. Binge drinking puts people at an increased risk of alcohol poisoning and accidents and men in particular are at higher risk of being both a victim and perpetrator of violence. Along with higher risks of sexual assaults, there are also higher levels of attendance at accident and emergency departments at hospitals for this group (Alcohol and Harm Reduction Strategy 2004). This type of use occurs mostly in entertainment districts of towns and cities, and in some countries has been attributed to young people with higher levels of disposable income and promotions of cheap alcohol by the drinks industry (EMCDDA 2002).

Underage drinking is also an issue. A study by Coleman and Carter (2005) defined underage drinkers as those between 14-17 years, who also often engage in high risk behaviour and are frequently arrested by the police. The outcomes mentioned by the underage drinkers in the Coleman and Carter study were incidences of unsafe sex, sustaining injuries and minor incidents involving police. However there was evidence of more serious incidents involving the police, usually acts of vandalism. Yet there is little research on treatment services to address problematic alcohol use among young people. A study in England and Wales of an early intervention scheme to address binge drinking and associated offending at the point of detention by the police showed that schemes demonstrating the harmful effects of alcohol to individuals and communities can reduce episodes of binge drinking, particularly when implemented as part of a criminal justice intervention (Sharp and Atherton 2006).

1.2 Problematic drug and alcohol use and offending

The EMCDDA definition of drug-related crime refers to 'crimes committed under the influence of drugs, crimes committed to finance drug use, crimes committed in the context of the functioning of illicit drug markets and offences in contravention of drug legislation' (EMCDDA 2006). The relationship between problematic drug and alcohol use and crime has been demonstrated numerous times, and is also recognised as a 'significant global problem' (Taylor et al. 2003).

The impact of problematic drug and alcohol use is widespread in relation to crime and disorder and those users who are responsible for the majority of such offending often have a set of complex social, health-related, economic and psychological problems and require long-term, sustainable and intensive treatment to address all the issues. Current practice tends to focus on the addiction alone (which can include both drugs and alcohol, plus others such as gambling), and not on contributing problems, for example, lack of good quality housing, poor employment prospects, a lack of social support and the impact of deprivation in the community where they live (Audit Commission 2004). The Association of Chief Police Officers in the UK have emphasised the value of immediate access to effective treatment, in that it should be a 'real option rather than a caution or in some cases a conviction' (ACPO 2003). Good quality treatment has been shown to be effective in reducing re-offending, as long as it provides ongoing support, post-release care and meets individual needs of its clients (Ramsay 2003).

The Drug Use Monitoring in Australia project (DUMA) showed widespread illicit drug use among police detainees, with 75.1% testing positive for at least one drug. The nature of offending was once again shown to be mainly acquisitive crimes directly related to financing drug use and also violent offences related to drug use. Similar findings have been shown in the UK, with 69% of arrestees testing positive for at least one drug, including 29% for opiates and 20% for crack (Bennett and Sibbitt 2000). In addition, among sentenced offenders, 35.4% committed their crime under the influence of alcohol. In the United Kingdom, 25% of all people arrested are described as drunk and 50% of all violent crime, 65% of suicide attempts and 75% of assaults are committed by people under the influence of alcohol (Rehn 2001).

Research has shown that a significant proportion of people with problematic drug use finance most of their habit through acquisitive crime; those using class A drugs, such as dependent heroin users, need up to several hundred pounds (148 Euro) a week to finance their habit. Such funds are also obtained through state benefits, selling property, loans and sex work. There are obvious costs to victims of crime, including trauma and the loss of property in cases of theft, as well as costs to the criminal justice system as a whole in dealing with such offenders (Hough 1996). For example, among a group of arrestees in the UK, there was a subgroup of 9% of people with problematic drug use (most using heroin or crack) who were responsible for committing 52% of all offences reported by the full group of arrestees: many admitted committing at least 20 offences a month over the past year (Bennett and Sibbitt 2000). An analysis (Edmunds et al. 1998) of spending habits among users whose habit costs approximately £200 per week illustrated an annual spend of £2 billion, with the national estimate of 130,000 people with problematic drug use in England and Wales. This same study showed the variety of ways in which this money was raised, including shoplifting, burglary, dealing drugs, fraud and sex work, and that people with problematic drug use are estimated to raise between £650–£850 million through acquisitive crime alone.

Research has shown that drug use can 'intensify and perpetuate criminal activity' particularly among heroin and cocaine users (Inciardi et al. 1997), which consequently leads to increased contact with the criminal justice system (Turnbull and Webster 1997). Figures suggest a continuing trend of over-representation of problematic and dependent drug users coming into contact with the police and other stages of the criminal-justice process. For example, dependent drug users constitute 30% of probation clients in the UK (NAPO 1994), two-thirds of the prison population in the US (Inciardi 1997) and 25% of both the prison and probation population in Sweden (Turnbull and Webster 1997). This is despite the many arguments made for diverting people with problematic drug and alcohol use from involvement in the criminal justice system, in particular in prisons, due to the lack of rehabilitative effect on people with problematic drug use and the dangers of using drugs within prisons (Parker 1994; Turnbull et al. 1994; MacDonald 2004).

The Alcohol and Harm Reduction Strategy for England and Wales (2004) details the economic, social and health impact of problematic alcohol use. For example, alcohol has been associated with approximately half of all violent crimes, along with a third of all incidents of domestic violence. Problematic alcohol use is also linked to increased anti-social behaviour and fear of crime, 61% of the population perceived alcohol-related violence as worsening. The public health impact of problematic alcohol use has been significant: in 2004, £95m was spent on specialist alcohol treatment, including over 30,000 hospital admissions for alcohol dependence syndrome. In addition, approximately 22,000 premature deaths per annum are attributed to alcohol misuse, along with 70% of all admissions to accident and emergency departments. The impact of problematic alcohol use on families has also been demonstrated, with between 780,000 and 1.3 million children affected by parental alcohol problems, such as increased levels of divorce (Alcohol Harm Reduction Strategy for England and Wales 2004).

1.3 Problematic drug and alcohol use and public health

The impact of problematic drug and alcohol use on public health includes deaths related to overdose, chronic conditions such as liver cirrhosis, lung disease and heart disease, and infectious diseases such as HIV and hepatitis. Throughout the EU, the most significant factors relating to mortality among people with problematic drug use is the use of opioids, as many such users are at risk of overdose and are also injecting drug users. Alcohol related mortality also includes chronic health problems, and is often associated with violent acts leading to death or serious injury and road traffic accidents (EMCDDA 2006).

1.3.1 Injecting drug use

There is considerable evidence of the risks to both individual and public health associated with injecting drug use, such as the spread of HIV, hepatitis and other infectious diseases (UNAIDS 2002; EMCDDA 2006; Lines et al. 2004; WHO 2007).

Approximately one third of AIDS cases and 68% of cases of hepatitis C are related to injecting drug use (Goldstein et al. 2002; Alter 2002). Alarmingly, this sort of use is responsible for 60% of cases of HIV in Eastern Europe and Central Asia (EMCDDA) 2002). In the UK, HIV cases among injecting drug users have slowly increased, and now stabilised, but in the Baltic states there have been recent outbreaks, during 2001 in Estonia and Latvia and 2002 in Lithuania, which was attributed in part to a significant rise in cases at Alytus prison, where almost 300 prisoners, all of whom were drug users, tested HIV-positive (EMCDDA 2006). Among injecting drug users, there has also been a high prevalence of Hepatitis B and C, with some variation across the EU. For example, during 2003–4 the rate of HBV among injecting drug users was approximately 60% in Belgium, Denmark, Germany, Greece, Spain, Ireland, Italy, Poland, Portugal, the UK, Romania and Norway and approximately 40% in the Czech Republic, Greece, Cyprus, Hungary, Malta, Austria, Slovenia and Finland (EMCDDA 2006). Evidence exists that HIV epidemics can be 'averted, halted and reversed if comprehensive HIV programmes targeting drug users are put into place' and where harm reduction is a central component of a public health response. The effectiveness of policies and programmes targeting drug users should be measured against public health outcomes. This requires the alignment of drug control measures with public health goals. (Ball 2007).

Research into the public health impacts of injecting drug use is a key driver for promoting harm reduction measures, such as needle-exchange programmes to reduce sharing of equipment and to engage users in treatment (EMCDDA 2006; Celentano et al. 1991; Friedman et al. 1995; Jose et al. 1993; Latkin et al. 1996; Møller et al. 2007). Numerous studies have also highlighted the growing problem of this spread among incarcerated populations (MacDonald 2001; Hammett et al. 1999). Treatment programmes for injecting drug users form an important element of preventing the spread of infectious diseases but it is increasingly recognised throughout the EU that there is a need for a more comprehensive approach to target those who are not necessarily considered as problematic users, such as information and education campaigns, voluntary testing and counselling and the distribution of sterile injecting equipment. Often provided through low-threshold services, or through outreach workers on the streets, such services are not always provided with a goal of ceasing use but with making current and future use safer.

The majority of needle exchange programmes (NEPs) in European countries are based in a fixed location, which is often complemented by outreach teams. In eight EU countries, vending machines are also available but the provision varies; only Germany and France report wide availability. In Spain, such

services are also reported to be accessible in prison settings (27 prisons in 2003). Many NEPs are distributed through pharmacies but, again, there is wide variation in the number of establishments that participate in such schemes: for example, 45% of pharmacies in Portugal distribute needles, whereas in Belgium it is just 1% (EMCDDA 2006).

The report of the National AIDS Council (1998) in France highlights that some detainees encounter difficulties in accessing medical treatments, such as not being able to comply fully with their treatment, particularly in the case of those receiving antiretroviral and drug-substitution treatments. This has been attributed, in part, to logistical problems that can be overcome, but also to the lack of clear protocols and directives for police officers and prison officers working in remand centres who are unaware of such detainees' health needs (National AIDS Council 1998). The National AIDS Council report presents some useful recommendations that are applicable throughout the EU to improve conditions for detainees during the various stages of police questioning, particularly in the area of adhering to previously-prescribed treatment. The recommendations that are particularly germane to this study are that:

- the police need to be made more aware, as part of a process of continuing training, of the medical and welfare needs of individuals living with HIV, and those undergoing drug-substitution treatment;
- the National AIDS Council emphasises that their recommendations on antiretroviral and drug substitution treatments are equally applicable to the treatment of other medical conditions;
- the medical examination provided for under the Code of Criminal Law and Procedure should be performed in a place guaranteeing patient-physician confidentiality.

Generally, conditions in detention should be made compliant with the demands of respect for individual rights (food, accommodation, healthcare) and that centres that do not meet those conditions should be closed. Finally, the Council requests that in no event should individuals requiring treatment be held in the same facilities as those used for custody during police questioning (National AIDS Council 1998).

1.3.2 Alcohol use and public health

The links with alcohol use and public health as well as criminal behaviour are also a cause for concern. Alcohol has been identified by WHO as the third highest risk to health in developed countries, including mental health problems. In addition, there are often difficulties for health professionals in diagnosing alcohol misuse and, therefore, failing to provide effective treatment (Jayatilaka and Phillips 2005). Alcohol-related harm includes an increasing risk of medical

problems, such as liver cirrhosis, certain cancers, raised blood pressure, stroke and congenital malformation, as well as problems for family and work, such as absenteeism, accidents, unintentional injury, domestic violence, criminal behaviour, homicide and suicide. In Estonia, death due to traumas and intoxication is three times higher than the European average, as about 40% of traffic accidents, 50% of drowning incidents and 60–70% of violent crimes are related to alcohol use. In Germany, for example, 16% of the total population misuse or have high use of alcohol, and alcohol-related mortality is estimated to be at 40,000 people per year. Hungary has one of the highest suicide rates in Europe (55.5 per 100,000 population in 1994), which is linked to alcohol use, and 77% of all traffic accidents were found to be alcohol-related.

1.4 Strategies to address problematic drug and alcohol use

It is important to make a distinction between strategies for reducing the supply of drugs and to reduce the demand for drugs. It is also important to differentiate the harms caused by problematic drug and alcohol use.

In national policies, the general trend is to use different legislation for possession for personal use and possession with intent to supply, meaning a reduction in the use of custodial sentences for those who are using drugs to encourage them into treatment (demand reduction) and increasingly harsher penalties for those who deal and traffic illicit drugs to disrupt their trade (supply reduction) (EMCDDA 2006).

Strategies to address problematic drug use cross boundaries between health and law enforcement, treatment and punishment. Supply reduction generally focuses on disrupting trade networks, using law enforcement on a global scale with international co-operation. Demand reduction includes preventative strategies, often in schools and colleges focused on young people and treatment programmes for a range of substance users, using detoxification, counselling, residential and outpatient services and criminal justice interventions. Harm reduction measures are more closely linked with demand reduction policies, as they are introduced with the intention to encourage users into treatment, whilst they continue to use drugs in a safer way. For example, injecting drug users face greater risks associated with overdose and serious infections such as thrombosis and septicaemia, as well as communicable diseases such as HIV and hepatitis. For this group, harm reduction measures such as needle exchange programmes are increasingly recognised throughout the EU as important, to prevent further health problems (EMCDDA 2006).

Attempts have been made to treat and rehabilitate people with problematic drug use who come into the criminal justice system, for example, Drug Treatment Courts in North America and Scotland. However, the use of such courts emphasises the enforcement nature of the treatment programmes, which have also been criticised as a breach of human rights and of the due process

model promoted by Western criminal justice systems (Fischer 2003). The Action Plan for European Drugs Strategy 2000–2004 stated that the European Commission will support with 'technical assistance and finance where necessary' candidate countries in developing national strategies and improved border controls, and assist them in adopting best practice guidelines. For example, the PHARE programme, which was established to implement national drug information focal points. However, reports by the EMCDDA have shown an increase in drugs use beyond major urban centres, which will have implications for harms associated with drug misuse, such as crime and the spread of infectious diseases. The EMCDDA (2006) highlights the need to identify good practice in prevention, treatment and harm reduction strategies to address the 'multifaceted nature' of drug and alcohol use in the EU, including poly-drug use, stimulant use and injecting drug use.

1.4.1 Supply reduction strategies

Supply reduction strategies refer to the tactics used by police, customs and excise, border control authorities and other agencies to disrupt supply and distribution networks of illicit drugs, from low-level street dealers to highly-organised gangs working on a global scale. The trafficking of drugs from production to distribution and sale is monitored to establish routes at which resources need to be targeted. In addition, on a smaller scale, police, prison and security staff at airports, ports and in various settings have powers to stop and search suspects, often using trained dogs, or technology to conduct searches (EMCDDA 2005).

In August 2005, two European Commission (EC) regulations came into force to address the supply of drugs, which placed tighter controls on chemical precursors and also addressed trade in the EU and beyond and within individual countries. In December 2004, a new regulation aimed to inhibit the production of synthetic drugs (Council Regulation (EC) No 111/2005 of 22 December 2004, OJ L 22, 26.1.2005, p. 1.), along with measures 'for intra-EU control and monitoring of certain substances frequently used in the illicit manufacture of narcotic drugs or psychotropic substances' (Regulation (EC) No 273/2004 of the European Parliament and of the Council of 11 February 2004, OJ L 47, 18.2.2004, p. 1.), in order to ensure member states properly monitor, as well as control, the use and supply of drugs. That specific sanctions in place for those charged with supply and trafficking of illicit drugs include confiscation of assets and proceeds related to such activity, as well as custodial sentences.

1.4.2 Demand reduction strategies

As part of the overall criminal justice response to problematic drug and alcohol use, it is important to explore the need for demand-reduction strategies, in conjunction supply reduction. Demand reduction offers users:

> moderate, flexible and appropriate provisions which encourage positive remedies and enable judges to give due weight to voluntary moves on the part of addicts to overcome their addiction and which also help protect drug users from exposure to all forms of drug supply (Leroy 1992).

At the point of arrest and detention, there is a range of demand-reduction activities undertaken by the police, either alone or in partnership with other agencies. Arrest referral schemes in the UK, aimed at users in police detention offer interventions for users and the opportunity for users to seek further advice and help from treatment providers (Dorn 1994). Detention by the police can also offer a point in some users' lives when they, after a period of abstinence, may consider it an opportunity to stop using drugs (Turnbull et al. 1996).

For problematic drug and alcohol users who have to attend court, there is a further opportunity for intervention leading to treatment and diversion from further involvement in the criminal justice system, i.e., through custodial sentences (Hough 1996). The key agency involved at this stage is the probation service who can recommend community-based, court-ordered treatment, through presenting pre-sentence reports for clients. However, there is a lack of evaluation of this process in the EU, with much of the literature focusing on the US (Lee 1994). To cope with the increasing number of arrestees presenting problematic drug or alcohol use in the US, drug courts were introduced to focus on diversion to treatment services, with strict regulation regarding the supervision of clients (Turnbull and Webster 1997). Through various mechanisms, the courts remain in control of managing the offender in the community (Bean 1995). An important part of offering such schemes is to provide additional training for prosecutors to better understand the needs of problematic drug and alcohol users and the impact of prison sentences for this group (Hough 1996). It seems that throughout Europe, diversionary measures at court stage exist but are rarely used. However, there is scope for expansion as more member states introduce the relevant legislation to allow this.

As the majority of problematic drug and alcohol users are likely to pass through prison at some point in their lives, it offers a 'unique opportunity for help and treatment' (Turnbull and Webster 1997), as well as an opportunity to properly assess users' needs (Reno 1993; Hawk 1993). Currently, this stage of the criminal justice process has had the majority of resources in developing formal treatment programmes, but with the introduction of more community based interventions, it is perhaps important to consider the role of the police and other criminal-justice agencies. In addition, the focus of prison-based treatment is abstinence and drug-free environments, which exclude those users

who do not wish to participate in this sort of programme, putting them at additional risk as they continue to use drugs within the prison.

An evaluation of therapeutic communities in prisons demonstrated that the length of treatment was important (Hough 1996), as was the need to provide adequate aftercare (Inciardi et al. 1997). Prisons also often offer detoxification programmes, and studies have shown that among those who took up these services, there were lower levels of drug use while in prison (Shewan 1994). With regards to methadone maintenance programmes within the prison context, a study of the KEEP programme in New York found that the majority of clients continue to make contacts with the community-based programme on release (Magura et al. 1994). There is more potential for such programmes in Europe, where use of heroin is wider, whereas in the US, cocaine use is more prevalent (Harvey et al. 1998). In a review of substance misuse and crime in the US, aftercare services to help offenders re-integrate into their community were found to be effective, as long as they were at least six months long and supported by ongoing out-patient treatment (Russell 1996).

The effects of problematic drug and alcohol use are felt by everyone as the associated problems fuel crime and antisocial behaviour. Problematic drug and alcohol users who cause the most problems often have a set of complex social, health-related, economic and psychological problems, hence the need for long term, sustainable treatment to address all the issues. Research has illustrated throughout Europe that prison-based drug treatment can work, and indeed it presents a unique opportunity to reach large numbers of clients. However, improvements can be made in the implementation of the treatment and provision of ongoing support and aftercare (Ramsay 2003; MacDonald 2005). Treatment services based initially at police detention units with aftercare, may have a similar effect if they are implemented and resourced properly.

1.4.3 Harm reduction strategies

The EU drug strategy (2005–2012) presented a framework for national policies to increase the coverage of prevention and treatment policies and also to widen harm reduction services. The increasing incidence of infectious diseases led to many countries adopting measures beyond abstinence oriented treatment, towards ‘low threshold services’ such as counselling, and harm reduction measures, for example, substitution treatment, needle-exchange programmes and information campaigns (EMCDDA 2006).

Harm reduction is not viewed as the most common approach to dealing with problematic drug and alcohol use in the criminal justice system, as it raises specific dilemmas regarding the legal implications of continued, if closely monitored, drug use (Hough 1996). Harm reduction theory takes the approach of considering the harm consequences of current drug policies that prohibit use and criminalise users, as well as looking at ways to alleviate individual and public health problems. It is also based on the recognition that achieving total

abstinence at the first attempt at treatment is unrealistic and that a more achievable goal is the controlled and safer use of drugs (Drucker 1995). There are different measures in place to reduce the risks to users' health, such as substitution treatment (e.g. methadone, buprenorphine) to help those addicted to opiates. The positive outcomes of this strategy include the obvious health benefits but also the reduction in criminal behaviour and improved socio-economic circumstances for people with problematic drug use.

A helpful definition of harm reduction is provided in the Dublin Declaration:

> Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. This includes discouraging the sharing of contaminated injecting equipment by providing sterile injecting equipment and disinfectant materials to users, and providing a range of drug dependence treatment including substitution treatment (Lines et al. 2004).

This strategy acknowledges and accepts the use of drugs and alcohol in the community and in prisons and other secure settings, and seeks to explore ways in which to minimise the harmful effects of such use, instead of condemning it and attempting to prevent it through supply reduction. It also highlights the need to understand the different levels of use, that is, recreational use, dependency and problematic use, and also the need to encourage those who wish to abstain. This approach is reflected in the work of many organisations who present a less judgemental approach, allow for users to relapse, attempt to deal with health problems that arise and also strive to meet drug users 'where they're at' (Lines et al. 2004). Harm reduction is increasingly becoming integrated into strategies to address drug use in prisons. A major problem associated with drug use in prison is the lack of acknowledgement among prison administrations that drug use exists, particularly injecting drug use. This leads to increasing risks of contracting and spreading infectious diseases among injecting drug users, as they have no means to access needle exchange programmes or disinfectant for cleaning injecting equipment (MacDonald 2005).

The implementation of services to treat HIV/AIDS and problematic drug use both within prisons and in the community varies and is subject to a country's socio-economic circumstances, cultural attitudes towards HIV and drugs and existing resources. Prevention and treatment initiatives must overcome many cultural barriers relating to attitudes towards sex, especially homosexual activity, as well as providing enough resources to deal effectively with the problem (MacDonald 2004; Stöver et al. 2002). This may determine whether or not harm reduction measures (e.g. clean needles, condoms) are in place and to what extent they, along with sexual activity and tattooing, will impact on the risk levels of spreading infectious diseases. Harm reduction has also been shown to be required to reduce rates of co-infection, that is, exposure to HIV, hepatitis C, syphilis and other diseases, particularly among injecting drug users

(Pallas et al. 1999). Strategies such as needle exchange programmes (NEPs) demonstrate the impact of acknowledging prisoners' right to treatment whilst ensuring that while they continue to use drugs, they are not spreading infectious diseases. A scheme at the Hindelbank prison in Switzerland, which provides sterile syringes via a dispensing machine, found that over a 12 month period, there were no incidents of the misuse of syringes or incorrect disposal, and sharing of syringes among prisoners 'almost disappeared' (Nelles 1997). Improving the management of courts, bail systems and prisons could mean better conditions for detainees, and making use of existing resources to distribute condoms, syringes, and bleach in prisons will no doubt contribute to improved health among incarcerated populations (MacDonald 2004; Burris et al. 2004).

Harm reduction while more usually associated with problematic drug use is also important to alcohol-related problems. Until recently the main focus on alcohol has been prevention that stresses the negative consequences of alcohol consumption with the clear message that 'drinking less is better'. In harm reduction approaches the message is different, in that it encourages users to avoid problems and to decrease the risks associated with heavy use (Single 1995). Other examples of harm reduction measures for the prevention of alcohol problems include such initiatives as promoting low alcohol beverages, advertising campaigns in drinking establishments and airbags in cars (which reduce the number of alcohol-related traffic injuries and deaths). In England and Wales, the government is working closely with the drinks industry encouraging them to advertise responsibly, to avoid condoning irresponsible or excessive drinking. This includes measures such as:

> Putting the sensible drinking message clearly on bottles alongside information about unit content; moves to packaging products in safer materials – for example, alternatives to glass bottles (Alcohol Harm Reduction Strategy for England and Wales 2004).

This strategy also recommends that drinks manufacturers make a financial contribution to pay for new schemes to address problematic alcohol use, on both a national and local level (Alcohol Harm Reduction Strategy for England and Wales 2004).

The World Health Organisation had identified three approaches to reducing alcohol-related harm, including:

- population-based policies that can shape drinking behaviour across the whole population, e.g. taxation, availability restrictions, minimum drinking age;
- policies targeted at particular problems, such as drink-driving or offences like sales to minors;
- policies to help individual drinkers, such as brief interventions or rehabilitation programmes. (WHO 2004).

1.4.4 The role of non-governmental organisations

Non-governmental organisations (NGOs) in Central and Eastern European countries (Czech Republic, Hungary, Poland, and Slovenia) are increasingly seeking to 'meet needs arising out of new recognised social phenomena, which state services are ill-equipped to meet' (EMCDDA 2003). This includes the links made between problematic drug and alcohol use and offending and a recognition that successful interventions to address both must be taken into context with levels of social support, resources and access to services and requires a response from the community to sustain the process of treatment, as well as state and criminal justice interventions (Terry-McElrath et al. 2002).

NGOs can play an important role in society and local communities by preventing, reducing, or treating drug and alcohol-related problems. NGOs have multiple roles in working with people with problematic drug and alcohol use by providing educational programmes, treatment centres, harm reduction, advocacy, involvement in policy debate, and provision of drug and alcohol free alternatives. Provision of services for alcohol-related problems provided by NGOs can be divided into three types: self-help organisations, general social and health organisations and temperance organisations (being the least common). One of the most well known NGOs is Alcoholics Anonymous (AA), present in many European countries, that has both a treatment and policy role (Craplet 1997). In Europe, there is a

> broad network of NGOs in the field of health and social problems, typically built around the interests of victims of a special health or social problem. When considering the role of voluntary organizations in providing services and treatment for problem drinkers, there are differences that lie in the historical division of labour between state, municipalities, church, commercial actors and civil organization. In most countries, however, these NGOs either do not exist or are not very active (Österberg and Simpura 1999).

1.5 The police response to problematic drug and alcohol use

The police is a complex institution and it is difficult to compare different forces in the EU due to differences in their organisation, whether they would describe themselves as a force or service and social composition – how far they reflect the general population, which may impact on how they treat certain groups and also the public's perceptions of them (Bayley 1999). For many citizens, the police are the first point of contact they will have with criminal justice professionals and subsequently, their experience of them will form the basis of their opinion for the whole of the criminal justice system (Zvekic 1996).

The arrestee population is viewed as being an 'early warning to future drug epidemics' (Taylor et al. 2003), and, therefore, the opportunity is there to prevent future problematic drug use and associated offending. The case for early intervention in the form of effective treatment is further strengthened by research from Australia, which highlights the need for diversion to 'break the nexus between drugs and crime' (Makkai et al. 2000). Research in the UK has also shown that 25% of police detainees test positive for alcohol (Bennett 1998) and of those who die whilst in custody, 25% is due to the use of drugs or alcohol (Leigh et al. 1998).

People with problematic drug and alcohol use in police detention present a unique set of problems relating to their physical condition, which requires vigilant monitoring and often assistance from health workers. Withdrawal and detoxification require supervised medical care: failing to provide this can jeopardise any future criminal proceedings and may breach arrestees human rights, which include access to medical care and being fully aware of the charges made against them (Kothari et al. 2002). Those in police detention are often at a vulnerable state, and present a prime opportunity for referral to treatment and more importantly, diversion from custodial sentences (Hough 1996).

The difficulties faced by forensic medical examiners in the UK when dealing with drunken detainees include the risks of deaths in custody (Johnson 1982; Giles and Sandrin 1992), as well as the health and behavioural problems associated with excessive alcohol use such as vomiting, injuries, withdrawal symptoms and violence (Noble et al. 2001). Assessing and dealing with the needs of problematic alcohol users in police detention can constitute up to 80% of the forensic medial examiners' work (Hunt 1996). Research has shown that contact with drunken detainees is greater in urban areas and usually involves young non-dependent alcohol users who engage in binge drinking, as well as dependent users (Noble et al. 2001).

The I-ADAM[6] study considers specifically people with problematic drug use detained by the police as a 'key sentinel group' and emphasises the burden they place on a key part of criminal justice systems throughout the world (Taylor et al. 2003).

1.5.1 Drug testing in police stations

In England and Wales, the police play a key role in engaging problematic drug and alcohol users with treatment services, through testing and arrest referral schemes based in police stations. Detainees are given the opportunity to meet with specialist drugs workers, who are not police officers and who aim to provide information and referral to specific services.

6 International Arrestee Drug Abuse Monitoring programme

A key purpose of drug testing by criminal justice professionals is to identify problematic users, monitor general use and target resources to reduce both supply and demand. However, concerns have been raised regarding the legal and ethical issues of testing in criminal justice settings, such as police detention and prisons, in that such information may be used beyond that of monitoring use and identifying those in need of treatment (Wish and Gropper 1990). It also raises concerns regarding detainees' confidentiality of their health status, and police officers' views on how such information can be used (MacDonald 2005). Drug testing in police settings appears to have a very different purpose to that which happens in prisons. In the latter, it is used to determine the health needs of prisoners and to refer them to treatment within the prison. It is not used as a monitoring tool, largely due to the lack of acknowledgement by national prison administrations that drug use continues in prison. This is very much reflected in their focus on implementing supply reduction strategies as opposed to demand or harm reduction (MacDonald 2001; 2005).

Identifying drug or alcohol users is also useful for criminal justice staff wishing to implement early intervention schemes, to address alcohol users' behaviour before it becomes problematic or dependant (Sharp and Atherton 2006). This can be done through testing but also through training police officers to observe the symptoms of use or withdrawal from use and use the time in detention as an opportunity for referral to treatment.

1.5.2 Arrest referral schemes

Arrest referral schemes are present throughout the police forces of England and Wales, and range from providing information and contacts, to using in-house drug workers who attempt to assist problematic drug and alcohol users in seeking treatment and ultimately to divert them from further offending and involvement in the criminal justice system (Hough 1996). A further dimension, which has proved to be effective is to refer arrestees to treatment programmes and then monitor their progress, and also give them priority over other service users in order to encourage compliance and reduce the possibility of a lengthy waiting time discouraging take up of treatment (Goldstein et al. 2000). Evaluations of arrest referral schemes have shown a varied response in the rates of referral, which were sometimes disappointing but with effective outcomes for those who did take up services (Edmunds 1994) and others that had higher take-up rates for people with problematic drug use but low for people with problematic alcohol use (Turnbull et al. 1996). Referral schemes within police stations may bring about additional problems, such as hostility towards officers from people with problematic drug use who deny they have a problem and also from the misguided belief that taking up programmes may reduce their charge. Confusion also arises as drug workers can be viewed as providing legal advice, which is not in their remit (Dorn 1994).

In the UK, three different models of arrest referral scheme have evolved: providing information; more proactive measures through employing drug

workers in police stations; and incentive schemes, which exploit the coercive nature of criminal justice sanctions, such as restriction on bail and caution plus. These latter measures encourage users to engage with treatment as a condition of diverting them from custodial sentences. A study of proactive schemes found several important elements that were necessary to ensure effective implementation, including gaining the respect of users, proper resourcing, capacity to provide ongoing support and having appropriate and adequately resourced treatment services in the community to which to refer users (Edmunds et al. 1998).

1.5.3 The police and harm reduction

The roles of healthcare professionals and the police in addressing drugs and harm reduction have been discussed in several research studies (Spooner et al. 2002; Lough 1998; Beyer 2002). These studies raise issues about who is responsible for harm reduction and the conflicts for the police whether law enforcement and harm reduction can comfortably co-exist. As a general rule health professionals are more exposed to and have the responsibility for dealing with different drug-related harms experienced by drug users whereas the police are responsible for dealing with crime and related issues experienced by the public. However, these different responsibilities are not mutually exclusive as policies and strategies implemented by health and police impact on each other:

> police activities can influence health harms such as overdose, the spread of blood-borne diseases, the age of initiation of drug use. Similarly, health activities can influence crime and public amenity. For example, drug treatment programs can influence criminal activity among drug users (Spooner et al. 2002, 3).

It can be argued that many police identify their key role as reducing drug-related harm by placing the emphasis on the reduction of drug supply with the rationale that reducing the supply of drugs reduces availability and thus the number of drug users (Martin 1999). The police face a contradiction in a situation where the use of alcohol and tobacco is accepted (despite the harm these cause) whereas the use of other forms of drugs are subject to an opposite set of legal values (Bradley and Cioccarelli 1989). Current practice in some police forces can have a negative impact on community initiatives such as needle exchanges. As Arachne (1996) found, uninvited police presence around community health programmes such as needle-exchange programmes had a dramatic impact on the number of clients who used the facility, usage rates of clean syringes and return rates of used ones.

Research has demonstrated that the police can have a role in harm reduction provision, without necessarily compromising their legal and moral values. For example, they can encourage users in detention to make use of local needle-exchange sites and provide information on their location, and they can use

discretion in not arresting users at such sites, while consulting with the community on the need for such methods (Spooner et al.2002).

In recent years, the position of the police as the first point of contact with drug users has led, in some countries, to police adopting a role in the provision of drug services and harm reduction. A number of studies have identified the emergence of harm reduction programmes, for example the work by EDDRA (Exchange on Drug Demand Reduction Action)[7] has analysed data available on harm reduction programmes that have been implemented in criminal justice settings (police, courts and prison) in the EU. The analysis centres on the following eight objectives:

- prevention of drug-related crime;
- social reintegration;
- harm reduction;
- demand reduction;
- outreach;
- organisational intervention;
- drug awareness;
- networking and family intervention.

The programmes based in the police stations were diverse, with the most common programme having the key objective of crime reduction. The main emphasis in police stations was on adults focussing on primary prevention or closed types of interventions such as networking, drug awareness and early intervention. The key recommendations of the report, in the light of criminal justice settings being optimal in reaching often hard-to-reach drug users, is that both the police and prison officers could:

> have a major role in developing early interventions at the beginning of drug users' careers in a holistic manner, that means by acting simultaneously on the criminal behaviour as well as on addiction (Merino 2003, 15).

Police stations were identified as being suitably placed close to local communities that are easily accessed by people with problematic drug use who have never attended drug treatment organisations and could in fact be:

> viable settings for first contact with community drug specialists or less specific services targeting drug users (Merino 2003, 15).

A crucial recommendation in the report also identified staff training as a key component that would contribute to improved drug-targeted services in the criminal justice system. This is particularly important in light of research that illustrates the problems that can arise when the police target drug users, as it may contribute to overcoming the 'climate of fear and uncertainty' experienced by users as a result of police practices (Burris et al. 2004, 134).

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7 http://eddra.emcdda.eu.int.8008/eddra/

1.5.4 Police training

The main concerns of the police in addressing problematic drug and alcohol use stem primarily from legislation that dictates their powers and responsibilities, consultation with local communities and national standards in place to measure their performance. To do their job effectively depends on their training, management, collaboration throughout the organisation, attitudes towards the various groups they come across at the point of arrest and the resources available to them (Spooner et al. 2002). In a study of the role of the police and harm minimisation in Australia, Fowler et al. (1999) identified several important components related to training police officers in these issues. These included a need to identify current standards and competencies in place relevant to harm minimisation and drug use, and to assess if new competencies need to be developed, at both the initial training stage and as an ongoing programme of education.

For police surgeons, research has raised concerns regarding their awareness of the healthcare needs of people with problematic drug and alcohol use, and of their skills to address those needs. The majority felt that there was a need for further training on problems associated with drug use, and also for specific guidelines for police surgeons on the management of people with problematic drug use in police custody (Stark 1994). There has been a need identified for health and safety training for police officers and police staff in the effective implementation of drug and alcohol policies, and a greater awareness of the extent of drug and alcohol use in the community (Eckerlsey and Williams 1999).

Training in harm reduction has generally been targeted at specific groups in the health sector (e.g. medical practitioners, nurses, drug service specialists) (Roche 1998) but the focus of such training has been broadened to other groups (social workers, prison staff, psychologists, GPs and police) in response to the recognition of the growth in alcohol and other drug problems and the fact that many people with problematic drug use will never or very infrequently come into contact with specialist drug services whereas they may well come in contact with other groups. It is also argued that the response to problematic drug and alcohol use requires a collaborative approach as:

> responding to alcohol intoxication problems may require health skills, but clearly police have a critical role in preventing high risk alcohol serving practices and in referral/diversion of intoxicated people to relevant support services. (Fowler et al. 1999, 7).

The need for a multidisciplinary approach to dealing with people with problematic drug and alcohol use also has implications for training police officers, who will require input from numerous agencies to cover the range of issues (Pompidou Group 2001). The benefits of providing education for law enforcement agencies include increasing staff awareness of problems and

solutions and how the police fit in to addressing the needs of problematic drug and alcohol users, particularly if they make use of existing expertise in the community. For example, the International Harm Reduction Development Programme of the Open Society Institute has provided police officers with the opportunity to attend study tours on sites where other police forces have already integrated a public health or harm reduction approach into their work (Burris et al. 2004). Public health being a valid concern for the police needs to be accepted by managers, to allow police officers to attend such training, and to acknowledge the need to change attitudes and behaviour within the organisation (Costigan, Crofts and Reid 2003).

1.5.5 Partnership working

The need for a multi-agency approach to addressing problematic drug and alcohol use have been highlighted by numerous studies, which call for a greater collaboration between the criminal justice agencies and health services, to help reduce offending and other harms associated with drug use (Souhami 2005; Harris 2003; Newburn and Jones 2002; Saunders 1998). There are formal structures in place that bring together health and law enforcement, and recognise the need for changing cultures and allowing for the exchange of information (Burris et al. 2004). These structures are reflected in policies which acknowledge users' health needs as a priority over making arrests. For example, in Australia and America, police officers are discouraged from making arrests at drug overdose scenes (Burris et al. 2001) and in New York City, police managers issued orders against arresting users at pharmacies who provide clean syringes (Burris et al. 2004).

Various areas of social policy in the UK have been encouraged to implement inter-agency working, such as crime prevention, urban regeneration and resettling ex-prisoners (Harris 2003). The introduction of the Crime and Disorder Act (1998) in the UK provides guidelines for partnership working to deal with a range of problems at community level. The police are often seen as having a pivotal role in leading initiatives to address problematic drug and alcohol use in their community, along with health services, schools, social services and local businesses. The need for a multi-agency approach emphasises that the police alone cannot address crime problems that are associated with other factors, such as substance use, social exclusion and health problems (Mawby and Worrall 2004). On a wider scale, throughout the EU there is recognition of the need to provide a more seamless approach, specifically to the healthcare of problematic drug and alcohol users at all stages of the criminal justice system, by collaboration with other agencies and NGOs (MacDonald 2001, 2005). This collaboration has also been identified in strategies to prevent drug use, particularly among young people, using the police, health and education services in order to emphasise that:

> the fight against drugs should be part of a wider range of policies to renew our communities … the fight is not just for

> the Government. It is for teachers, parents, community groups, those working in the field and everyone who cares about the future of our society (DfEE 1998, 1).

However, studies have illustrated some of the problems that arise when different agencies work together, such as the lack of clear aims and objectives, the lack of ownership and leadership that can affect the group's ability to make decisions and the lack of additional resources as for most organisations, such collaborations mean additional workload (Harris 2003; Gibbs 2001). The partnership between the police and healthcare professionals can be problematic in that the two professions have different goals, agendas and priorities, for example the police are more likely to be concerned with the welfare of the victim of crime and may not feel they have any responsibility towards the detainee (Spooner et al. 2002).

1.6 Healthcare and treatment for detainees

Generally, throughout the EU those with problematic drug and alcohol use in police detention are the responsibility of custody officers (in the UK) or police officers with a specific role of monitoring suspects in detention centres. The healthcare services provided in such centres range from employing medical staff to work directly in the detention centre or custody suite, such as nurses and forensic medical examiners, or to use external services and emergency provisions as necessary. The guidelines from the British Medical Association for the care of police detainees in the UK consider the healthcare needs of problematic drug and alcohol users in police detention, with particular attention to problems associated with withdrawal symptoms, but the guidelines also indicate the need to determine whether detainees have been injured during detention and if they are fit for interview by police officers. Healthcare staff are also brought in to assess if detainees are able to be transferred to prisons, other police stations, or if they are particularly vulnerable (for example, suffering from mental illness) and require additional treatment (BMA 2004).

The recommendations for providing healthcare services in police detention in the UK are similar to those found in guidelines for prison healthcare, for example, from the World Health Organisation and the European Committee for the Prevention of Torture (CPT). They refer not only to having adequate facilities and proper, hygienic equipment but also to maintaining detainees confidentiality with regards to their health status and that detainees are offered the same level of service as they would in the community.

1.6.1 Continuity of treatment

Continuity of healthcare treatment for people with problematic drug and alcohol use is of prime importance within criminal justice settings. Research

has shown that, frequently, healthcare staff and other staff are not adequately trained to deal with all the needs presented by people with problematic drug and alcohol use. Furthermore, those who, prior to arrest, were receiving treatment specifically to deal with their substance use, often face disruption in treatment during police detention and treatment is not available if they are then sent to prison (MacDonald 2005). Disrupting opioid dependence treatment has also been shown to lead to criminal activity, as it becomes the only means by which the user can access the money to buy the drugs they need. Such use also tends to impact more widely on the socio-economic circumstances of people with problematic drug and alcohol use as they begin to rely on state support, rather than employment and there are higher health risks associated with uncontrolled, unmonitored use (Boucher 2003).

For detainees with mental disorders, the disruption or cessation of treatment can be particularly harmful, especially if they also have problematic drug or alcohol use. The lack of provisions in many countries to cope with dual diagnosis in the community means services in criminal justice settings are also very limited and the police are often in a position of being unable to find a suitable facility to which to release such offenders. It has been shown that for detainees with mental disorders diversion from custodial sentences is important as they often slip through the net of community care services and often end up in the care of prison health services, which cannot adequately accommodate such offenders (Birmingham 2001).

1.6.2 Confidentiality of medical records in police detention

The National Health Service's code of practice for the UK (2003) for example states that everyone has the right to confidential medical treatment and information on their health status can only be provided with their consent or in the case of particular legal requirements. In theory this should apply to people who have been detained:

> all medical information on a prisoner should be treated in confidence and is not to be disclosed except for specifically defined purposes (Liberty 2005).

Concerns regarding the issue of confidentiality of prisoners and detainees have been raised in previous research, as it was found that there was a lack of consistency in respecting prisoners' rights, among both staff and prisoners themselves. In a study of ten countries and their prison systems, many staff reported that they felt they had a right to know a prisoners' health status, due to health and safety concerns, even among security staff. This was particularly problematic when security staff were responsible for distributing medicines, usually during evenings and weekends when healthcare staff were not working, as they were not trained and were not aware of the impact of not keeping health information about prisoners secure (MacDonald 2004).

For the police in the UK there are clear guidelines regarding under what circumstances police officers can access detainees' medical files (BMA 2004), and these include situations where such information is relevant to a police investigation, or is considered to be in the public interest. For example, if a person wanted in connection with a serious offence is treated in an accident and emergency ward, the staff in that ward have to disclose this information. However, this does not mean police officers can go to the ward and search through files of all patients, in order to identify a suspect (Dimond 2000).

The difficulties faced by physicians working in secure settings such as prisons and dealing with confidential information represents the conflict they have with their obligations to their employer but also to their patients. The reasons for allowing the release of confidential medical information include risks to others, life-threatening conditions and public health concerns, such as the transmission of infectious diseases (CPT 2001). Dealing with police detainees also raises ethical concerns for forensic medical examiners who are dealing with complaints of ill-treatment by police officers towards detainees, as they also carry other healthcare functions within the police station and work with those police officers accused of ill-treatment (Police Complaints Authority 2002).

A key principle guiding healthcare staff in police stations states that:

> health professionals have dual obligations, in that they owe a primary duty to the patient to promote that person's best interests and a general duty to society to ensure that justice is done and violations of human rights prevented (CPT 2001).

This can be particularly difficult in police stations, where healthcare staff have to meet the interests of non-medical police colleagues as well as ensuring the welfare of detainees, and:

> They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly (CPT 2001).

1.6.3 Conditions of police detention

The guidelines developed in England and Wales for police detainees' welfare include standards for maintaining the condition of police detention cells. Reports by the CPT into healthcare services for detainees in Europe highlights the unsatisfactory conditions found in police cells, particularly for those experiencing withdrawal symptoms, or those on medication, such as for diabetics or mental illness. Police cells are not designed to hold suspects for long periods, and as a result are not well kept, have inadequate lighting and ventilation. In addition, due to lack of resources and security concerns, detainees in police custody do not have the same access to showers or opportunities for exercising.

Studies have also raised concerns about the distribution of medication, in that nurses in the police station, or police officers themselves did not record the type and frequency of medication given to detainees, in the same way they would in a hospital, which could lead to misplaced or wrongly dispensed medication (BMA 2004). The UK Royal Pharmaceutical Society (2007) have compiled a guidance document for pharmacists who work with detainees in police custody. Key issues outlined in the guidelines are the 'treatment of drug users who may be receiving daily opiate substitute treatment' where 'to avoid duplicate dispensing, a forensic physician who issues new prescriptions should inform the regular prescribing doctor and the pharmacist responsible for dispensing' and the need for 'supervised consumption of medicines by detainees, the legal requirements relating to private prescriptions written by forensic physicians', and the importance of 'record-keeping provisions and requisitions for stocks of medicines to be stored at a police station'.

A study of prisoners in several EU countries also highlighted the problems experienced by those with problematic drug and alcohol use. Many reported being held in detention for longer than the maximum period dictated by law (usually 24–48 hours), particularly if they were arrested over the weekend. The conditions of the detention cells were described as unhygienic with uncomfortable beds, sometimes with no beds at all, and with no access to showers. Detainees also report receiving particularly harsh treatment from police officers, such as physical and mental abuse and exploitation of their suffering withdrawal symptoms (MacDonald 2005).

1.6.4 Deaths in police detention

The death of detainees in police custody is frequently linked to the health problems of detainees on arrival which are not fully identified by officers, and which are not properly addressed such as drugs overdose and alcohol poisoning. However, research has also shown that such instances may also be down to problems that police officers could only identify through testing detainees and also being better trained to understand the risks of suicide (Giles and Sandrin 1992).

Clearly the behaviour of people with problematic drug and alcohol use in police detention can cause many problems for police officers who are responsible for their welfare. In such cases, officers may have to use restraint tactics, which coupled with intoxification may lead to deaths (Ross 1998). A study in Denmark revealed that the most common cause of deaths in police detention was asphyxiation brought on by alcohol or drug poisoning, and in these cases, a physician was brought in but had not identified the seriousness of the condition in 42% of the deaths (Segest 1997). A similar situation was found in a UK study, in which alcohol was described as a significant factor in causing deaths in police detention, where up to 25% of deaths involved substance abuse, sometimes poly-drug use (Noble et al. 2001).

Concerns regarding deaths in police custody relating to cocaine use have been raised in a study looking at incidences of suspects swallowing drugs to avoid detection. This study reported that a high number of those who die in police custody who were arrested for cocaine possession did so through swallowing the drug. The explanation for this was attributed to the route of consumption and the drug involved, as they would frequently be contained in packages that could block airways or rupture and leak into the body. The study showed that the risks associated with drug-related death are higher when cocaine users come into contact with the police, and suggest that in such cases, police officers must adopt a 'safety first' approach and get the detainee to hospital immediately. It also recommends that patrol officers need additional first-aid training to ensure they act in accordance with the Human Rights Act (1998), that is, fulfil their basic duty of care (Best et al. 2004).

1.7 Dealing with vulnerable groups among police detainees

A key element of dealing with vulnerable groups in the criminal justice system is to divert them from any such contact altogether, and place them in the care of health and social services.

In the UK, developments for offenders with mental health problems include court-based diversion schemes and police liaison schemes (James 1999). However, there has been little evaluation of such schemes and the difficulties that arise when people with problematic drug and alcohol use with mental health problems are arrested by the police. The priority of police officers to disrupt the supply of drugs and arrest those with problematic drug use may override concerns regarding detainees' long-term health problems, particularly if they are in police detention for a relatively short period. In addition, many offenders with mental health problems may go undiagnosed at police stations, again due to the short time that healthcare professionals have to assess such offenders, but research has also highlighted that both drug and alcohol use can mask mental health problems (Rice and Harris 1997). The needs of this group also further emphasises the failures of current interventions as they often have repeated contact with psychiatric services and the police, and that there is a requirement for a more integrated response to meet the complex needs of offenders with mental health problems who are also people with problematic drug and alcohol use (McGilloway and Donnelly 2004).

There are also higher levels of deprivation and social exclusion among people with problematic drug and alcohol use, who are often considered hard to reach, with regards to engaging them in treatment programmes, or with harm reduction services. They are also higher incidences of self-harm and suicide for drug users who are hard to reach which has important implications for the police who need to understand and put in place proper measures to monitor and identify such problems. The failures of police officers in identifying and

diverting offenders with mental health problems to support and healthcare services has implications for public health as such offenders are released into the community with no further support (James 2000).

Services for detainees who are under 18 can be very limited, and there is a lack of consistency over who is responsible for young people who have problematic drug and alcohol use when arrested (MacDonald et al. 2006). Other groups that experience additional problems during police detention as they are not covered by current drug treatment programmes include sex workers, as many are also drug users, and experience repeated arrests as they commit offences linked to their work and their drug use.

Foreign nationals and people with problematic drug and alcohol use from ethnic minority groups can also face problems, due to language difficulties, especially if extra time is needed to find interpreters, during which time the health problems of this group can go unidentified. In addition, foreign nationals may not have the same rights as other citizens and may face problems accessing legal support.

1.8 Human rights issues

In the case of detainees, issues of human rights raise important questions about the responsibilities of the police and prison service in ensuring the welfare of suspects and prisoners, whilst also addressing criminal justice priorities, that is, detecting and preventing crime and the rehabilitation and resettlement of offenders. Articles 2, 3 and 8 of the Human Rights Act (1998)[8] stipulate standards for the provision of 'adequate, timely and appropriate medical care' to police detainees, specifically they refer to the right to life, the right to freedom from ill-treatment and the right to physical integrity. With regards to problematic drug and alcohol users in police detention, evidence from the Police Complaints Authority in the UK suggests there are many inconsistencies in the standard of care given to this group, as well as a lack of knowledge and need for training of police officers.

In some countries, particularly in Central and Eastern Europe the most common response to drug use and drug users are repressive laws and policies as well as punitive policing. According to the Open Society Institute:

> A number of countries have recently passed legislation partly inspired by the 'zero-tolerance' approach that dominates current U.S. drug policy. In general, official policy across the region continues to be guided by international conventions on drug use that emphasize drug interdiction and drug user incarceration approaches. Police harassment of drug users is also widespread. It is reported that, in some countries, police

8 See www.publications.parliament.uk

> round up young people suspected of drug use to search for signs of injecting or force them to be tested for HIV (Open Society Institute 2003).

This repressive approach along with human rights abuses are often exacerbated by the lack of services available for people with problematic drug and alcohol use and those that do exist reflect the punitive nature of the approach to drug use as laid down in official drug policy. Approaches such as peer-group support and counselling that attempt to address the social and psychological needs of people with problematic drug and alcohol use are rarely available, despite the evidence that such approaches are effective in reducing drug-related crime and the spread of infectious diseases.

The right to health for all citizens is covered by international human rights law although it is not always explicitly stated. The Constitution of the World Health Organization states that health relates to 'complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1946, no.2, 100). It emphasises this right as fundamental to all groups regardless of race, religion, political beliefs and socio-economic status, which is the responsibility of government.

The *Universal Declaration of Human Rights* (Article 25(1), 1948) and Article 12 of the 1966 *International Covenant on Economic, Social and Cultural Rights* provides for the right of everyone to have the highest attainable standard of physical and mental health (IFRC and RCS 2004). In addition the 1965 *International Convention on the Elimination of All Forms of Racial Discrimination* (Article 5(e) (iv)), the resolutions passed by the UN Commission on Human Rights in 1999, 2001 and 2003, and the UN General Assembly Special Session on HIV/AIDS in 2001 (*Declaration of Commitment*) are relevant to people who inject drugs, including HIV-positive injecting drug users (IDUs) to ensure that they receive the highest attainable standard of physical and mental health. The International Federation of Red Cross (IFRC) and Red Crescent Societies (RCS), in keeping with their roles:

> in protecting and promoting the health of the most vulnerable populations, IDUs as a vulnerable population merit the strong and privileged voice of social conscience. The International Federation can advocate governments to fulfil IDUs' right to the enjoyment of the highest attainable standard of physical and mental health (IFRC and RCS 2004, 24).

The above convention provides the legal basis for 'states to respect, protect and fulfil, equitably and in a non-discriminatory manner all IDUs' human rights'. This includes comprehensive harm reduction programmes, along with treatment and support services (IFRC and RCS 2004, 24).

Harm reduction measures present additional options for criminal justice professionals attempting to address the problems caused by drug and alcohol use, by helping people with problematic drug use maintain their health and to continue use in a form which is not illegal. Such measures also demonstrate a

way in which the human rights of detainees can be met, in allowing them to address their drug and/or alcohol use without the pressure of criminal justice sanctions or additional punishment in prison.

In many countries, harm reduction measures, such as needle-exchange programmes and substitution treatment, are available in the community. However, due to a lack of training in harm reduction strategies, police forces can inhibit people with problematic drug or alcohol use from accessing existing services provided by governmental or non-governmental bodies. In order for measures such as needle-exchange programmes to be successful, injecting drug users need to be able to access the service without needing to register, have their names recorded by the police or be subject to harassment or arrest on the basis of possessing needles.

1.9 Equivalency of care principle

There are numerous international instruments that aim to address the rights of prisoners and their access to health services, which are particularly relevant for those identified as injecting drug users who are at risk of contracting infectious diseases. For example, Article 35 of the *Charter of Fundamental Rights of the European Union* states:

> Everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.

In addition, Recommendation 10 of the Council of Europe Recommendation No R98 (7) states:

> Health policy in custody should be integrated into, and compatible with, national health policy. A prison health care service should be able to … implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public.

The measures which should be applied under this principle include preventative measures, comprehensive treatment options for diseases such as HIV and hepatitis and harm reduction measures such as providing sterile needles and substitution treatment (Lines et al.2006).

Studies have shown that strategies to prevent the spread of HIV in European prisons and manage the healthcare needs of all prisoners are still not being met, particularly when compared to services available in the community (MacDonald 2004). This is despite WHO providing guidelines in 1993 to establish principles and ensure that:

> All prisoners have a right to receive health care…equivalent to that available in the community (WHO 1993).

The CPT states that without ensuring that prisoners have full access to health services equivalent to those in the community, situations can arise that could be defined as 'inhuman and degrading treatment' (CPT 2003). In addition to prison systems in the EU and their duty of care to provide healthcare services equivalent to those in the community, it must be emphasised that prisoners are a particularly vulnerable group who may already be presenting a wide range of health problems on reception to prison (WHO 2001). The same can be said for those in police detention, and due to factors such as unemployment, homelessness or engaging in problematic drug and alcohol use, time spent in detention may be the first time such groups access any sort of healthcare. This is particularly important in those countries where detention by the police can be relatively long term, that is, beyond the 24–48 hour standard found in many EU countries.

1.10 Barriers to implementation

The priorities of police officers, prison staff and other criminal justice professionals in maintaining security and community safety should not override the health concerns and treatment needs of detainees, which must be provided in all settings (Walmsley 2003). However, despite this there are frequent problems associated with treating people with problematic drug and alcohol use in secure settings, due to security concerns but also environmental and financial restraints, such as overcrowding, lack of staff and facilities. Overcrowding in prisons has a knock-on effect on other settings such as police and court detention facilities as they can be used by the prison service to accommodate prisoners, but they do not have the necessary healthcare facilities or staff available, and cannot offer other services such as work, education and training, opportunities for religious worship or consultancy with health care staff (Walmsley 2003; MacDonald 2005).

The reliance on law enforcement and supply reduction strategies to address problematic drug and alcohol use also impedes the implementation of harm reduction measures, which have been introduced to address public health issues (Friedman et al. 2006). This is particularly apparent in prison systems throughout the EU whose priorities are focused on security and abstinence-based treatment for drug users, therefore there is a lack of acknowledgement that drug use, especially injecting drug use and other high-risk behaviours actually occur (MacDonald 2005).

Studies have demonstrated that among injecting drug users with HIV, law enforcement practices have a low deterrent effect, and generally criminal justice interventions, which do not allow for users to relapse, often result in users being referred back to the court for further sentencing (Wodak 2006). In addition, lack of awareness of the needs of users among criminal justice staff has identified the need for better training, much of which can be provided through the expertise of NGOs. However, without the necessary resources,

training and the implementation of harm reduction initiatives can be short lived (McDonald 2005). Such training can help to overcome the negative attitudes of criminal justice staff, and others, in promoting the health benefits of such measures and allaying fears among staff that measures such as needle exchanges do not pose a threat to them (Lisbon Agenda for Prisons 2006).

The stigma associated with problematic drug and alcohol use affects users' compliance in both prisons and the community, as they may feel that accessing services such as needle-exchange programmes exposes them as users (Wodak 2006). To overcome this, there needs to be a guarantee of confidentiality for users in the community and in prisons, and also reassurance that accessing such measures will not result in being arrested by the police (Arachne 1996).

The literature report has indicated that there is a lack of research or common policies that govern the response by police forces to people with problematic drug or alcohol use in Europe at the point of arrest and during detention. In addition the guidelines provided by the CPT and such documents as provided by the BMA in the UK are inconsistently implemented, which has led in some cases to abuse of detainees' human rights, lack of health care provision and a missed opportunity to refer those detainees who wish to be, to community drug and alcohol services.

Chapter 2: Methodology

To provide an in-depth analysis of the policy and practices involved at the point of police detention and the response to people with problematic drug or alcohol use in the sample countries, an ethnographic approach was used. This involved semi-structured, in-depth interviews with key criminal justice professionals, healthcare staff, government and NGO representatives and people with problematic drug or alcohol use who have experienced police detention.

The partners in the research played a key part in collecting data from their countries to inform the literature review and country reports. Data from a range of sources was used, including national policies that address problematic drug and alcohol use and official statistics demonstrating trends in use and associated problems, such as crime and public health problems.

2.1 Comparative research

The literature on comparative research into criminal justice is mainly focused on the United Sates and Western Europe. There is a lack of comparative studies that address Central and Eastern Europe. The need for research into criminal justice policy in Europe is particularly important in light of the expanding membership of the EU, especially for emerging democracies in the Central and Eastern European regions, as:

> New democracies often face the challenge of transforming a police force that traditionally operated against the people into one that actually serves them (Pakes 2004).

Another key reason for comparative study is that criminal justice systems, for example in Europe, are likely to face similar challenges especially in the field of problematic drug use. As Pakes (2004, 49) argues.

> Comparative research helps us gain a deeper understanding of the various types of relationship that exists between the police, the state and the people. It illustrates that policing may constitute both a promise and a threat, depending on the nature of these relations – to be protected from crime and disorder or more generally 'looked after' by benign servants of the people, or, on the other hand to be singled out for persecution, to be harassed or oppressed.

Research that adopts a comparative approach towards subjects involved in the area of criminal justice across national boundaries is difficult to find, due in some part to the problems inherent in such an approach. However, an ethnographic approach lends itself to such research and has been used in a

variety of European studies on problematic drug use in prisons that involve a number of different countries (MacDonald 2005; Decorte 2006).

There are various potential problems in undertaking comparative research that need to be considered and strategies developed to overcome these. One key problem is the use of interpreters, necessary in multi-country studies across Europe. When using interpreters, one is reliant on their skills and understanding of the key issues, whilst also ensuring they remain independent from the participants involved. Linguistic difficulties can present a major inhibitor of comparative research, unless the researcher is fluent in the language and cultural concepts of the countries being compared, as there is a danger of misinterpreting data. Without good linguistic skills it is possible to miss the subtleties of 'intonation, nuances of speech, or most problematic of all, that which is left unsaid' (Zedner 1995, 12).

The differences in the recording of data regarding drug and alcohol use in each country and the criminal justice response can also hinder the comparative approach; requiring that such information is confirmed from a range of sources. Comparative research also raises problems regarding the different terms and definition used in different criminal justice systems and the need to establish correct understandings.

The comparative researcher also needs to be wary of organisations and agencies that appear similar across countries, as they share the same name, but which can operate very differently and have different working relationships. A good example of this is the concept of probation. Official descriptions of such organisations can also be problematic as they may not fully reflect the actual purpose and practices that exist. In addition, the lack of understanding about different societies, for example, ex-Soviet states may mean that a researcher from Western Europe may ask inappropriate questions. Equally, 'insider' researchers may also fail to grasp what are perhaps key features about that society as seen from the outside, whereas an 'outsider' may bring a different perspective to comparative research because of their geographical and cultural distance. This also allows the researcher to ask 'naive' questions that challenge presuppositions. Similarly:

> as a 'nobody' one may be allowed access to information or be made party to disclosures which prudence might withhold from a fellow national' (Zedner 1995, 18).

The differences in the organisation of the police, health services and the existence of community drug services also meant that not all questions were relevant to all the sample countries, for example, in Italy the role of the prosecutors during police detention is much more pronounced than in other countries.

Despite these difficulties, it is important to undertake comparative research to learn as much as possible about the current practice of the police and their response to problematic drug and alcohol users in Europe. This presents a

means by which such research can both fill the gap in knowledge in this area and provide examples of best practice and improve current policy.

2.2 Definition of terms

It is important to establish that, although in each country different definitions of the same terms and concepts exist, there are also terms that apply across countries, which need to be clearly defined.

2.2.1 Police detention

In the sample countries, police detention is the term used to refer to the period after arrest when suspects are taken to a police station for questioning about their offence, and where, generally speaking, they are held for a maximum of between 24–48 hours.

In some countries the police also run detention centres, which are similar to remand prisons in the UK, where suspects are held pending further investigation of their case. The various types of detention are explained further in Chapter 3 in each of the profiles of the sample countries.

2.2.2 Problematic drug and alcohol use

Problematic drug and alcohol use refers to use that has a detrimental impact on users' health, financial status, social support networks, employment and can lead to them becoming engaged in criminal activity.

For the purposes of this report, the focus is on those users who come into contact with the police, and who may suffer health problems such as HIV/hepatitis if they are or have been injecting drug users, and during detention, may suffer withdrawal symptoms from a range of substances.

2.3 Aims and objectives of the study

The key aim of the study was to investigate legislation, policy and practice in relation to treatment of people with problematic drug or alcohol use in police detention in eight countries in the European Union (Bulgaria, Estonia, England and Wales, Germany, Hungary, Italy, Lithuania and Romania). In order to achieve this, the objectives set for the research were as follows. For each country in the study to:

- explore trends in problematic drug and alcohol use;

- examine national legislation and strategies in place to address problematic drug and alcohol;
- investigate the provision of healthcare and treatment services for problematic drug and alcohol users in police detention and establish who is responsible for this;
- consider vulnerable groups relating to problematic drug and alcohol use;
- identify gaps in service provision for people with problematic drug or alcohol use in police detention;
- identify and disseminate good practice identified by partners involved in the study;
- consider the impact of joining the European Union, where appropriate, on strategies and service provision for people with problematic drug and alcohol use in police detention.

2.4 Ethical and procedural guidelines

The sensitive nature of the research requires clear ethical and confidentiality procedures and guarantees for the participants. The key principles in place to ensure adherence to the ethical guidelines included ensuring that all researchers were made aware of their responsibilities and obligations to consider ethical issues arising from their research and that the dignity, rights, safety and well-being of participants must be the primary consideration. Therefore, it was imperative that all participants were fully informed of the purpose of the project and were asked to give their consent to participate, were guaranteed their responses would be treated confidentially and that data would be kept securely and that they were able to withdraw their participation at any time.

The primary method of data collection was in-depth, semi-structured interviews, which enabled a range of themes to be discussed that allowed flexibility depending on the participants' role or perspective. Participants came from a range of government and non-government organisations, including ministerial staff (responsible for criminal justice, policing and healthcare), criminal justice staff from the police, prosecution service, courts, prisons and probation, drug-treatment centres in the community, NGOs who provide services for problematic drug and alcohol users and also promoted the human rights of users in detention, and problematic drug and alcohol users who had experienced police detention. Access to the participants in each country was facilitated by the partners who also compiled the country profiles (see Chapter 3).

Interview checklists were developed for different groups of participants, including ministerial staff, criminal justice staff, NGO staff and detainees[9]. The

9 The full interview checklists are available in Appendix A.

general issues for discussion with the ministerial and criminal justice agency staff (from the police, prosecutors, magistrates, prisons and probation services) were the extent of problematic drug and alcohol use in their country, the governance of the police and the key personnel involved in dealing with problematic drug and alcohol use, public perceptions of problematic drug and alcohol use and the national strategies in place. They also covered procedures and policy for police officers dealing with detainees' with problematic drug or alcohol use, links with other agencies and NGOs, procedures for detainees medical records, vulnerable groups in police detention, the implementation of harm reduction measures, training for police officers, alternatives to prison for people with problematic drug or alcohol use, the impact of European Union membership (where appropriate), the adoption of good practice from other countries and the organisation, regulations and procedures of healthcare for detainees.

For police officers, in addition to the above issues, participants were asked about the regulations regarding the length of detention and problems that arise among those with problematic drug or alcohol use, along with detention as an opportunity for treatment or referrals, the appropriateness of the criminal justice response, specific initiatives in place to deal with problematic drug and alcohol use and the potential for the use of harm reduction measures in police stations and detention centres. Police officers and staff were also asked about their relationship with other agencies, their perception of the more vulnerable groups they come into contact with, the conditions of detention and treatment of detainees and to identify anything that would help them improve their effectiveness in dealing with problematic drug and alcohol users.

Healthcare workers, police surgeons and forensic medical examiners were specifically asked about the problems they came across when dealing with problematic drug and alcohol users, their relationship with the police, their training, links with healthcare services outside the police station or detention centre and their views on harm reduction, the conditions of detention and the treatment of detainees. NGO staff were asked to discuss their role and the aims of their organisation, their relationship with the police, their views on the national drug strategy and the key problems identified by their clients.

Finally, problematic drug and alcohol users detained by the police were asked to recount their experiences of police detention, including the length of time they spent there, the conditions, attitudes of the police, the access they had to medical care, assistance they received to address their drug or alcohol use and two things they would like to see changed in police detention.

There were two seminars for all the partners, one held at the start of the project (December, 2005 in Birmingham, UK) and the second towards the end of the project (January, 2007 in Romania). The first was set up to ensure that all partners agreed with the ethical and procedural guidelines developed for the research and the checklists to be used with the various participants (see Appendix A). It also provided an opportunity to set a provisional timetable for the fieldwork and for the partners to discuss issues specific to their country that

were important to explore in the fieldwork. This seminar was also important in providing guidelines to the partners on their role and in the production of the country profiles (see Appendix B). Due to the problems with differing definitions of terms and concepts in each criminal justice system, this seminar also provided an opportunity for the researchers to ensure they understood the various meanings and took them into account when conducting fieldwork.

The second seminar took place after all the fieldwork was completed and during the final phases of the analysis of the data. The main purpose was to discuss the principal themes emerging from the country profiles and fieldwork, and to agree the structure and content of the final report.

2.5 Use of translators

It was necessary to use translators during the visits to Bulgaria, Estonia, Hungary, Italy, Lithuania and Romania. The interviews in Germany and in England and Wales were carried out by a native speaker. The translators used in the research ranged from professionals working in the criminal justice systems, representatives from NGOs and professional translators. Prior to the interviews the aims and objectives of the research and the methods used were discussed with the translators to ensure they had an understanding of the key issues. The interview checklist was used to act as a guide during the interviews, for both the researcher and translator, and was provided to key participants in their native language prior to the interview in order to enable them to understand the focus of the discussion. However, this approach must be treated with caution, as this does not guarantee full understanding as 'despite the utmost efforts of the researchers, differences in meaning often creep in that can change the results' (Taylor 2002, iv).

2.6 Issues arising from the fieldwork and data collection

The development of ethical guidelines and the invaluable assistance from country contacts and participants meant the majority of the fieldwork ran smoothly and produced some very useful data. However, some difficulties arose, many which could not be foreseen and it is important to identify these issues, both to inform future research studies and to contextualise the findings of this report.

The partners in each country and researchers completed fieldwork diaries to ensure that:

- the research design was appropriate;
- logistical problems were anticipated and addressed;
- the research ran to the specified timetable;

- the interpreter worked well with the fieldworker and understood the nature of the research and the key issues;
- the participants were appropriate for the aims and objectives of the research;
- the participants fully understood the purpose of the research, their contribution to it and their rights.

One of the most common issues was having group interviews instead of the planned one-to-one interviews. This often came about as a result of time constraints, of both the participants and the researcher, and emphasised the need to properly manage the group to ensure all participants had an opportunity to express themselves.

The use of interpreters in each country was generally very well co-ordinated, and in most cases, they were independent of any of the criminal justice or other government organisations involved in the research. On occasions where this did not happen, it was again due to resource and time constraints and it was made clear exactly what their role in the research was: that they would not be collecting and recording data themselves or be given any information after the interview by the researcher.

There were no major logistical problems and the country contacts had planned and executed the fieldwork very well. None of the participants requested not to be interviewed and all reported they were fully informed of their rights and of the purpose of the research.

The data collected gave an extensive list of themes and issues regarding the experiences of problematic drug and alcohol users in police detention, which were discussed extensively at the second partner seminar in Romania in January 2007. This seminar was also very useful in allowing all partners to express their views on the structure and content of the final report. It also enabled an exchange of ideas and raised issues regarding conducting comparative research and of examples of good practice found in each country and identified any errors.

Chapter 3: Profiles of the Eight Sample Countries

This chapter presents a more specific and detailed overview of the general structure of the criminal justice system and the police service in each country, including links with other criminal justice agencies and organisations, such as probation, the courts and NGOs. Each section also contains details of trends in problematic drug and alcohol use and its impact on offending and public health, and national strategies in place to address this. It also highlights some of the current problems previously identified for detainees in police detention, such as breaches of human rights and complaints against the police.

3.1 Bulgaria

3.1.1 The police

The Ministry of Justice is responsible for the administration of criminal justice proceedings, as undertaken by the court, prosecution and prison systems. The police are governed by the Ministry of Interior, which also co-ordinates efforts to adhere to EU guidance, which are enshrined in the *Charter of Fundamental Rights*.

The Ministry of Interior is responsible for the protection of public order, and co-ordinates the work of the National Police Service, the National Organised Crime Control Service, the National Security Service (non-military home intelligence service), the National Fire and Emergency Service, the National Gendarmerie Service (military police) and the National Border Police Service. The National Police Service is a specialised investigating and security division of the Ministry of Interior responsible for the protection of the public order, crime prevention, detection and investigation.

3.1.2 Training for police officers

Training of police officers under programmes approved by the Ministry of Interior is carried out throughout Bulgaria. Generally, officers of the Regional Department of Interior provide training to the police section officers who in turn instruct the rest of their colleagues. In almost all sections multi-disciplinary lecturers are invited, such as physicians, judges, prosecutors and leaders from the Roma community. In addition, individual police force areas offer complementary training other than that of the Ministry of Interior, for example, in Kazanlak officers were instructed about how to work with NGOs.

3.1.3 Legislation relating to police detention

Suspects must not be detained for more than 24 hours at the request of a prosecutor or police officers any extension of that period must be done at the request of the prosecutor and sanctioned by the courts. Detainees, under the Constitution, have a right to legal counsel as from the moment of detention, access to medical care and contact with family members.

In a case where a person in possession of an illegal narcotic substance is seized by the police, an investigator orders that a psychiatric examination be made (by specialists), which must determine whether the person is dependent on drugs and whether the drug is intended for personal use or for trade. The results of this examination will determine whether or not the person should be prosecuted. On 23 July 2003, the Ministry of Interior adopted Instruction No.I-167 for the actions the police authorities should perform when detaining persons in the structural units of the Ministry of Interior, and the equipment of the places in which the detainees are accommodated.

As a whole, the adoption of this instruction was positive in the measures it imposes to avoid torture, and inhuman and humiliating treatment during police detention. The Instruction obliges police officers who have witnessed illegal use of physical violence, torture or inhuman treatment of a detainee, to report this to the Chief of Police. Instruction No.I-167 lays down regulations as to how the rooms in which detainees are accommodated should be equipped. There must be plank-beds or a bed (Art.63 (2)) and detention rooms must be provided with continuous ventilation and access to natural light (Art.73). Juvenile detention rooms should contain bedclothes, a table with chairs, cabinet, soap and towels. The interrogation rooms must not contain any 'suspicious objects', for example:

> wood truncheons, broom handles, flails, metal bars, pieces of electric cables, imitations of firearms or knives and other objects, which could be used for violence or for implying threat to the detainee (Art.80 (5)).

3.1.4 Violation of human rights as a result of police acts

Detainees are often taken to remand centres after the 24-hour detention in police custody, where they are supposed to be formally examined by a doctor, however often they rarely possess medical documents suitable to be submitted to the prosecution or the court. Detainees report that they were refused examination in police custody as well as in the remand centre. Furthermore, reports of abuse by police officers are frequently not recorded, and the detainee is not given a copy of any such records or documents, making it very difficult for them to pursue complaints against police officers.

3.1.5 The courts

In 1998, Bulgaria introduced a three-level court system to try criminal and civil cases. The Court system consists of regional and district courts; courts of appellate jurisdiction divided into regional courts and courts of appeal; and the Supreme Court of Cassation. The decisions taken by regional courts can be taken to appeal by the respective district court and at the Supreme Court. Regional courts, which are the lowest trial courts in rank, hear all cases that are not explicitly sent for trial in another court (for example, district courts). There are more than a hundred regional courts across Bulgaria. Smaller civil cases and less serious criminal cases, which fall within their competence, are normally heard by one judge.

District courts function both as trial courts and courts of appellate jurisdiction. Within the country there are twenty-eight district courts, including the Sofia Town Court whose jurisdiction extends over the territory of the capital. Generally the district courts are organized into divisions — criminal and civil divisions. As a trial court on civil matters they hear civil cases that are substantial, including all trade matters, as well as serious and complex criminal cases. Civil cases are tried before benches of three judges. Criminal cases are reviewed by a judge and two jurors who are not judges. Criminal cases in which the sentence can be no more than 15 years' imprisonment or life imprisonment are tried before a bench of two judges and three jurors.

Courts of appeal deal with appeals and protests against acts of the district courts. Courts of appeal sit in benches of three judges, wherein there are civil, trade and criminal divisions. There are six courts of appeal within the country, one of them dealing with military issues, and their decisions may be appealed to the Supreme Court of Cassation.

The Supreme Court of Cassation, the third and last level, reviews appeals and protests against acts of the district courts when the latter have acted as courts of appellate jurisdiction, as well as against acts of the courts of appeal, and sits in a bench of three judges. In case of an issue about legitimacy the Supreme Court is obliged to refer this matter to the Constitutional Court. The respective civil and criminal divisions of the Supreme Court of Cassation render interpretation decisions to ensure equal and precise administration of law by the courts.

3.1.5.1 Alternatives to prison sentences for people with problematic drug use: the probation service

Within the legal commission of the National Assembly, there are discussions taking place regarding the amendment of bills that supplement the Criminal Code, the Code of Criminal Procedure, and the Law of Execution of Punishments. A substantial part of provisions is directly related to drug dependents because they regulate the procedures for their involvement in treatment programmes. The development of the previously-discussed bills and

the activities relating to the implementation of the treatment programmes has been accompanied by public debates in Sofia, Ruse, Stara Zagora, Varna, Burgas, Plovdiv and Blagoevgrad. The problems most often discussed were those related to the drug population among criminals, their needs and deficiencies, as well as the problems connected with their treatment.

Within the correctional treatment of offenders sentenced to a probation order, who serve their sentence within society without being imprisoned, various programmes will be implemented for treatment of drug-dependent criminals. The programmes provided for in the probation-related bills could be completely addressed to the drug-dependent offenders. In order to implement these programmes, probation staff are trained and volunteers recruited. The programmes are created, accredited and implemented by Central Department 'Execution of Punishments' to the Ministry of Justice in cooperation with the National Council of Narcotic Drugs. The structure of cooperation in this context is under development, in order to establish a continuous exchange of information between the two institutions. This will encourage the faster development, approbation and implementation of programmes relevant to probation and work with convicted drug-dependent offenders.

The institution directly committed to the development of probation measures and programmes for work with convicted drug-dependent offenders is the Central Department 'Execution of Punishments', and its structural Probation Unit. Within this structure are included the specialists who will directly deal with the administration and implementation of the programmes designed for working with offenders sentenced to probation who are dependent on drugs in the probation centres. In practice, all types of treatment (drug-free, hospital/outpatient) are legally accessible to probation clients but the insufficient medical funding also creates considerable hindrances. Alternative forms of punishment are already applied but this will intensify as the whole probation practice regulations become effective.

There are five times as many people with problematic drug use directed to probation than those serving their punishment in prisons. Treatment under probation conditions saves the unpleasant negative effects that inevitably occur in case of imprisonment but it also creates new risks of relapse, due to the challenges and the risks of being treated in the community. The major difficulties related to the application of probation measures and programmes in respect of drug addicts are connected with their social support networks, the difficulties in ceasing drug use, and the resistance to control and limitations.

Clients on probation are monitored and in the event that the prescribed treatment is not observed and the risk of criminal behaviour is not decreasing, the court may, on the recommendation of the probation staff, retry the particular case and ordain effective serving of imprisonment. This mechanism will also apply to those paroled from prison if, during the probationary period, they commit a new crime or fail to adhere to the limitations imposed.

3.1.6 Drug use in prisons

As of September 2004, there were 565 people with problematic drug use in prisons and prison hostels, with 722 on remand. Some of them were released because of a change in the punishable measure, and others were imprisoned. The highest concentration of incarcerated drug addicts are in prisons in Sofia and Plovdiv, and the closed prison hostel in Kremikovtsi. A gradual increase has been noticed in the number of imprisoned drug addicts. Within two years their number has increased by 200 people in prisons and prison hostels. Table 1 shows the prevalence of drug use within prisons during 2004.

Detainees often come to prisons with no medical records, as they do not understand they have a right to ask for help in police detention, or do not wish to declare any problems. Therefore, prison staff often start with a 'clean slate' on which to record detainees' needs and health problems.

Table 1: Use of illicit drugs within prison during 2004

Drug	*% Users*
Cannabis	13.2
Cocaine	5.3
Heroin/opiates	44.1
Amphetamine	4.9
Ecstasy	10.9
Other	14.2
N	**533**

Source: *Ministry of Justice, Execution of Punishments Department*

3.1.7 Drug use

The period from 2003 to 2005 is marked by a rise in the spread of psychoactive substances among young people aged 15 to 25. Marijuana, synthetic drugs (amphetamines and ecstasy) and heroin are the most widespread illegal drugs. The tendency toward a rise in the number of people experimenting with or regularly taking marijuana and/or synthetic drugs (amphetamines, ecstasy) is maintained. Experimenting with cocaine is rising but this does not lead to a rise in the number of those regularly taking cocaine, the reasons for this being difficulty in obtaining cocaine and the high market price.

It could be concluded, from the information available, that drug use within the general population in Bulgaria is increasing in all its main forms – problem, experimental, and recreational. The number of people (including mostly young

people) in Bulgaria who have used any drug at least once in their lives is growing, although this increase is not as vigorous as it was in the mid- and late-1990s. Special attention should be paid to the increased drug use by young people, mostly by students. The data available and the continuing observations show that the most widely used narcotic substance in Bulgaria is cannabis. It is evident that there is a tendency toward increased use of synthetic drugs such as amphetamines and ecstasy. In places of entertainment, discotheques, clubs, and at rave, techno and other parties, there are a certain group of substances earmarked as 'dance drugs' or 'disco drugs' that include mainly synthetic stimulants (ecstasy, amphetamines), cannabis and very rarely hallucinogens (LSD).

An additionally important feature of drug use among young people is that consumption (in all forms) is progressively spreading from the larger towns to the small and more isolated towns and villages. In the early 1990s the phenomenon was developing mainly in Sofia, in the big Black Sea Ports of Varna and Burgas, and in some towns and villages located near the main drugs route across Bulgaria. In practice, drug use (especially experimental) can be seen in any town and village that have sufficient numbers of young inhabitants.

3.1.8 Drug use among students and young people

According to the research, approximately one-third (31%) of young people admit that there are drug users among their peers and 21% of the young people reported that they have friends who are using drugs. In practice, every fifth young person in the capital and in the district centres is moving in circles of friends where drugs are present. As for use, 17% of the young people in the capital and in the district centres have tried drugs. In absolute figures, this means approximately 176,000 young people. In Sofia, the percentage of those who have ever tried a drug is twice (26%) that of the district centres (13%). The most frequently used drug is Indian hemp (15%) and other types of marijuana have been tried by 19% of young people, with 2% trying amphetamines and ecstasy, 1% using heroin and 1% using cocaine. Approximately 5% of the young people have tried more than one narcotic drug.

3.1.9 Alcohol use

A sociological study conducted by the Prevention Department of Municipality of Varna among youths aged 15 to 19, shows that cigarettes and alcohol remain the most widespread substances both in respect of experimental use (cigarettes (70.7%), alcohol (95.7%)) and regular use (cigarettes (39%), alcohol (72%)). The average age at which people start using cigarettes for the first time is 13.5 years and for alcohol 12.45 years. This context explains the high levels of experimental use of illegal drugs (40% have at least once in their life tried some illegal narcotic substance).

3.1.10 Roma communities

Problematic drug use is also evident in ethnic communities including the Roma. However, the incidence is not uniform, the available data (which is limited and needs to be treated with caution) suggests that there appears to be an increase in problem use in Sofia and some other larger towns but there is relatively less experimental use of illicit narcotic drugs among the Roma around the country, in comparison to young people in Bulgaria as a whole.

Available data suggests that, among the Roma, the most frequently-used drugs are volatile substances (glues, diluents, etc.) and cannabis. Volatile substances have been used by 2.7% of Roma at least once in their lives and cannabis by 2.0%. The use of all other main drugs on the Bulgarian market at least once varies between 0.6 % and 1.6%. While it is important to note the concerns about experimental use, according to a number of other research studies, heroin is the most problematic substance among Roma.

In 2003, 7.5 % of those who sought treatment of a drug-related problem in Sofia were of Roma origin, three years earlier this rate was 6.7 %. Within this group the spread of drug use is often accompanied by other social problems such as prostitution, criminal behaviour (including drug-related) and social exclusion.

3.1.11 Injecting drug use

In 2003–2004 there was a rise in those taking oral morphine by injection; mainly heroin dependants who changed over to morphine due to the increased price and lower quality of sold heroin. The number of people in this group dropped in 2005 because, on one hand, the heroin quality went up and, on the other, these people were included in the Community Program for Methadone Maintenance Treatment. Expert opinion suggests 4,000–5,000 individuals were involved in problematic drug use.

Among those seeking treatment for problematic drug use, over 90% use heroin, which is considered to be the most problematic drug in Bulgaria. The number of problem heroin users is, although at reasonable rate, increasing compared to the mid-1990s. Now the probable annual increase is 2,000–3,000 people nationwide. Further, there has also been a slight increase in the presence of cannabis as an accompanying drug (to heroin) among those seeking treatment. There are, though, indications that risk-associated behaviour among problem drug users is declining. For example, the use of used needles and syringes is gradually decreasing, which decreases the risk of contracting infectious diseases such as HIV or hepatitis.

Unfortunately, there is still a lack of reliable data on problem use of opiates (apart from heroin), cocaine and other stimulants. Still, according to expert assessments, the probable number of everyday cocaine users throughout the

country is assessed to be approximately between 1,000–2,500. For the most part, people having problems with heroin (approx. 90% of those undergoing treatment in the National Drug Centre) are seeking treatment for a serious abuse or dependence on drugs. Therefore, there is a great deal of pressure on the health system to address the needs of people with problematic drug use. Research conducted through an outreach organisation amongst people with problematic drug use in four towns in Bulgaria reported a significant rise in amphetamine users. While the percentage of amphetamine use in 1998 (in Sofia) was low (9%), in 2003 it covered 41% of the problem drug users, and in most cases amphetamines were taken by injection.

3.1.11.1 Drug-related infectious diseases (HIV/AIDS, hepatitis, STIs, tuberculosis)

Among injecting drug users there are increased health risks, especially among those who use heroin, which when combined with lack of experience, information, and indifference, results in the use of shared injecting devices (over 60% of those who sought treatment in 2004). Often there are also indiscriminate sexual relationships without contraception among this group. At the same time there is a direct relation between men and women prostitutes and drug use, which creates a possibility for transmission of sexually-transmitted and infectious diseases such as hepatitis C, hepatitis B, HIV/AIDS, and syphilis.

Over 60% of those who sought treatment in 2004 were not tested for hepatitis C, hepatitis B, and HIV/AIDS. Of those tested, 24% were infected with the hepatitis C virus. There is no data on HIV/AIDS-infected people among this population, but the risk behaviour and the high percentage of people infected with hepatitis C, when no prevention and harm reduction programmes are available, raises serious anxiety for the future. In Bulgaria the total registered number of HIV-positive cases is 586, of which 40% fall within the age group 20–29.

3.1.12 Drug-related criminality

According to police reports, the percentage of young offenders (aged 18–30) is indicative of an obvious tendency toward increased offending behaviour, and of concern is the problem with the increase in the criminal activity of young people in committing various drug-related crimes. Young people aged 18–30 have the highest rate of criminal activity; 69 out of 100,000 individuals from this age group.

The criminal behaviour is the main factor for the formation of negative public response to the users. Approximately 4% of individuals taken into custody by the police in 2004 were drug users. The District Prosecutor's Office reports

that the individuals with newly-issued indictments based on preliminary proceedings for drug-related offences in 2004 make up 39% of the total number of individuals having newly-issued indictments based on preliminary proceedings.

3.1.13 National drug strategy

The *Drugs and Precursors Control Act*, the National Program for Prevention, Treatment and Rehabilitation of Drug Addiction in the Republic of Bulgaria (2001–2005), and the National Drug Control Strategy (2003–2008), are the legal foundation of the government's fight against illicit drugs in Bulgaria. The purpose of the *Drugs and Precursors Control Act* is to regulate the actions connected with the control of drugs and precursors in accordance with the requirements of the international treaties to which the Republic of Bulgaria is adhering.

The National Program for Prevention, Treatment and Rehabilitation of Drug Addiction in the Republic of Bulgaria (2001–2005), was prepared in 2000 and endorsed by the Council of Ministers[10]. The Programme is based on the experience of the developed countries in Europe and North America and fully corresponds to the Strategy and Programme on Narcotic Substances adopted by the European Community (2000–2004). The principal aim of the national programme is to promote health care reforms in the field of drug-abuse related problems. It is grounded in the idea that general practitioners play a very important role in improving medical care for drug users and those with drug-addiction problems. They should provide education and early diagnosis of drug addiction, and short-term interventions with the individual and their family to help improve the quality of and increase the scope of health services to people with problematic drug use.

The National Drug Control Strategy (2003–2008) was developed within the framework of the Partnership Agreement with Great Britain. This is a complex project that aims to speed up the elaboration of measures necessary to address both the national and international policy regarding narcotic substances. The strategy was adopted by the National Drug Council in 2002. Its fundamental principles conform to those of the EU Drugs Strategy for 2000-2004. It provides for particular measures to reduce both drugs supply and demand. After it was adopted, the corresponding Action Plan for Bulgaria was prepared. This first national strategy to fight against narcotic drugs outlines the scope of actions to be taken in the next five years. It provides for renovation of the structures to achieve the strategic objectives, and it will, in time, be complemented by an Action Plan determining the specific objectives and terms. The strategy lays the beginnings of a difficult but crucial transition to promote the joint efforts of ministries and departments to develop strategic

10 Decision No.159/27 March 2001

interactions. To develop such an approach, the strategy includes the following four key elements:

- improvement of the elaboration and implementation of a balanced policy in the field of narcotic drugs;
- creation of strategic coordination;
- improvement of information exchange;
- implementation of a local policy that will strengthen the role of the municipal drug councils.

According to Bulgarian legislation, and the *Drugs and Precursors Control Act* in particular, a National Drug Council has been formed to enforce the implementation of a national policy to fight against drug abuse and drugs trafficking. Their focus is on the supply of drugs and precursors, and includes co-operation with other countries.

3.1.14 The healthcare system

It is acknowledged that medical services in Bulgaria are regulated by the *Healthcare Organizations Act*. The provision of medical services to a detainee is not regulated in Bulgarian legislation. It is often necessary to provide police detainees medical aid immediately after arrest. In other cases a decisive factor for making a preventive examination is the police officers' assessment in order to determine whether the individual may spend a certain period of time under police arrest without the risk of deterioration in health.

At present the system of providing treatment for those with problematic drug and/or alcohol use in Bulgaria is undergoing a change, being a combination of modern and more traditional methods for treating dependencies. Psychiatric healthcare providers in Bulgaria, which also cover dependencies, comprise 11 state psychiatric hospitals, 12 psychiatric clinics, 11 psychiatric departments to hospitals of active healthcare and 4 psychiatric clinics to university hospitals. The total number of beds is 5439, from which 201 are allocated for dependent patients (there being no differentiation between problematic drug and alcohol users). However, this does not limit admittance of dependents if necessary. In 2002, the specialised healthcare institutions were visited by 1,362 patients diagnosed as being dependent on drugs and 55 patients who were drug abusers but without showing dependency. A total of 1,047 patients were under clinical observation diagnosed with dependency on drugs 220 were diagnosed as problem drug users. Simultaneously, there is a step-by-step introduction of modern forms of organisation and technologies for treatment of dependencies: substitution and maintenance-treatment programmes, day centres for intensive psychosocial work, therapeutic communities, and the use of opioid antagonists.

3.1.15 Drug-free treatment, abstinence and substitution treatment

Drug-free treatment is essentially a psychosocial therapeutic approach aiming at a full psychosocial recovery and reintegration of the dependent in which there is no, or minimum, medication. Normally, in Bulgaria this programme follows after detoxification and in some cases the intensive inpatient treatment. They are divided into two programmes, residential (therapeutic community) and ambulatory (day centres for community work).

These types of programmes are very important, and are planned to be increased in view of the further development of the healthcare system. At the end of 2003, residential treatment in Bulgaria was provided by two therapeutic communities: the Phoenix House in the village of Vrakyovtsi and the Open Society Programme, Veliko Tarnovo, in the village of Debelets. Ambulatory treatment is provided by three daily centres for community work, two in Sofia and one in Varna, the total number of beds being approximately 40. Abstinence treatment, also called detoxification, is at present, the main form of treatment in Bulgaria.

In 2003, the Ministry of Health adopted the Methadone Maintenance Development Programme increasing the number of places with such development and geographical coverage. As a result, at the end of the same year three new programmes were introduced, and the places for substitution and maintenance grew from 300 to 670. The substance currently used in these programmes is methadone hydrochloride. In addition, in the ambulatory practice (mostly private) opioid antagonists are also used (e.g. naltrexone) for continuous treatment of young patients dependent on heroin who have successfully passed the detoxification treatment.

3.1.16 Drug-related treatment: HIV/AIDS programmes

3.1.16.1 HIV/AIDS Programmes

The HIV/AIDS Prevention and Control Program is funded by the Global Fund Fight AIDS, Tuberculosis and Malaria and is coordinated and controlled by the National Coordination Committee at the Council of Ministers. By virtue of an agreement with the Global Fund the beneficiary of the funds is the Ministry of Health, which enters into contracts for periodic award of funds to other organisations to implement the programme. The representatives of the most vulnerable group are actually reached through the activities those programme subcontractors and partners perform. These are 55 NGOs, 10 Regional Public Health Protection and Control Inspections, the National Infectious and Parasitic Diseases Centre, 29 pilot schools and 10 municipalities.

The Government Information Service reported that the HIV/AIDS Prevention and Control Programme have supported the creation of a network of 15 offices[11] for anonymous and free AIDS counselling and testing. The report from the National Coordination Committee[12] at the Council of Ministers (2006) regarding the first stage of the implementation of the HIV/AIDS Prevention and Control Programme[13] during 1 January 2004 to 30 November 2005 indicates that:

- a total of 14 mobile health clinics run by NGOs are functioning in the country, 8 of which have been financed entirely with programme funds, while the work of the others is partially financed;
- local AIDS coordination offices have been set up in 10 municipalities, as well as one national division and eight regional divisions for second generation epidemiological control. The programme works with 111 schools from 13 municipalities on the stage-by-stage introduction of health studies and the development of a sexual health and AIDS prevention programme;
- seven centres are working with the Roma community;
- five key health institutions have been renovated and re-equipped within the programme. They include the AIDS Ward at the Prof. Ivan Kirov Infectious Hospital in Sofia, Division for Treatment of Patients with AIDS in St. Marina Hospital of Active Healthcare in Varna, and St. Georgi University Hospital of Active Healthcare in Plovdiv, as well as the two national referent laboratories (in virology and immunology) for therapy monitoring;
- three centres for psychosocial help for people living with HIV, their relatives and partners (two centres in Sofia and one centre in Varna) are financially supported.

The National Coordination Committee also adopted an Action Plan for 2006 to continue with the objective to preserve the low level of HIV dissemination within the country by establishing a HIV prevention capacity in the health and social sectors; establishing a functioning National System for Second

11 These offices are in Blagoevgrad, Burgas, Varna, Veliko Tarnovo, Pazardzhik, Pernik, Pleven, Plovdiv, Stara Zagora, and Ruse

12 The chairperson of the National Coordination Committee of the HIV/AIDS Prevention and Control Program is the Deputy Prime Minister. Members are from the Ministry of Health, and Deputy Ministers from the Ministry of Labor and Social Welfare, Culture, Education and Science, Defense, Internal Affairs, the Foreign Office, Finance and Transport, and representatives of academic institutions, NGOs and international organisations.

13 The principle objectives of the programme being to keep the low level of HIV dissemination in the country, to reduce risk among risk groups, and to allow target groups and people living with HIV access to quality medical care and treatment.

Generation Epidemiological Control and strengthening and supporting voluntary counselling and testing services, HIV prevention among intravenous drug addicts, HIV prevention among the Roma community, HIV prevention among prostitutes, HIV prevention among youths, as well as suitable and accessible treatment for people living with HIV/AIDS.

3.1.17 Prevention

The prevention of drug-related infectious diseases is an integral part of the two main instruments adopted by the Council of Ministers of the Republic of Bulgaria: the National Programme for Prevention, Treatment and Rehabilitation of Drug Addiction in the Republic of Bulgaria (2001–2005) and the National Strategy for fighting against drug addiction (2003–2008). In the National Programme for Prevention, the activities for the prevention of drug-related infectious diseases relate to Area 4, 'Activities and programmes for decreasing health and social damage caused to the society and the individual by drug abuse.' The objectives of the interventions in this area are:

- to maintain the low level of HIV infection among intravenous drug addicts;
- to decrease the level of the hepatitis C-infected intravenous drug addicts;
- to decrease criminality of drug addicts and drug dependents.

In the Action Plan to the National Strategy the activities on the prevention of drug-related infectious diseases are in Area 5, 'Decrease in the spread of diseases among drug users that affect society — blood transmitted infections (HIV/AIDS, hepatitis B and C, etc.), tuberculosis, STIs, etc.' The sub-objectives of this are to train field teams to work with problem drug users; develop and implement programmes for field work, exchange of needles and syringes, distribution of condoms and consultations; identify problems and preparation of harm reduction programmes in particularly difficult-to-access and high-risk groups and to provide early testing programmes (including in field), pre- and post-testing consultations, and ensuring referrals for specialised treatment. The National Drug Addiction Centre (NDAC) provides courses of training to professionals engaged in the programmes for decreasing the damage to health as a result of drug use. This module is also included in the NDAC postgraduate qualification course for the training of physicians, psychologists, social workers and nurses.

However, there remains a serious problem in the treatment of hepatitis C infection. According to the existing regulations of the National Health Insurance Department, drug dependents could be included in the interferon treatment programme only if they have not taken drugs for more than six months. This treatment is provided to a very limited group of patients in the gastroenterological clinics, and because of the above reason it is essentially not

accessible to drug users. However, according to unconfirmed reports for 2003, such a treatment was provided to 10–15 persons who had taken drugs.

3.1.18 Human rights

The human rights situation comes under the jurisdiction of various ministries and the following indicates some actions that need to be taken.

3.1.18.1 Human rights under the Ministry of Justice

The institutions for deprivation of liberty under the Bulgarian Ministry of Justice need serious reform to comply with international standards. The most urgent need at present is to deal with the overcrowding in most prisons and in some of the remand centres. At the same time, the government needs to launch a programme for reform that envisages more diverse forms of custody, including individual placement. Urgent steps should be taken to improve the material conditions in cells, especially those for life-sentenced prisoners and disciplinary cells and all underground remand centres should be closed down. The staff and the authorities of the prisons should make use of all means at their disposal to prevent inter-prisoner violence and intimidation and must ensure assistance to the victims, and conduct prompt and impartial investigations.

Medical services in the institutions of the Ministry of Justice are not integrated with the national healthcare system. In future, doctors and other medical staff should be given independent status and supervised only by medical authorities to allow the fulfilment of their duties as medical professionals. Detainees at both prisons and remand centres should be offered more opportunities for activities and rehabilitation. The Bulgarian system should envisage and arrange for long-term and spousal visits to the inmates and should provide for appropriate establishments for this.

All prisoners, including foreigners and prisoners from ethnic minorities should be treated equally and without discrimination. More due-process guarantees should be introduced in imposing disciplinary measures in order to avoid arbitrariness. The practice of regularly checking the correspondence of sentenced prisoners is a clear violation of a number of international standards and should be repealed.

3.1.18.2 Human rights under the Ministry of Interior

The practice of torture and prohibited ill-treatment in police establishments, which was widespread in the past, decreased somewhat but still takes place. A lot of this is practiced with impunity and not all cases of police detention are

duly recorded. The Prosecutor's Office and the Ministry of Interior should take further measures to investigate these cases to bring perpetrators to justice. A special crime of torture should be adopted in the Penal Code and independent human rights defenders should be allowed to regularly monitor places of police detention.

Material conditions in some police stations are very bad and need to be improved. Unlawful practices of physical restraint while in police custody still take place. Access to legal aid from the moment of detention should be made effective through further strengthening of the legal framework and practice.

3.1.18.3 Human rights under the Ministry of Health

Despite serious efforts to reform the legislation regulating the commitment of patients to psychiatric institutions for active treatment a lot remains to be done to respect the law and to allow the inmates of these institutions to benefit from it. Forms of treatment in the hospital should be diversified and should include occupational, art, sports and group therapy, in which all patients should be involved. Treatment should make use of the modern anti-psychotic drugs, which should be made available and accessible to the patients. A clear and precise complaints procedure should be made available to all patients. Patients in the closed wards should be allowed to spend sufficient time for outdoor exercise. The staff should make sure that patients are not subject to physical abuse from other patients or from orderlies. All signs of physical abuse by officials should be reported to the relevant authorities, investigated and prosecuted.

3.1.18.4 Human rights under the Ministry of Labour and Social Policy

Despite some progress, the material conditions in many social care homes for persons with mental disabilities in Bulgaria need to be substantially improved. The government should consider developing a programme of deinstitutionalisation of social care for the mentally-disabled through programmes that discourage placement of children in social care institutions and through establishing facilities and types of care that are akin to a family environment. At the same time, the quality of care in institutions should be substantially improved. A meaningful programme of activities should be organised in all social care institutions for all residents on the basis of a careful assessment of their individual needs.

A court procedure should be established for placement of people under guardianship in social care institutions, as at present the procedure allows for arbitrary placements and does not respect the international standards for treatment of persons deprived of their liberty. Personal security is a serious problem in the social care institutions of Bulgaria. Measures need to be taken to eradicate any physical abuse of residents by the staff or by other residents.

Staff in the social care institutions should be trained to understand and to attend to the specific needs of the residents.

3.1.18.5 Human rights under the Ministry of Education and Science

The schools for delinquent children in Bulgaria in their present form deprive the students of a family environment and hardly serve any educational and rehabilitative purposes. Their future, therefore, should be seriously reconsidered. The procedure for placement in the schools for delinquent children should be further reformed and brought in line with international juvenile justice standards. Material conditions in some of the schools are bad and need to be improved. The situation with personal security in these institutions should also be improved. Measures should be taken to prevent any form of violence. Meaningful educational and rehabilitative activities should be envisaged.

3.1.19 Police detention: duration and registration of police detention

Human rights violations as a result of the actions of police officers in Bulgaria have often been made the object of investigations and comments on the part of local and international governmental and non-governmental organisations. These violations are connected to illegal detention in the structural units of the Ministry of the Interior or outside them and with the use of physical force, auxiliary means or weapons during arrests or after detainees have been taken to police stations in the course of interrogation and other procedural actions.

On the 23rd June 2003, the Interior Ministry adopted *Instruction No. I-167 on the procedure and actions of police bodies in detaining persons in the structural units of the Interior Ministry, on equipping facilities for accommodating detainees and maintaining order in them*[14]. Adoption of this instruction was a positive step, mainly because it introduced some measures for the prevention of torture, inhuman and degrading treatment during police detention for the first time in Bulgaria. It requires the duration of detention under the Interior Ministry Act to be considered as from the moment when the freedom of movement of these individuals is restricted (Art. 12). In February 2006, the Parliament of Bulgaria adopted a new *Interior Ministry Act*, in which the guarantees introduced by *Instruction I-167* were provided for by law.[15]

During its research, the Bulgarian Helsinki Committee (BHC) documented a number of cases in which persons had been *de facto* detained in district police stations without this being duly recorded by order and without observing the

14 Promulgated in the *State Gazette*, Issue No. 71 of the 12th August 2003, in force from the 12 September 2003
15 *State Gazette*, No.17/2006 in force since 1 May 2006, hereafter IMA.

guarantees for adherence to the three fundamental rights of detainees. During BHC interviews with detainees in prisons, *de facto* detentions exceeding 24 hours were described, despite the fact that the duration of the detentions entered in the book of detainees and their detention orders was less than 24 hours. In examining the documentation on district police station detentions, the BHC discovered that in many detention orders the time and date of release of the detainees were not entered.

3.1.20 Cases of torture and other ill-treatment

Bulgarian legislation contravenes international law, in some of the provisions it contains and what is lacking in it. Although Bulgaria has been a party to the UN Convention Against Torture since 1987, Bulgarian criminal legislation still contains no provisions to criminalise torture as is required under Art. 4, subparagraph 1 of the Convention. In June 2004 the UN Committee Against Torture yet again recommended that the necessary changes be entered into the criminal code to criminalise torture.

Investigation of the reasons for the use of torture and ill-treatment by police officers shows that such practices facilitate the extraction of evidence but in some cases are purely punitive in character. *Instruction No. I-167* does not contain detailed provisions for cases in which physical force, auxiliary means and firearms are used and refers these cases to the *Interior Ministry Act*. The new Act regulates the use of force and firearms in Articles 72, 73 and 74. The provisions are the same as in the old law, including on the use of firearms. The new law too permits the use of firearms during the arrest of an individual who is committing or has committed even a petty crime, or to prevent the escape of an individual arrested for committing even a petty crime. This does not conform with Principle 9 of the *UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*. *Instruction I-167* obliges police officers who have witnessed the excessive use of physical force, torture or inhuman and degrading treatment against a detainee to intervene with the purpose of preventing it and to inform their superiors immediately.

However BHC documented numerous cases of torture and other illegal use of force, practiced with impunity during a focused research in December 2005-January 2006 mainly through interviews with detainees during visits in four prisons in Bulgaria. Such information became available to the organisation also through other sources: letters, verbal statements received in the offices of the BHC personally from the victims of violence, and media announcements.

3.1.20.1 Cases of abuse by police officers

- In an interview in the Bobovdol prison, P. P. K. declared that during detention by police officers in Plovdiv in October 2004 he was punched and beaten with a metal pipe. The policemen continued to beat him after loading him into a police vehicle. He was also beaten for a long time in the police station.
- C. M. in the Belene prison declared that in May 2004 he and three of his friends were detained in Dobrich by a total of ten uniformed policemen while they were collecting scrap metal. The four were brutally beaten with truncheons on their arms and legs and were kicked with boots. The beatings continued after they had been taken to the police station. As a result of the blows his arms and legs swelled up. The policemen told him to put his limbs in cold water to bring down the swelling.
- R. C. in the Bobovdol prison said that in December 2004 he had been arrested at his home in Velingrad. From the moment they entered his home, the four policemen began to beat him. The beatings continued after he had been taken to the police station. The policemen used truncheons with which he was even hit on the head. He was also threatened with a pistol, which was also used to hit him on the head. During his 24-hour detention he was taken several times to the hospital and was refused first aid.
- A twenty-year old illiterate Roma prisoner in the Bobovdol prison (E. V. M.) was detained on the 12th April 2004 in the Dupnitsa district police station by two uniformed policemen who punched and kicked him during an interrogation in the district police station building. Afterwards, he was taken to the hospital in Dupnitsa and the doctor who examined him said that there were no traces of injury. He was not given any document from the examination. After the assault he was provided with a legal aid defence counsel, who also failed to advise him to seek protection against police violence with regard to the assault.

According to detainees in about 70% of cases, assaults continued at a later stage with various auxiliary means: truncheons and other objects. Assaults are frequently combined with insults and threats. The use of physical force is not the only means of extracting evidence or inflicting punishment. The use of threats and other means of torture unrelated to the use of physical force should also be added to the list. On the basis of information from the Military Court of Appeal, a total of 35 Interior Ministry officers were punished in 2005 for police brutality. Seventeen of them were detained and administrative sanctions were applied to the other eighteen. Court statistics indicate that the use of force by policemen is usually to obtain confessions.

Several surveys conducted by BHC and other organisations over the period 1999–2005 indicated a decrease in torture and other types of prohibited ill-treatment by law enforcement officials in Bulgaria.[16] This was due to a number of factors, including the improved access to legal aid during the pre-trial stage; domestic and international pressures to bring perpetrators to justice and several decisions of the European Court of Human Rights in Strasbourg. Yet, prohibited ill-treatment is still practiced during arrest and inside police stations and is not investigated adequately.

3.1.21 Recent cases of death after use of force by police officers and their investigation

In the last few years the number of cases of death or severe mutilation as a result of the excessive use of physical force or auxiliary means and firearms has decreased but did not cease. Over the past four years the BHC received information about four cases in which police officers killed civilians. Action was taken to investigate some of the cases and hand the offenders over to the judicial authorities. In other cases the behaviour of the investigation authorities was inadequate and led to impunity for the police officers.

An example of this is the case of Angel Dimitrov. On the 10th November 2005, as part of the planned police operation dubbed "Respect", 38-year old Angel Dimitrov, nicknamed Chorata, died while resisting arrest on Doyran Street in Blagoevgrad. According to the Interior Ministry version, in order to arrest him, five police officers (three officers and two sergeants from the Blagoevgrad District Police Directorate special forces) resorted to the use of force because Dimitrov was resisting arrest. Shortly after he had been handcuffed, Angel Dimitrov fell to the ground and the ambulance team, which had been summoned, merely noted his death. Witnesses to the incident, however, assert that Angel Dimitrov did not resist, but pleaded with the policemen to stop beating him because he could not breathe. According to the forensic results made public on the 11th November by the Head of the Blagoevgrad District Police Directorate, General Bogomil Yanev, Angel Dimitrov had had a heart attack, and although the policemen had used force, his death had been unconnected to their actions. Angel Dimitrov's relatives refused to have him buried and demanded a second forensic investigation, which was carried out on the 19th November. On the 7th December it was revealed that the second five-fold forensic investigation had shown that Angel Dimitrov had died as a result of the injuries he sustained during the arrest (a brain haemorrhage), provoked by the police assault. On the 14th December, the Sofia Military District Prosecutor's Office unexpectedly issued an order to discontinue criminal proceedings. This act, which legitimised police impunity, shocked the whole of

16 Cf.: BHC, Human Rights and the Work of the Bulgarian Police, Sofia, 2004, p.36; Cf. also the annual reports of the BHC on the human rights in Bulgaria, available at: www.bghelsinki.org.

society and provoked stormy debate in the Bulgarian media. On the 8th January 2006, the lawyer acting for the victim's family submitted an appeal to the Sofia Military Court against the 14th December order. On the 19th January 2006 the Sofia Military Court withdrew the prosecutor's order and resubmitted the case for further investigation.

3.1.22 Notification of rights: access to a lawyer and an independent physician

Article 18 of *Instruction No. I-167* regulates the obligations of detention authorities to acquaint detainees with their rights to medical assistance, legal defence, to inform relatives or other close acquaintances of their arrest and to appeal to the court against the legality of the arrest. For this purpose, the detainees fill in a special declaration form, of which they keep one copy. Apart from declaring that they have been acquainted with their rights, the detainees also declare whether they wish to use a defence counsel, to be examined by doctor and to notify their relatives or close acquaintances of their arrest.

In accordance with Article 63, para. 5 of the new *Interior Ministry Act*, persons have the right to legal defence from the moment of their arrest. *Instruction No. I-167* also stipulates the requirement for the person to be informed of the grounds for detention immediately after arrest and of his or her right to a defence counsel. Investigation of practices with regard to observing the right to a defence counsel shows that police officers do not commit themselves to such practices during 24-hour detention. In many cases they explain that the detainees do not need a defence counsel before they have been charged, or argue that there are problems with the solicitors hired by persons detained who have committed serious criminal acts, who often threaten the district police station staff. In the text of the declaration signed by the detainees, no explicit distinction is made between legal-aid defence and the choice of detainees to hire their personal solicitor. BHC surveys of the right to counsel conducted every year reveal that legal defence counsels are usually not allowed to participate during the 24-hour police detention under a variety of pretexts.

Just as the old *Interior Ministry Act*, the new Act too does not provide for the access to a medical doctor of detainee's choice from the moment of detention. *Instruction No. I-167* provides for such possibility in Article 20, paragraph 5. BHC research of the medical care during police detention revealed that practices in that regard vary. In a few police stations, medical examinations are carried out immediately after the arrest of all detainees. In all other police stations medical examinations are only carried out if the person's state of health requires it. The examinations are usually carried out by paramedical teams and less frequently by doctors employed by the District Police Directorates. In very rare cases, medical examinations are carried out by the detainees' own general practitioners. In most police stations the medical certificate is attached to the detainee's file. However, in some police stations a

copy of the medical certificate has been attached to the arrest warrant and the declaration.

With the text under subparagraph 3, the detainee not only declares that he or she wishes to have a medical examination but also declares that he or she wishes to be examined by a doctor of his or her choice and at his or her own expense, that is, the detainee would have to have a particular doctor in mind or be given the opportunity to choose a doctor whom he or she would pay for after the examination. Formulated as such, the text far from encourages detainees to call for a medical examination even if they are ill. The BHC found that only in a few of the district police stations visited have contacts been made with general practitioners on specific demand by detainees. The text under subparagraph 3 also gives rise to a number of problems for police officers. In cases where there are large numbers of detainees, in order to avoid the problems which would arise from them all wishing to have a medical examination, usually the police officers fill in the declarations themselves and give them to the detainees to sign at the bottom, or the employees dictate to the detainees what to write in the declarations.

In the police remand houses health care is provided by a felcher:

> a felcher is something from the past, they study for 3 years and get training above nurses but they are not doctors. They are like a paramedic and are able to prescribe some medicine governed by a series of restrictions. They can't work with the health insurance offices. It used to be usual for them to work in the villages on simple cases but with the introduction of the health insurance system they no longer exist apart from in the remand houses (Interview Director of the Methadone Programme, Varna March 2005).

3.1.23 Notification of third persons about the arrest

The new *Interior Ministry Act* provides for the right of detained persons to have a person of his/her choice notified about their detention.[17] This is usually done by the police, which are under an obligation to inform such a person 'immediately'. In cases of illegal detentions however, when the risk of ill treatment is the highest, this is usually not done.

17 Interior Ministry Act, Article 63, paragraph 6.

3.1.24 Prevention of drug dependencies, hepatitis B/C, HIV and syphilis: pilot project[18]

The project was implemented within the period April–July 2005, with a preparatory stage in February and March. The scope of project involved training sessions for drug-dependent prisoners; HIV, hepatitis B and C, and syphilis blood testing; distribution of information materials and condoms and training sessions for the prison officers.

As a principle, the delivery of health messages and health status motivation to drug users is not easy, and far more difficult under prison conditions. Most of the participants shared their willingness to participate regularly in similar training that may be organised as a whole cycle.

To test for HIV, hepatitis B and C, and syphilis, blood samples were collected between 26.04.2005 and 28.04.2005 in the prison's health service in Sofia. Initially, the testing was planned to be conducted only among drug dependents but the selection process proved to be problematic as drug taking was self-reported by participants and it was felt unethical to refuse testing to those who did not identify themselves as drug users. A total of 111 prisoners were tested (Table 1) but it is not clear what percentage are dependent on drugs, and the spread of infections among such a subgroup cannot be analysed. As a whole blood testing for virus infection carrier state was well accepted by prisoners.

Table 1: Details of the blood tests results

	HIV	*Anti-HCV*	*HBsAG*	*Syphilis*
Positive	3	22	9	11
Reactive (newly infected, require re-test in 1 month)	6	0	0	0
Negative	102	89	102	100
Total	**111**	**111**	**111**	**111**

18 Project Partners – Initiative for Health Foundation, and Central Administration "Execution of Punishments"

Table 2: Details of participants with co-infections

Co-infections	*Number of persons tested*
HIV+HCV	1
HIV+HBV	0
HIV+ syphilis	1
HIV+HCV+HBsyphilis	0
HCV+HBV	3
HCV+ Syphilis	2
HBV + syphilis	0
With no infections	69

Several kinds of information materials (brochures) were printed and distributed in 13 prisons within the country. Most of them were materials already prepared by the Initiative for Health Foundation providing information about the different kinds of drugs and the risks connected to HIV and hepatitis, safe injection, overdose, and trauma caused by improper injection. Furthermore, in consultation with specialists from Central Administration 'Execution of Punishments', a specialised health brochure for male prisoners was developed, in the form of a pocket book covering the following themes: personal hygiene, cares for teeth, dermatological diseases, infectious diseases, tuberculosis, hepatitis, sexually transmitted diseases and use of condoms, HIV/AIDS, drug use and injection, first aid, and psychological advice. In addition, 1,500 condoms were provided to the prison's health service in Sofia. The objective of the sessions for the prison officers was to make them well informed about drugs and infections among officers that are socially significant. The difficulty here resulted from the process of organisation: the 24-hour shifts of the officers and the inability to engage them in any other time except after their long shifts.

3.2 England and Wales

3.2.1 Organisation of the criminal justice system

The Criminal Justice System (CJS) of England and Wales incorporates the police, the courts, the prison service, the Crown Prosecution Service and the National Probation Service. The work of all these agencies is overseen by the

Ministry of Justice[19], the Attorney General's Office[20], and the Department for Constitutional Affairs[21].

Decisions regarding the prosecution of a case falls, first, to the police or other law enforcement agencies such as Customs and Excise, and then to the Crown Prosecution Service (CPS) which reviews the evidence collected by the police. In reviewing cases, the CPS has strict criteria to determine whether a case can proceed to court, which includes the evidential test and public interest test. The evidential test must confirm that there is enough evidence against an offender to lead to a conviction and the public interest test is in place to help prosecutors decide if a case warrants further action, depending on the seriousness of the offence and the characteristics of the offender. This then proceeds through various different courts, for trial and sentencing, which can be in the community or in prison.

3.2.2 Structure and organisation of the police service

The police service for England and Wales is under the management of the Justice Ministry. The police force is not centralised, there are 43 county police forces across the UK, including the London Metropolitan Police. In addition there are specialist forces that operate at a nationwide level, such as the Serious and Organised Crime Agency (SOCA), British Transport Police and military police. At the county level, police officers' roles include patrolling the streets, acting as community liaison officers, working with other agencies to prevent crime and also investigating crimes, processing suspects in detention and working with the probation service in supervising offenders.

Those responsible for dealing with problematic drug and alcohol use are part of the new Drug Intervention Programme, which sets out a range of strategies to address the harms caused by problematic drug and alcohol use. For example, arrestees are tested for drug use and those who test positive are required to attend an assessment, even if they are not charged. The assessment is carried out by specialist drug workers, also known as arrest referral workers, who aim

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19 Formerly the police, courts and prisons were governed by the Home Office which is the government department responsible for the criminal justice system and is now focusing on immigration and security issues

20 The Attorney General, assisted by the Solicitor General, is the chief legal adviser to the Government. The Attorney General is responsible to Parliament for the Crown Prosecution Service (CPS), the Serious Fraud Office (SFO), the Revenue and Customs Prosecutions Office, the Treasury Solicitor's Department and the Director of Public Prosecutions in Northern Ireland (see www.cjsonline.gov.uk).

21 The Department for Constitutional affairs is the government department responsible for upholding justice (courts and criminal justice system), rights (including human rights legislation) and democracy (law and policy relating to elections and the constitution) (see www.dca.gov.uk)

to establish users' needs and refer them to appropriate treatment. Failure to comply with this can lead to a prison sentence or restrictions on bail.

3.2.3 Police detention

Those arrested by the police or who arrive voluntarily at a police station and are subsequently arrested can be detained for the purposes of carrying out the investigation of an offence. Detainees are monitored and processed by custody officers who must keep accurate records of what happens during the time in detention, including health problems, meeting with lawyers and interrogation by other police officers. Detainees' rights include:

- the right to have someone informed of his or her arrest;
- the right to consult privately with a legal adviser;
- the right to consult this and any other Codes of Practice currently in force (See PACE 1984, Code C, Section 3).

Detainees must also be detained in a warm cell with clean bedding, have food and exercise regularly and at least eight hours rest in every 24-hour period. The maximum length of detention is 24 hours, which can be extended to 36 hours under the authority of the Police Superintendent and 96 hours by the authority of a magistrate. At the end of the period of detention, suspects must either be charged and remanded in custody at a pre-trial prison, charged and released on bail (sometime with conditions such as curfews and reporting to the police on a daily or weekly basis) or released without charge. The main exception to this is the Terrorism Act 2000 under which detainees can be held without charge for up to seven days.

The Police and Criminal Evidence Act (PACE 1984)[22] sets out a range of guidelines for police officers when dealing with suspects at arrest and detention. During detention, police officers must inform detainees of their rights and get signed acknowledgement, and also provide additional help for non-English speaking detainees, in the form of a translator. There are also additional provisions for juveniles arrested by the police, such as informing the person responsible for the juveniles' welfare about the reason for the arrest, length of detention and where they are being held. Section 3.11 of Code C stipulates guidelines for mentally disordered detainees, who must be assessed by a qualified medical practitioner as soon as possible to determine if they are fit for interview and fully understand what has happened to them. Annex G of code C sets out regulations regarding 'fitness to be interviewed' and is

22 The Police and Criminal Evidence Act (PACE) and the PACE Codes of Practice provide the core framework of police powers and safeguards around stop and search, arrest, detention, investigation, identification and interviewing detainees. PACE sets out to strike the right balance between the powers of the police and the rights and freedoms of the public (see http://police.homeoffice.gov.uk/operational-policing/powers-pace-codes/pace-code-intro/)

primarily concerned with ensuring police officers establish the physical and mental health of detainees, with assistance from forensic medical examiners, or police surgeons. This can include identifying those intoxicated with drugs or alcohol who may require treatment to deal with withdrawal symptoms, or other health problems that may arise.

3.2.3.1 Partnership working

Partnership work has been defined as organisations with 'differing goals and traditions, linking to work together' (Home Office 1992). In the case of dealing with problematic drug and alcohol users, this can include strategic partnerships, for example, drug action teams (DATs), crime and disorder reduction partnerships (CDRPs) and local strategic partnerships (LSPs). The *Crime and Disorder Act, 1998* stipulates guidelines for criminal justice agencies, including the police, to work in partnership with each other and also with other social services such as health and education providers. These guidelines have been formalised with the development of Crime and Disorder Partnerships, which aim to address the problems of local communities, including drug- and alcohol-related crime. In addition, arrest referral workers, based in police stations, need to make contacts in the community to refer drug users identified in police detention to community-based treatment and harm reduction services. Partnership working enables healthcare services, treatment services and criminal justice professionals to co-ordinate the various interventions to address all the needs of problematic drug and alcohol users. This can involve information sharing, referrals, and the development of clear protocols between mental health and drug misuse services, to treat service users with a dual diagnosis. It is also important to consider the role and contribution made by consulting with users and user groups, carers and carers' groups, communities and community groups and voluntary and community services (National Treatment Agency 2005).

3.2.3.2 Forensic medical examiners

The majority of healthcare services, including assessment and treatment in police detention are provided through forensic medical examiners. The general principles for forensic medical examiners to follow are to ensure equivalency of care for all detainees, including those in prisons, police stations, young offenders' institutions and asylum seeker detention centres. The British Medical Association has developed guidelines to address the healthcare of detainees in police custody. A report by the Audit Commission in 1998 identified a need for reform and standardisation of medical care for police detainees to address problems such as difficulties in recruiting doctors to work in police stations, variable standards, inadequate facilities for examining and monitoring detainees, poor communication and feedback, lack of formal protocols in some areas and poor management. The report also recommended

that other healthcare professionals could assess and treat some of the health problems presented by detainees, such as nurses based in police stations and paramedics, which would also provide wider and more comprehensive coverage. Custody nurses have been piloted in one police force in England, and the evaluation of this service is due for reporting soon (British Medical Association 2006).

3.2.4 The courts

The structure of the courts system in England and Wales ranges from locally-based magistrates, Crown Courts and County Courts, to specialist courts dealing with family law, juveniles and administrative cases, and at the highest levels, the High Court, Court of Appeal and the House of Lords. The court system in England and Wales deals with both civil and criminal cases. County courts are set up to deal with civil cases only (for example divorce, contract disputes, negligence cases). Magistrates courts deal with limited civil cases (licensing and family law) and criminal cases and the Crown Court deals only with criminal cases. Beyond that is the High Court and European Court of Justice, which will deal with the most serious cases. The Crown Court, House of Lords and European Court can also all deal with appeals against judgements or sentences. Most cases begin in the Magistrates Court, and depending on the type of offence are either referred to Crown Court, or dealt with by the magistrates. Magistrates' courts are a key part of the criminal justice system and 95% of cases are completed there, however, magistrates cannot normally order prison sentences longer than six months (or 12 months for consecutive sentences), or fines exceeding £5,000. In cases where sentences may exceed six months, the offender may be sent by magistrates to the Crown Court for sentencing.

There are a range of sentences for problematic drug and alcohol users, in both the community and in custody, which include Drug Treatment and Testing Orders (DTTOs), conditional cautioning and the Integrated Drug Treatment System (IDTS) in prisons. Drug treatment and testing orders are community-based sentences, requiring offenders to undergo treatment and random, compulsory testing. In 2000, it was rolled out nationally as research findings demonstrated a significant reduction in the use of illegal drugs and associated criminal activity among those offenders subject to the order (INCSR 2002).

3.2.4.1 Drug courts

Courts dealing specifically with drug users on treatment orders in the community were piloted in Scotland in 2001, with a key aim of reducing problematic drug use and offering treatment options to offenders. Drug Court ‘Sheriffs’ also have responsibility for reviewing orders passed by the Drug Court, along with a supervision and treatment team that reports regularly to the

court. An evaluation of this scheme found that greater use was made of existing sentencing provisions for drug users, such as DTTOs. Offenders could be referred to a range of treatment services, provided either in the community or in-house (depending on the extent of services already available) and included methadone maintenance and reduction, lofexadine detoxification and naltrexone maintenance and benzodiazepine detoxification, and abstinence-based programmes.

A key element of the approach of Drug Courts is multi-agency working to include other criminal justice and social services agencies to address the range of needs presented by people with problematic drug use. The results of the evaluation were generally positive, in relation to resources issues and effectiveness, however no plans are currently in place to introduce these courts on a national level (McIvor et al. 2003).

3.2.4.2 Prison and probation

The prison service in England and Wales is now managed, along with the probation service, by the National Offender Management Service (NOMS). This organisation aims to manage offenders both in prisons and on community sentences from the start of their sentence and also beyond it. This involves working with other public sector, voluntary and community-based agencies, in order to work towards its key aims of protecting the public and reducing re-offending.

The National Probation Service (NPS) is responsible for supervising offenders on early release from prison sentences and those on community based sentences such as curfews and drug treatment and testing orders. The main role of probation officers is to help rehabilitate offenders, enforce court orders and licenses, conduct risk assessments and ensure protection of the public and address the causes of clients' offending behaviour.

3.2.5 Training for criminal justice staff

The majority of training programmes for staff working in the criminal justice system is based on in-house provision, specific university (undergraduate and post-graduate level) courses and specialist courses provided by outside agencies. For example, Centrex is the main organisation dealing with police training, and works with the Home Office, Her Majesty's inspectorate of Constabulary, Association of Police Authorities and the Association of Chief Police Officers as well as directly with the 43 police forces in England and Wales.

Training in drug use, harm reduction and related issues is usually provided by outside agencies, such as Drug Scope and HIT UK (an organisation based in

Liverpool specialising in harm reduction training for criminal justice professionals).

3.2.6 Extent and trends in problematic drug and alcohol use and associated health problems

In the UK, problem drug use has been defined as:

> "anyone who experiences social, physical, legal or psychological problems with one or more drugs" (Advisory Council on the Misuse of Drugs 2006).

This can include health problems with the continued and excessive use of drugs and alcohol, as well as the risks of contracting communicable diseases through injecting drug use and the development of mental illness. In addition, problem drug users often come from more socially deprived groups and are often engaged in offending as a result of this (Table 1).

Table 1: National prevalence estimates for problem drug use and injecting drug use in the UK

Country	*Year*	*Problem drug use*	*Injecting drug use*
England	2000/01	287,670	93,185
Northern Ireland	2000	828	No estimate
Scotland	2000	55,800	24,696
UK	**2000/1**	**360,811**	**123,498**

Source: Information Services Division (ISD 2002); McElrath (2002); Frischer et al. (2004); Hay (2005b), from EMCDDA 2005

The prevalence of drug use in the UK has remained relatively stable in the last few years, although concerns have been raised regarding the use of cocaine and ecstasy. Young adults, particularly those under 25, are more likely to use drugs. Lifetime prevalence rate for this group is 45% (EMCDDA 2005). Cannabis is the most widely used drug, followed by class A drugs such as cocaine, ecstasy and crack. The use of amphetamines and LSD has decreased. Certain groups are more likely to use drugs such as young offenders, children in need, care leavers, homeless young people (Lloyd 1998; Gilvarry 2001; DrugScope and DPAS 2002), and children of drug-using parents (ACMD 2003). Males are significantly more likely to report drug use than females, the reported lifetime prevalence of any illicit drug being 39.9 per cent for males and 28.2 per cent for females (Hay 2005a).

Findings from the British Crime Survey have shown that illicit drug use is higher in urban centres, compared to rural areas (Chivite-Mathews et al. 2005). Within inner cities, use was higher in more affluent areas, and overall in the UK, London has the highest prevalence of drug use (14.7% for use in the last year) compared to 12.3 per cent for the whole of England and Wales (EMCDDA 2005).

In England and Wales, the risk factors associated with class A drug use were identified as being young, male, single, visiting pubs or wine bars three times or more a week or visiting a nightclub and living in a terrace or flat/maisonette (Chivite-Mathews et al. 2005).

3.2.7 Drug-related crime

In the UK, between 2000 and 2003, drug-related offences increased by 14% (from 102196 to 116,429) (Mwenda 2005). The National Treatment Outcome Research Study (NTORS) showed that just over 1,000 drug users reported committing 27,000 acquisitive and 40,000 drug-supply offences in the 90 days prior to starting treatment (Gossop 2005b).

As noted in Chapter 1, new legislation in the UK in 2000 (*Criminal Justice and Court Services Act*) means that police officers can now test all suspects charged with a trigger offence (acquisitive crimes, violence): this has now been extended to include all detainees in recognition of the wide range of offences which can be attributed to drug use. Prostitution is a clear example of drug-related crime as many sex workers are also engaged in drug use, and as a result of police operations focusing on the crack market, out of 118 prostitutes arrested, many were referred to drug-treatment services (Home Office 2004d). In addition, between 1985 and 2002, the number convicted for sex work offences decreased by 73% (from 10193 to 2717) in England and Wales. Among those defined as people with problematic drug use, there is overwhelming evidence of clear, but complex links to offending.

Patterns of drug use among populations in police custody have changed significantly, for example a, study in London showed that, in 1992, 30% of detainees reported using crack cocaine, whereas in 2003, the figure was 87%. Heroin and injecting drug use decreased, as did reports of needle sharing (Payne-James et al. 1994 2005).

3.2.8 Blood-borne viruses among injecting drug users

HIV prevalence among injecting drug users in England and Wales declined in the early 1990s from 5.6 per cent in 1990 to 0.6 per cent in 1996 and then increased in recent years to 1.4 per cent in 2003 (Hope et al. 2005). Amongst current IDUs participating in the UAPMP (Unlinked Anonymous Prevalence Monitoring Programme) agency survey in England and Wales in 2004,

prevalence of HIV was recorded at 1.5 per cent (Health Protection Agency 2005a). This increase may be due to higher levels of crack cocaine injecting as evidence shows this group are more likely to engage in high-risk behaviours. Among such users two-fifths were more likely to have engaged in sharing needles and syringes in the last month (42% compared to 29% of those not injecting crack cocaine) (Health Protection Agency 2005a). The UAPMP survey also showed that in 2004, 45 per cent of the current IDUs have been infected with HCV (viral hepatitis) (Health Protection Agency 2005a), which constitutes an increase from 40 per cent of current IDUs in 1998 (Hope et al. 2001).

3.2.9 Alcohol use trends in the UK

The recommended weekly allowance for alcohol consumption in the UK is 21 units for males and 14 for females[23]. A survey of 'heavy and hazardous' drinking in the UK found that 38% of men and 23% of women reported having drunk more than four units of alcohol on at least one day in the past week. In addition, 21% of men and 10% of women reported having drunk twice the recommend daily amount of alcohol units on at least one day in the previous week.

The World Health Organisation (WHO) GENACIS Study (2000) defines heavy episodic drinking as 'consumption of 75g or more of pure alcohol in one sitting at least once a month in the last year', and it is also referred to as 'binge drinking'. A national survey of 18–64 year olds showed that, in the last 12 months, men reported that 40% of their drinking occasions could be defined as binge drinking, and that for women this figure was 22% (Eurocare 2003).

The health and social problems associated with excessive alcohol use in the UK have been reported as affecting work performance (including loss of productivity, absenteeism, safety, employee relations, poor behaviour and the impact on company image). A survey found that 90% of British organisations reported alcohol to be a problem in their workplace. In addition, 25% of accidents at work and 60% of fatal accidents at work were attributed to alcohol use (Department of Health 2003). Alcohol is also seen as a strong contributing factor to many admissions to hospital: up to 150,000 admissions occur each year as a result of acute or chronic alcohol use and one third of all accident and emergency attendances may have alcohol as a direct cause or contributing factor (WHO 2004).

Another impact of alcohol use is road traffic accidents, with 6% in 2002 involving illegal alcohol levels, and 15% of fatalities were due to someone driving over the legal limit (Institute of Alcohol Studies 2003).

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23 http://www.bupa.co.uk/health_information/asp/healthy_living/lifestyle/alcohol/alctest.asp

The 1998–99 Youth Lifestyles Survey showed among those aged between 18–24 years, engaged in binge drinking, 39% had committed a criminal offence in the last 12 months. Among this group 17% had committed a violent crime, 15% had taken part in a group fight in a public place, 11% had committed theft and 4% had committed criminal damage (Goulden and Sondhi 2001).

Research into the offences of drunkenness among police detainees, showed that being drunk often lead to aggressive behaviour, the need for medical assessment and treatment, additional observation by police officers and delays in implementing interview procedures. In addition, it was observed that the general physical condition of many chronically-drunk people was very poor (Gibb and Pearson 1995).

3.2.10 Research into problematic drug and alcohol users detained by the police

Problematic alcohol users detained by the police constitute a significant proportion of arrestees, with 15% being arrested for an alcohol-specific offence, and 16% for alcohol-related offences. Half of the police officers interview for this research reported that dealing with intoxicated detainees was a misuse of police resources, and many felt they were not adequately trained to deal with them. Other problems that problematic alcohol users present include using cells for longer periods of time compared to other arrestees, as they need to sober up and also displaying aggressive, noisy and violent behaviour whilst in custody (Man et al. 2002).

Current research has shown that interventions to treat problematic drug and alcohol arrestees are dependant upon obtaining trust, of both the arrestee and also police personnel, in order that they view the intervention treatment as a contribution to their welfare (Turnbull et al. 1996). This research also found that from the 'client's' perspective, it was important to have quick access to services and a high level of support from first contact through to referral. Research in the West Midlands has highlighted the benefits of an arrest referral scheme to deal with intoxicated offenders. The scheme's aims included increasing awareness about the dangers of alcohol misuse and diverting offenders from the criminal justice system and the likelihood of custodial sentences (Sharp and Atherton 2006).

A study by Robertson et al. (1995) reported that drunken detainees are a 'significant problem for the police', due to the additional risks they pose with regards to deaths in custody and health problems requiring emergency interventions. Forensic medical examiners have reported that they have two key roles in dealing with drunken detainees, including offering therapeutic services and medical treatment, and that they are also often the only access such detainees have to any sort of healthcare (Noble et al. 2001). This study also highlighted the need to consider the role of forensic medical examiners and whether they were the most appropriate professionals to deal with

detainees, beyond providing medical care and also whether police detention itself was an adequate setting to offer therapeutic services and advice. However, it was recognised, by this research and previous studies, that brief intervention at the point of arrest could be effective in pointing both binge drinkers and chronic alcohol users towards treatment services (Heather 1995).

3.2.11 National drug strategy

The *Misuse of Drugs Act 1971* classifies controlled drugs into three classes (A, B and C) depending on their potential for harm, which also determines the scale of punishment for possession and supply. In 2004, cannabis was reclassified from a Class B to a Class C drug to reflect changing priorities of the police in dealing with more dangerous drug use and drug trafficking and the lower risks to health associated with cannabis use. The first UK Drug Strategy was launched in 1998, with four principal aims:

- preventing drug use amongst young people;
- safeguarding communities;
- providing treatment;
- reducing availability.[24]

The main focus for the Updated Drug Strategy (2002) for England and Wales is to build on these aims, by targeting the most vulnerable groups and maintaining the stance of prohibition in the use of all currently illicit drugs. It also aims to provide education and support for young people as a means to prevent drug use, reduce the availability of drugs on the streets and reduce drug-related crime, using criminal justice interventions. Treatment provisions for users also include harm-minimisation measures, to prevent health problems often associated with use, whilst the user is engaged in treatment. The National Treatment Agency for Substance Misuse has been set up to increase participation in treatment programmes by 100% by 2008. The Home Office and the Department of Health together will aim to provide 'timely access to the highest quality treatment', along with advice about best practice and working in partnership with the criminal justice agencies. The co-ordination of the drug strategy is the responsibility of the Drugs Strategy Directorate of the Home Office at a national level, and implementation of its aims is delivered through local drug partnerships, Drug (and Alcohol) Action Teams (D(A)ATs) and Crime and Disorder Reduction Partnerships (CDRPs) in England and Community Safety Partnerships in Wales. In addition, the *Drugs Act 2005* increases the police and court's powers in relation to drug use and also aims to increase the effectiveness of the Drug Interventions Programme (DIP) by getting more offenders into treatment. It allows police officers to test offenders at the point of arrest, in order to refer them to treatment services. This builds on the Criminal Justice and Court Services Act 2000, which allows criminal

24 see homeoffice.gov.uk/drugs.

justice professionals to test all offenders aged 18 years and over who are charged with a 'trigger offence' and also includes provisions for police and prosecutors to offer 'conditional cautioning', which aims to build on voluntary schemes to encourage offenders into treatment. The testing will take place in police detention, under probation service supervision, and include those serving a sentence for a trigger offence and released on licence or Notice of Supervision (EMCDDA 2003).

An example of innovative practice in the criminal justice system for England and Wales is the 'Out of Crime, Into Treatment' programme (formally the Criminal Justice Intervention Programme (CJIP)), which will involve the police, probation, courts and prison services working with drug-treatment agencies to 'reduce crime and make communities safer.' In the West Midlands region, such a scheme has been implemented, to cover those offenders aged 18 years and over charged with trigger offences, to provide an 'end-to-end approach, including through-care and aftercare for drug-misusing offenders'.[25]

The Drugs Prevention Advisory Service (DPAS) supports local Drug Action Teams (DATS) in delivering targets set by the Home Office, including to:

- reduce the number of young people using heroin and cocaine;
- decrease the availability of heroin and cocaine among young people;
- decrease recidivism by drug-misusing offenders (all by 25 percent by 2005, and 50 percent by 2008);
- increase the number of people accessing treatment services (by 66 percent by 2005, and 100 percent by 2008) (US Embassy 2002).

Strategies also include the introduction of the CARATS (Counselling, Assessment, Referral, Advice and Care/Treatment Services) in prisons, to offer treatment and support services to those prisoners who wish to cease drug use. One of the recent developments in addressing problematic drug and alcohol use through criminal justice interventions is the 'Restriction on Bail', which has been implemented across England since 31 March 2006. This applies to adult offenders who have tested positive for drug use at the point of arrest, and puts additional conditions on offenders' bail. Its primary aim is to engage drug-using offenders with treatment, as by refusing this they risk a prison sentence.

3.2.12 Harm reduction strategy

Reducing the harms caused by drug use is recognised in England and Wales as an important issue, particularly for those users engaged in injecting drug use and who commit crimes to fund their use. Currently, there are approximately

25 See West Midlands Police. http://www.google.com/search?client=safari&rls=en&q=West+Midlands+Police&ie=UTF-8&oe=UTF-8

250,000 people with problematic drug use (Godfrey et al. 2002), who are often addicted to class A drugs such as heroin and/or crack/cocaine and who are at risk of harming both themselves and others. Drug use can have severe health consequences such as death from overdose, contracting blood-borne viruses such as hepatitis and HIV, and users can suffer from poor nutrition, injuries from accidents and mental illness. The 'harm minimisation' strategy aims to improve the basic health of drug users, with general practitioners (GPs) having a key role in attracting users into treatment. However, engaging drug users with harm reduction is still very much seen as a route into treatment and abstinence from drug use, as reflected in the updated strategy for the UK.

Community-based treatment and voluntary organisations are often the main suppliers of harm reduction provisions to users, with the understanding that some users do not or are not able to cease using drugs. They provide exchange of needle and other injecting equipment and advice and referrals for treatment and other services. Needles, syringes and cleaning equipment can also be obtained through GPs and pharmacies, during working hours. However, in England and Wales there are no such provisions available at police stations, through medical staff. In Scotland (Lothian and Borders region), a pilot scheme to introduce such measures at police stations (free needles on release from police detention) was implemented not only to reduce the risks of spreading blood-borne viruses but also as a health and safety measure for police officers. It was felt that providing needles on release would encourage injecting drug users to surrender their equipment at the point of arrest, therefore reducing the risks of needle-stick injury to officers during searches (Edwards 2005).

3.2.13 Alcohol harm reduction strategy for England

An alcohol harm reduction strategy for England was developed in 2004. It aims to prevent alcohol-related harm and will form part of future government public policy in dealing with problematic drug and alcohol use. The harms associated with problematic alcohol use are estimated to cost the UK approximately £20 billion each year: they include health problems, loss of time from work and crime and anti-social behaviour. It is estimated that the annual cost of crime and disorder related to alcohol misuse is in excess of £7 billion. A key element of the Alcohol Harm Reduction Strategy for England (2004) is the identification and treatment of those with problematic alcohol use via an integrated care pathways approach for the most vulnerable often who have multiple problems (Cabinet Office 2004).

The strategy also aims to provide better education and communication measures to promote sensible drinking, both on products and the advertising of alcohol, and also to provide advice and education programmes in schools and the workplace. Health and treatment services are also being revised to improve early identification and treatment of problematic alcohol use, especially among the more vulnerable and hard-to-reach groups such as the homeless, drug users, mentally ill and young people. Addressing alcohol-related crime and disorder

is also an important element of the strategy, for example, dealing with violence associated with binge drinking in town centres and in the home, introducing the use of new fixed-penalty fines for anti-social behaviour and working with licensees to ensure better enforcement of existing rules (Cabinet Office 2006).

3.2.14 National health service provisions for problematic drug and alcohol users

Healthcare for all citizens in the UK is provided by the National Health Service, funded by the state and through employment contributions. It is open to all, in theory, however some groups, such as the homeless, are unable to access healthcare services. Accessing health services at the local level is done through General Practitioners (GPs), who require patients to have a fixed address. Often the homeless also includes those with problematic drug and alcohol use. The structure of primary care interventions, provided through GPs and primary healthcare teams is as follows:

Tier 1 interventions: screening drug-using clients and referring them on to other service providers; provision of general medical services (GMS). Under the terms of the GP contract, all GPs must provide Tier 1 interventions.

Tier 2 interventions: triage assessments, harm reduction. All practices can provide at least some Tier 2 interventions via the primary healthcare team as a whole (e.g. simple harm minimisation advice, brief interventions and immunisations).

Tier 3 interventions: prescribing for drug users within the context of a care plan. Many GPs provide Tier 3 services under specific contractual arrangements.

Tier 4 interventions: medical monitoring of residential rehabilitation or detoxification services, provided by a few GPs where there is local need (British Medical Association 2006).

Treatment provision in the community, including state and privately-run facilities, includes prescribing services (offering maintenance and withdrawal-based prescribing) and drug-free treatment offering counselling and support. Detoxification programmes are also available for clients as out-patients or in residential facilities, hospitals and psychiatric units. Substitution treatment is available for opiate dependence; previously it usually involved methadone but increasingly buprenorphine is also being used. This is generally provided through GPs. Aftercare services and reintegration programmes are also available in residential rehabilitation or halfway houses, particularly for those who have undergone treatment while serving a prison sentence (EMCDDA 2004).

In prisons, healthcare provisions are the responsibility of local Primary Care Trusts (PCTs), which are organisations co-ordinating health services at a regional level. They are also responsible for providing healthcare in police

detention through forensic medical examiners and other healthcare staff. Services for people with problematic drug use in prisons are primarily managed by CARAT teams (Prison Service Order 3550, HMPS 2000). There is also now a greater emphasis on aftercare for problematic drug and alcohol users in order to continue support for ex-prisoners as part of their resettlement. This also includes making links with other services and agencies such as housing, employment and other health services.

3.3 Estonia

3.3.1 The criminal justice system

With the fundamental political changes that have taken place in Estonia, as in other Eastern European states, beginning with independence from the Soviet Union and membership of the European Union in 2004, the Estonian criminal justice system faces a real challenge. It must address changing crime patterns and other social phenomena and also develop a system that maintains all citizens' rights (Saar 1999).

The Estonian criminal justice system is organised into three main branches:

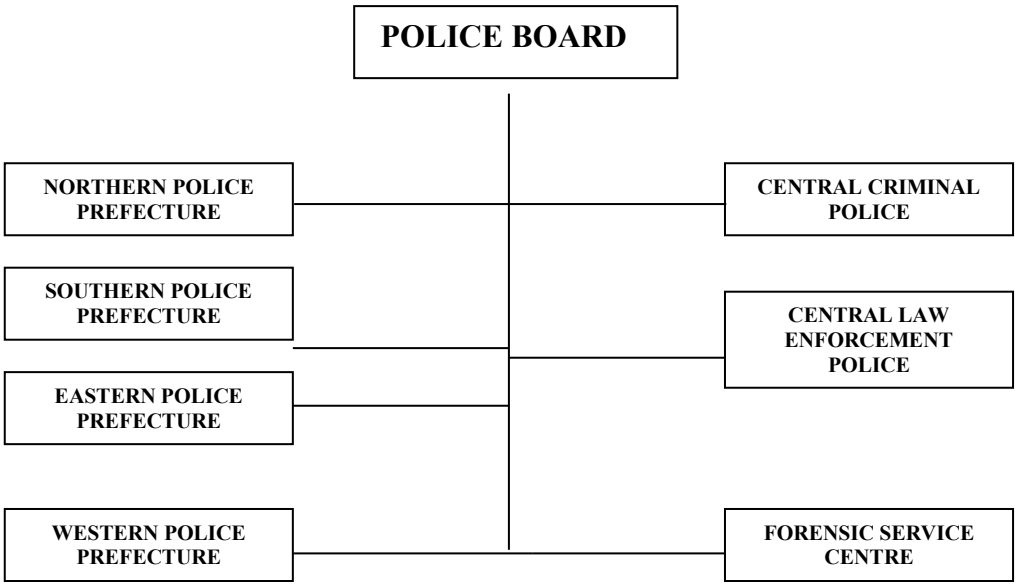
- the police and the preliminary investigation (administered by the Ministry of the Interior);
- the court and the prosecution services (administered by the State Court and Ministry of Justice);
- the correctional system and the prisons (administered by the Ministry of Justice).

The activities of all these branches have quite different and specific aims, however they are not independent of each other and must consider the impact of their decisions and practices. Articles 148–151 of the Estonian Constitution state that justice in Estonia may only be administered by the court, which is independent in its activities and administers justice in accordance with the Constitution and law. Judges are appointed for life, by the President of the Republic (Eesti Vabariigi Põhiseadus 1992).

3.3.2 The police

The structure of the Estonian police was re-established under the *Police Act* of 1990 and finalised in 1991. The police are under the control of the Ministry of Internal Affairs.

Table 1: Structure of the Estonian Police



The Police Board is the central supervisory authority, which manages, directs and co-ordinates the activities of all the police agencies under it's administration. The Estonian police service incorporates two larger independent branches:

- the State Police is responsible for public order and internal security, crime prevention and crime detection, and for carrying out pre-trial criminal investigations;
- the Security Police is responsible for maintaining the state's constitutional and territorial integrity, protecting state secrets, conducting counter-intelligence, fighting against terrorism and corruption.

The State Police is divided into 17 prefectures and the Security Police operate in four regional sections. Within the State Police there are two main branches: the Central Criminal Police and the Constabulary (Saar 1999). The role of the Criminal Police is to investigate organised crime, drug crimes, economic and IT related crimes and crimes requiring international co-operation. At the operational level the police prefectures maintain public order and ensure internal security in its area, prevent, combat and detect offences and conduct the preliminary investigations. The size of the regional police depends on the level of crime and population of the area (Police Board 2006). The police are

inspected by the Public Prosecution Office and internally by the Ministry of the Interior, as well as by external organisations such as the CPT[26].

There is a lack of police due to recruitment problems and one reason for this is that work conditions are not very good and the salaries are not high enough, although police salaries are due to rise by 20% in the next budget (2007). In addition, one impact of Estonia joining the European Union (EU) is the number of skilled people leaving Estonia to work abroad. Police recruitment also relates to the decreasing birth rate, which now presents as a drop in number of 18 year olds, who could potentially join the police. Currently there are more women officers applying and the Estonian police have the highest rate of women officers in Europe, for example, in the North East prefecture 48% of the police are women. The police also provide language training to accommodate Estonian nationals who are predominantly Russian speakers.

The *Police Act* states that the police are an institution of executive power within the area of administration of the Ministry of Internal Affairs. Thus, institutionally, the prosecution service and the police fall under different ministers which impact on their functional relationship to a considerable extent.

The Head of the Police Board is responsible for the performance of the police to the Ministry of interior. Formerly members of the police called heads of pre-trial investigation, were responsible for directing pre trial proceedings and had the authority over the work of the investigators. In addition, the prosecutors also had the power to direct the investigator. This double leadership of the investigation was sometimes problematic. As a result it was decided to change this situation in the new CCP, which no longer mentions pre-trial investigation and now it is the prosecutors who direct pre-trial investigations. In this role the prosecutor is involved in the criminal proceedings from the earliest stages and takes an active leadership role in controlling the investigation. However, in reality the extent to which the prosecutors lead pre-trial procedure depends on the capacity of the prosecution service. It is currently difficult to predict the future but it is clear that the prosecution service will not be able to perform this function in all criminal cases. Hence, a selection between the cases has to be made, in other words, procedural priorities will have to be set[27].

3.3.3 Training of police officers

In 1990, two police basic training centres were created, one in a Tallinn suburb in a former ‘militia’ school and the other near the resort town of Pärnu (Paikuse). In 1992, the Estonian Public Service Academy’s Police College offered degrees in policing, and the first class graduated in 1996. However,

26 European Committee for the Prevention of Torture and Inhuman or Degrading Punishment

27 (http://www.interpol.int/Public/Region/Europe/pjsystems/Estonia.asp)

once in service, there is very little specialised training for police officers, and many of Estonia's present police officers are former members of the Soviet 'militia' or other law-enforcement agencies, and, therefore, received their training during the Soviet era. The lack of co-ordination of police training since independence has led to problems with establishing a unified grading system and in general, implementing an effective training programme for police officers (Saar 1999). The Police Board provides training in health and safety for officers, including information about communicable diseases and work place safety and using protective gloves for blood spills, which are available for police officers in the arrest houses. In addition to the training provided by the Police Board, the police prefectures also have their own training budget and this training links, to some extent, with that offered by the Police Board.

3.3.4 Arrest and detention

The police may hold a person suspected of a criminal offence for up to 48 hours and, after this, there needs to be an extension made by the courts via the prosecutor. The detainee must be interviewed by a police investigator within 24 hours, starting from the time of deprivation of liberty. If the investigator is not ready to bring charges at the end of the first 48-hour period then police custody can be extended by the order of a judge for up to 10 days. After this, in exceptional cases, police custody can then be extended to a maximum of 30 days. If the detainee has not been charged by the 30-day period then they must be released.[28] Usually the case file will be sent to the court within six months but if the case is complicated then it can be up to 12 months to prepare. Arrest houses are used for those detainees expected to be held for up to 30 days while the formal charge is prepared.

When a suspect has been charged they may be remanded in custody by an investigating judge and sent to the remand section of a prison. However, the *Imprisonment Act* of 2000 has provided the alternative possibility of placing such persons in police arrest houses.[29] In addition, the police investigator may decide that a remand prisoner should be returned to police custody from the remand prison to a police arrest house in cases where it is deemed necessary for the preliminary investigation. The length of time that remand prisoners stay in the police houses in this situation is variable but the CPT delegation (2003) found that there were 'certain cases where remand prisoners were returned to arrest houses for periods up to one month'.

28 Cf. Section 67 of the 1961 Code of Criminal Procedure (as amended up to 2003).
29 Cf. Section 90 (1) of the Imprisonment Act (2000). It should be noted that persons may be held on remand up to six months or, exceptionally, up to one year (cf. Section 74 of the 1961 Code of Criminal Procedure, as amended up to 2003).

Detainees can also be held in arrest houses for other reasons, such as administrative detention[30] (up to 30 days) for those found guilty of minor offences, or who have been given a short prison sentence (up to three months) and, on the authorisation of a prosecutor,[31] for sentenced prisoners (up to 14 days) who could provide information about a criminal offence committed by another person.

In the majority of countries, detainees are held for only a relatively short time on police premises. However, in Estonia, a person can be held in a police arrest house for prolonged periods, which can reach and, on occasion, exceed three months.

3.3.5 Healthcare in police detention

In response to the CPT visit (2003), the Estonian authorities indicated that police prefectures have concluded agreements with local family physicians, in order to provide preliminary health examinations and healthcare services. Full-time medical assistants employed by the police also carry out preliminary medical checks in detention centres. At the moment requirements concerning the provision of medical examinations are fulfilled in five arrest houses;[32] soon other police prefectures will conclude agreements for the provision of health care services (CPT 2003).

Currently, the police houses do not provide any drug treatment and do not liaise with community drug treatment services. Alcoholics who are experiencing withdrawal in the police houses are sent to the psychiatric clinic and people with problematic drug use are given some pills for withdrawal to reduce the pain. If there are major problems they send the problematic drug user more quickly to prison. The emergency services will be called if there is a problem and will examine the arrestee in the arrest house.

3.3.6 Court system

The Estonian judicial system is based primarily on the German model, especially within the field of civil law with which it has direct historical links. Judges are appointed for life and may not take up any other appointed public offices. The Estonian court system is divided into three levels with district and city Courts, regional courts and the Supreme Court.

30 Cf. Section 85 of the Imprisonment Act (2000) and Section 48 of the Penal Code (2001).
31 Cf. Section 337 of the 1961 Code of Criminal Procedure (as amended up to 2003).
32 The Lääne-Viru (Rakvere), Narva, Pärnu, Tallinnand Tartu Arrest Houses.

3.3.7 The prosecution system

The year 2003 and the beginning of the year 2004 were important years for the prosecution service when in 2003 Parliament adopted the new Code of Criminal Procedure (CCP)[33] and in 2004 when the changes to the Prosecution Service Act were adopted[34]. Also, the new General Decree of the Prosecution Service (GDPS) came into force on 29 March 2004. The prosecution system contains both state prosecutors and district prosecutors who work within their respective jurisdictions and who are under the authority of the Ministry of Justice. The key tasks of the prosecutors are to bring all prosecutions to court and to ensure that police activities and preliminary investigations in criminal cases are conducted with due respect for the appropriate procedures and in accordance with the law[35].

3.3.8 The probation service

The Probation Service came into effect on 1 May 1998, after the passing of the *Probation Act* (1997). This was considered an important step towards 'western style correctional system, in which after care is used for bringing people back from prison into society' (Saar 1999). The probation service works after the court decision and sometimes with the prosecutors. The prosecutor must order social assessments (pre-sentence reports) for all juveniles arrested and they can also request this for adult offenders as well. There are three main reasons why the prosecutor would ask for a pre-sentence report for adults: if the person has an addiction, psychiatric problems, or if alternative measures will be requested. If their client is in an arrest house the probation officer goes there to interview them and within 1 month the report must be completed.

Usually the probation officer will meet the arrestee twice. The report will contain information about what social services the person has been receiving, information from the police about previous crimes and so on. In the case of juveniles it is also obligatory to interview the parents and a named other key person. If the person agrees, the medical records will also be accessed, a resumé from the school or employer and if they have been on a NGO programme (methadone, alcohol addiction) their key worker will also be interviewed. The final report will make an assessment about the trigger factor for the client to commit crimes and the impact of alcohol or drugs on their behaviour.

33 Which came into force on July 1, 2004.
34 Which came into force on March 1, 2004.
35 (http://www.interpol.int/Public/Region/Europe/pjsystems/Estonia.asp)

Alternatives to prison have been available in Estonia for several years. According to a study carried out by the Ministry of Justice (2002) it was identified that only 38.5% of the sample of people on probation had been provided with health insurance thus their access to health care was limited. In addition, it was shown that only 35.5% of persons on probation with problematic drug and/or alcohol use had health insurance.

3.3.9 Prison system

In Estonia, the prison system is managed by the Department of Prisons in the Ministry of Justice. At the time of the research (2006), there were 4,463 prisoners in seven institutions, with an occupancy level of 102.2%. Two percent of the prison population are juveniles (World Prison Brief 2006). The administration of penal institutions changed in May 1997, with the new Statute of the Prison Department. From 1992, reforms were also made to the education and training of supervisory personnel at the newly established Correctional College of the Estonian National Defence and Public Service Academy. Expertise from both the European Councils' North-Baltic Prison Project, and Denmark, Finland, Norway and Sweden was employed to develop the Estonian Correction System.

The *Imprisonment Act* (RT 1 2000, 58, 376) emphasises a commitment to the 're-socialisation' of prisoners, which is provided through psychological support available in all Estonian prisons, with 21 psychologists currently working in prisons. Health care for prisoners is part of the National Health Care System paid by the state through the Ministry of Justice. The central prison hospital is now based at Mardu and no longer in Tallinn.

3.3.10 Harm reduction in Estonian prisons

After the HIV outbreak among Estonian prisoners in 2000, harm reduction started to play a more important role, however, harm reduction projects such as needle exchanges are not currently available in any Estonian prisons. The medical staff in the prisons provide counselling and testing for HIV/AIDS. Since 2002 projects initiated by NGOs have impacted on the effective implementation of prevention work. Two key organisations, the NGO CONVICTUS and the AIDS support centre, have been active in organising training in HIV and other health issues for prison staff and prisoners.

A recent study found that a large number of prisoners in Estonia are at risk of contracting hepatitis B and C infection as a result of sharing syringes while injecting drugs and of unhygienic tattooing practices. It has been estimated that about 30% of Estonian prisoners are injecting drugs (Eurosurveillance 2006).

The study found that at Tallinn prison, from a sample of 122 HIV-positive prisoners, 89% had HBV antibodies, 98% HCV antibodies and 89% had both HBV and HCV antibodies. These findings are significantly higher than those found in IDUs in the community who have visited anonymous HIV testing facilities.

Since 1997, the HBV vaccination is provided free of charge for health care workers, those aged 13 (since 1999) and since 2003 to newborn babies. However, due to a lack of sustainable programmes and the cost of the vaccine, efforts to vaccinate adults both in the community and those in prison (particularly people with problematic drug use) has been limited (Eurosurveillance 2006). Nonetheless, at Tallinn prison an accelerated schedule for hepatitis B vaccination amongst injecting drug users was carried out where the full vaccination course (three vaccinations) was administered to 457 IDUs (81% of 566 inmates included in the study). The results revealed that a short hepatitis B vaccination schedule among imprisoned IDUs has a significantly higher compliance and zero-protection rate than the standard six-month schedule, and should therefore be recommended for use in this population. Low zero-protection rate was correlated to concurrent hepatitis C infection (EuroHIV 2005).

The epidemiological situation with regards to viral hepatitis indicates the need for preventative measures and behavioural interventions to reduce the harms associated with HBV/HCV infections. It is also important to provide HBV vaccination and proper medical care of those infected, both among IDUs and the community as a whole, in order to prevent a serious public health problem (Eurosurveillance 2006).

3.3.11 Drug use

In Estonia, the population survey 2003 and ESPAD survey 2003 indicated a marked increase in illicit drug use, particularly among young people. When looking at lifetime prevalence (that is, reported use at least once in their lifetime), it was found that 6.4% of schoolchildren aged 14–15, 13.4% of 16–18 year school students and 17.3% of young people aged 19–24 had used drugs. In the general population, lifetime prevalence among 15–64 year olds was at 15.4%, and for those aged 15–34 years, it was much higher at 28.4% (EMCDDA 2004).

In addition, the differences between Estonian citizens and non-Estonian citizens and urban and rural residents found in previous surveys is lessening. For example, use among respondents in Tallinn (based on lifetime prevalence) was 18%, whereas in rural areas it was 12–13%. With regards to type of drug use, prevalence was highest for cannabis, ecstasy and amphetamines. Amphetamine use was higher among females aged 25–34, as was the use of sedatives and tranquillisers (Hansson 2004).

3.3.12 Injecting drug users

There are estimated to be 13,800 IDUs in Estonia and the majority are poly-drug users who are injecting amphetamines, with up to 55% injecting more than one substance. HIV was high in 2001 and has been going down every year. The rate stabilised in 2005 and the virus is becoming more sexually transmitted with more than 50% of new cases being sexually transmitted to partners of IDUs. A report by the Ministry of Social Affairs (Uusküla et al. 2006) on HIV and risk behaviour among injecting drug users in Tallinn and Kohtla-Järve has shown that Estonia has the most rapidly expanding HIV/AIDS epidemic, with the highest reported incidence and estimated prevalence of HIV (1.5%) in the European Region fuelled by injection drug use. Since the beginning of the HIV epidemic in Estonia in 2000:

> The total number of registered HIV infection cases have been 4,662 (as of May 2005), of which 34% (N=1602) have been reported among the residents of Tallinn, and 20% (N=949) have been residents of Kohtla-Järve. Based on this data, HIV prevalence is 0.8% among the adult population (aged 15–49) of Tallinn and 4.2 % in Kohtla-Järve (Uusküla et al. 2006).

The report on *HIV and risk behaviours among injecting drug users in Tallinn and Kohtla-Järve* (Uusküla et al. 2006) was based on a sample of 450 injecting drug users from these two cities (Table 1).

Table 1: Mean age at initiation of the particular drugs and the frequencies of their use.

	Fentanyl [1]	*Amphetamine*	*Heroin*	*Homemade opiates*[2]	*Sudafed*
No (%) of respondents who have used particular drug within the last 4 weeks	292 (64.9%)	281 (62.4%)	107 (23.8%)	135 (30.0%)	14 (3.1%)
Mean age of initiation (range)	21.6 (13–39)	18.1 (12–39)	19 (10–39)	17.6 (10–36)	19.2 (12–37)
Main drug used during last 4 weeks No (%)	261 (58%)	85 (18.9%)	7 (1.6%)	88 (19.6%)	-

[1] *Fentanyl / fentanyl analogs: China White or Persian White* [36]
[2] *Home made opiates: home made poppy liquid*
Adapted from Uusküla et al. 2006

Injecting drug users in the sample who mainly injected China White/heroin were significantly more likely to be HIV-positive than injectors of other illicit substances (e.g. amphetamine, homemade opiates). A key factor that potentially contributes to the higher prevalence of HIV amongst Fentanyl (and heroin users) is needle sharing, a risk behaviour that is significantly more likely to be reported by Fentanyl users (29.5%) than users of home made opiates (17.4%) or amphetamines (19%). The same study showed that 29% of respondents had practised the sharing of needles and syringes and other injecting supplies in the previous four weeks.

It was also evident that IDUs involved in the research had little contact with harm reduction initiatives, for example, 50% had never accessed a syringe from an outreach worker. Also, 71% of the respondents had been arrested by the police, often for possessing or using injecting equipment and drugs or being

36 The illegal drugs known as China and Persian White (in Estonian: Valge hiinlane, Valge pärslanee) appeared in the Estonian illegal drug market in 2001. According to the National Institute on Drug Abuse (NIDA), US, fentanyl and fentanyl analogs such as Actiq, Duragesic, Sublimaze (commercial names) known by street names as Apache, China girl, China white, Dance fever, Friend, Good fella, Jackpot, Murder, 8, TNT, Tango and Cash are administrated by injection, smoked or snorted (NIDA 2004). Fentanyl is 50 times more potent than heroin and can rapidly stop respiration (NIDA 2005).

accused of selling drugs. Many had subsequently been in prison (64%) and almost two thirds reported injecting drugs during their time in prison, most had shared needles. There was an extremely high prevalence of HIV, 62.1% of the whole sample, and as demonstrated in previous studies (Kang 2005; Wood 2005), being in prison was seen as an extremely high risk factor. In addition a high proportion of the IDUs surveyed did not have health insurance (55%) and the majority came from the Russian community (Uusküla et al. 2006).

Given the high prevalence of HIV among IDUs in this study and the common practice of incarcerating them it is very likely that the problem of HIV transmission in jails and prisons is increasing. Programmes to reduce HIV transmission in jails and prisons, including drug-abuse treatment of inmates, syringes exchange, and programmes to reduce the likelihood of incarceration of IDUs, are urgently needed (Uusküla et al. 2006).

3.3.13 Alcohol use

Estonia has one of the highest alcohol consumption levels, with 86% of the population (aged 16–75 years) consuming alcoholic beverages (Estonian Institute of Economic Research 2003). There is wider use among men, young people and those with lower education, and use is greatest in the North East and in small towns. Generally, wine and beer is most consumed, with stronger alcoholic drinks being consumed by older people. Due to its alcohol consumption, Estonia is considered among the most unhealthy states (World Health Report 2002).

There is rising concern regarding alcohol consumption among young people and the link with problematic use during adulthood. Sixty per cent of those aged 10–13 years, have tried alcohol. Fifty-five per cent of 14–15 year olds reported they having been drunk at least once and 52% are regular alcohol drinkers, which rises to 69% for those aged 16–18. Along with concerns about consumption, the general population of Estonia is considered to be at high risk of other problems associated with problematic alcohol use, such as alcohol-related psychosis, injuries, suicide and traffic accidents as a result of driving while intoxicated (National Institute for Health Development 2004).

3.3.14 National drug strategy

Responsibility for the overall administration of the Alcoholism and Drug Prevention Programme 1997–2007 rests with the Ministry of Social Affairs, and the National Institute for Health Development the main institution responsible for the implementation of the programme. In 2004 the Ministry of Justice of Estonia initiated a discussion on alternatives to prison for drug users, as the current provisions in the Penal Code, passed in June 2001, were not being put into practice, due to very limited access to drug treatment in the

community. Therefore, improving the quality and accessibility of services for drug users in the community were given priority in the Alcoholism and Drug Prevention Programme in 2004. Consequently, in 2005, the National Strategy on the Prevention of Drug Dependency 2004–2012 took effect, which aimed to deal with:

- prevention of drug use (managed by the Ministry of Social Affairs, the National Institute for Health Development and the Ministry of Education and Science);
- treatment/rehabilitation and harm reduction (managed by the Ministry of Social Affairs and the National Institute for Health Development);
- supply reduction (managed by the Ministry of Internal Affairs);
- drugs in prison (managed by the Ministry of Justice);
- monitoring and evaluation of drug situation (managed by the Estonian Drug Monitoring Centre, governed by the National Institute for Health Development). (EMCDDA 2005)

3.3.15 The healthcare system

The Estonian health care system was subjected to reforms during the early 1980s resulting in a shift away from a centralised and state-controlled care delivery system to a decentralised system, including private provision based on health insurance. The main reasons for reform were that:

- there was no relationship between health care expenditure and the national economy;
- the health care system had too much hospital capacity and too many specialist-doctors for the needs of the Estonian population;
- alongside over-capacity in the secondary and tertiary care sectors there was a disproportionately weak and underdeveloped primary health care system (MacDonald 2004).

Another key date was 1995, when the public health system was reorganised (Public Health Law 1995) to establish the appropriate structures, role and finances for the provision of public health.

3.3.16 Drug-related treatment

Drug treatment is a part of the National Strategy on the Prevention on Drug Dependency 2004–2012 adopted by the government on 22 April 2004. One of the key objectives of the strategy is to provide professional and efficient treatment for drug-addicts and to improve the quality of treatment and expansion of drug treatment services across Estonia. For example, in Tallinn, there is now a Drugs and HIV/AIDS Action Plan for 2003–2007, which focuses on treatment and availability of treatment, and resulted in the first

specialised substitution treatment centre in Tallinn in 2003, by the Tallinn City Government.

Previously treatment had been provided in psychiatric hospitals and the move towards specialised centres was seen as a positive step to improving services. In 2004, there was an increase in the number of treatment institutions, including a new treatment centre for minors, at Jõhvi Hospital in Ida-Viru County. This was set up to provide (drug-free) treatment for 30 children and young people aged 19 and younger. In addition, in 2004, Estonia continued to expand programmes of substitution treatment and increase the quality of drug treatment services by provision of practising medical staff with relevant training. The first substitution treatment programme with methadone was launched in 2003 at the West Tallinn Central Hospital, which provided medically-assisted treatment to 60 drug addicts (substitution treatment for 30 and detoxification treatment for 30 clients) (EMCDDA 2005).

3.3.17 Impact of joining the EU

Some changes have occurred as a result of some inspections (for example, CPT) where suggestions were made to improve practice, including installing telephones for prisoners to be used with phone cards, which will happen very soon. The arrest houses are subject to European prison rules.

There have not been any really positive benefits, so far, to joining the EU apart from the involvement in international police training and co-operation with Moldova. The Estonian police are now part of the European Police Learning Network, which has been considered to be useful (Interview at the Police Board).

3.4 Germany

3.4.1 The police service

The police are the government agency primarily responsible for the maintenance of public security and order. The police service is, for the most part, under the jurisdiction of the Federal States and thus organised differently in each of the 16 States (Länder). Police authorities are usually situated at the community or district level (Gemeinde/Landkreis). There are some exceptions, where legal matters are under the responsibility of the Federal Government. Police forces are normally divided into the following areas, which are more or less the same in all States:

- general police forces dealing with the prevention of crime, disturbances of public order and averting of other dangers (including traffic police);

they also support the Public Prosecution Service with the prosecution of crime, especially petty crime;
- the Criminal Investigation Department (CID) or Kriminalpolizei, under the Prosecution Service dealing especially with more serious crime;
- the Emergency or alert police is the barracked support and rapid reaction police to the general police forces;
- special weapons and tactics units and mobile surveillance units;
- the Federal Border Guard (Bundespolize), which deals with domestic security tasks, controlling the country's border to prevent the illegal entry of foreigners, organized crime, smuggling and drug trafficking. Their competencies have been expanded in recent years. They are especially responsible for border areas, airports and train stations.

While averting dangers is the genuine task of the police, further responsibilities are given to the police by law. The most important is investigations in criminal law with respect to crimes that already have been committed. Not all police officers but only those above a certain rank are allowed to intervene in this area. There is also a special police without uniform that is solely responsible for criminal investigations (C.I.D.). According to the law of criminal proceedings, the police is subsidiary to the prosecution service, acting only on its behalf. In practise though, the police usually lead investigations independently and only later inform the prosecution service about their results. The more important differences are not between police forces but between the legal duties they fulfil when taking part in a certain intervention.

3.4.2 Legal sources for police detention

There are three groups of detainees with problematic use of drugs or alcohol who come to the attention of the police:

1. Detention for reasons of criminal law. There are those arrested, because they are suspected of having committed a criminal offence, and who are intoxicated at the same time. Intoxication in these cases is usually due to alcohol alone or in combination with drugs. In this case, the legal ground for detention does not have a direct connection to the consumption of alcohol or drugs, they would have been arrested even if they had been sober. The reason for arrest is to secure a prosecution and subsequent trial with respect to an offence of the past, and to prevent the suspect from running away. The purpose of police detention in these cases is for a judge to remand the detainee and transfer him or her to prison or to release him or her as soon as possible. The medical problems presented by this group of detainees are due to excessive use of alcohol and or other drugs, sometimes in combination with other substances, and also the impact of time spent in detention while the police secure a prosecution, that is, withdrawal symptoms or at least the threat that they could occur.

2. Detention for reasons of police law: preventing a danger to others. Suspects can be detained who are not yet suspected of having committed a crime but there is a certain danger imminent that a criminal offence will happen. The detainee can be sober or intoxicated and the purpose of police detention in these cases is to keep the detainee away from the public for crime prevention. Often the expectation of delinquent behaviour is due to or enforced by the influence of alcohol. The medical problems presented by this group of detainees will usually relate to the direct effects of alcohol, therefore, the detainee should usually be released before withdrawal symptoms can occur, because the potential danger will pass after sobering up. However, there is often a conflict between deciding the detainee no longer poses a risk and trying to avoid withdrawal symptoms, meaning there are occasions when this has to be dealt with during detention.

3. Detention for reasons of police law: self protection. There is a third group that are neither criminal law suspects nor who are considered to be a danger to anyone else, but themselves. Detention in these cases is intended to only protect the individual detained. The risks to the detainee relate to the toxic effects of alcohol (and drugs) and the effect on their behaviour, putting the detainee in risky situations, for example, traffic accidents. In these cases, medical care in detention always has to weigh the risks and burdens of detention against those of release. This group poses questions regarding the appropriateness of providing medical care for sobering up in police detention, in that referral to a hospital may be a more effective response.

3.4.3 Duration of police detention

The constitution in Germany sets out the rule that no one may be detained by the police without seeing a judge longer than the end of the day following arrest. This is the reason why many people, including most police officers and some judges, think the police are allowed to wait up to 48 hours until they have to consult a judge. However, in 2002 it was necessary for the Constitutional Court to remind the police that this time frame is an upper limit during which detainees must be brought before a judge.[37] Therefore, judicial emergency services have to be provided during the day (4 am until 10pm in the summer and 6 am until 10 pm in the winter). On-call-services of judges had to be introduced after the decision of the court. This lead to the somewhat overstated conclusion that from a legal perspective there is almost no time for medical diagnosis or treatment in police detention, because it is not allowed to prolong the period until the detainee is going to see the judge for medical interventions or diagnosis (except for cases of an emergency causing danger to life or continuous bodily harm). Though in practise there still may be a lot of time, while waiting for paper work to be done, transportation to the court to be organised and the judge to be present.

37 BVerfG 15.5.2002, 2 BvR 2292/00 (www.bverfg.de).

To reserve important decisions to a judge instead of leaving them to the authorities involved is one of the most important safeguards used in German law to protect the rights of the individual against the state. However, recent studies have shown the ineffectiveness of this instrument.[38]

Interestingly, it has been stated in police literature (Brenneisen and Martins 2003, 107) that bringing a detainee, who is completely intoxicated before a judge is neither necessary nor reasonable. The authors argue that the detainee would lack the ability to be interrogated anyway and that it would be against the dignity of the individual to meet a judge while being in a state of drunkenness. They also reject judicial hearings after sobering up, because they would unnecessarily prolong detention for the time during the hearing. With this perspective, the constitutional principle of judicial decisions on custody would be completely abandoned for suspects under the influence of alcohol. Police could arrest and detain them with the purpose of sobering up without any control.

3.4.4 Forensic medical examination in police detention

While in police detention several medical examinations have to be done for legal reasons. In cases of doubt, a doctor is asked to decide whether a detainee is able to undergo detention or custody, to undergo interrogation, to participate in legal proceedings or to undergo trial. All these conditions are specifically relevant in cases of problematic alcohol or drug use. Ability to undergo detention (Gewahrsamsfähigkeit) refers to the relatively short period of police detention, while ability to undergo imprisonment refers to the ability to undergo (pre-trial) confinement (Haftfähigkeit), penal confinement (Vollzugsfähigkeit) (Rothschild 2005,177) or detention awaiting deportation (Abschiebungs-(Haft) fähigkeit). Usually the ability to undergo imprisonment will be examined after referral from police detention to prison by doctors from within the prison system. As opposed to this, doctors from outside have to be called by the police for medical examinations in police detention. Usually they will have a contract with certain doctors who are regularly involved, for example, from a forensic medical institute.

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38 Backes and Gusy (2003) found this for the example of telephone surveillance. At least in situations were another lawyer, the prosecution, applies for permission of a judge (as well the case with applications for a remand warrant), the judge almost always agrees without questioning. Out of 307 requests for telephone surveillance by the prosecution, just one was rejected by the judge. In all the other cases the judge used the same wording as in the request for his/her permission. Similar results are reported in Asbrock (1997). As to the verdict of ineffectiveness the question remains to which extent prosecution (and police) anticipate patterns of judicial decision they know. Possibly they would decide even more often in favour of intrusive measures if a (formal) judicial control did not exist.

The law for the police in the different federal states of Germany (Gewahrsamsordnungen) lists reasons for consulting a medical doctor to examine the detainee's ability to undergo detention. A medical doctor regularly has to be consulted in cases of obvious and severe diseases, if the detainee claims to be sick or asks for medical assistance or medication or if his or her behaviour is extremely unusual. The most important indication for a medical examination is intoxication with psychotropic substances or symptoms of withdrawal from such substances (Rothschild 2005, 178; Greiner 1999; Heide, Stiller and Kleiber 2003), mostly alcohol. This means that most of the cases where a doctor is involved to check the health status of a detainee in police detention will be cases of problematic drug or alcohol use.

As symptoms of intoxication with alcohol are similar to symptoms of severe brain damage or other life-threatening diagnosis, there are situations in which an immediate transfer to hospital is necessary. Clear cases of intoxications with alcohol though often lead to the decision of the doctor that detention may be continued (Rothschild 2005,279). In cases of intoxication with psychotropic substances it is considered to be difficult to judge, from a medical point of view, whether symptoms of withdrawal needing medical treatment will occur before the end of detention and with what intensity.

3.4.5 The prosecution process

In Germany, crimes reported to the police are passed to the Public Prosecution Office, which will determine if a case has enough evidence to go to court. In German criminal law the principle of compulsory prosecution (Legalitätsprinzip) is still applicable, meaning that police and prosecution service are obliged to take legal action in any case of suspicion that an offence has been committed.[39] This principle is meant to ensure the purpose of equality in prosecution. Though theoretically still in force in Germany the principle of compulsory prosecution has been eased at some points during the last decades. For minor offences the prosecution is also allowed to drop a case before a thorough investigation has taken place. In the case of minor drug offences authorities may refrain from prosecution if the offence only relates to a so-called 'small amount' of an illicit drug. How this small amount is defined, differs between federal states, for example, up to three units of consumption can be considered to be such a small amount, but there are diverging guidelines enforced on how these consumption units are to be quantified. For cannabis the 'small amount' is defined to be something between 6 and 30 grams of hashish or marihuana without considering the proportion of THC. For drugs other than cannabis, there are even states that only very rarely drop cases at all.40 This is due to different regional traditions of sanctioning, and to the fact that a decision

39 § 152 II StPO.
40 Weber § 31 a BtMG.

of the Constitutional Court forcing them to recede from compulsory prosecution explicitly only dealt with cannabis.[41]

3.4.6 The courts

Local courts (Amtsgericht) are often the first point in a criminal trial. As long as the punishment is not likely to exceed two years imprisonment, cases are presided over by a single judge (Strafrichter). For cases where a prison sentence between two and four years, there will be a judge and two lay assistants (Schöffengericht). For those cases which may lead to a sentence of over four years or commitment to a psychiatric institution, a Small Criminal Chamber (Strafkammer) at a regional court (Landgericht) is used, and for very serious cases such as murder, a court with three professional and two lay judges (Schwurgericht), is used. Crimes against the state are heard by the Higher Regional Court (Oberlandesgericht). There is also an appeals system, through the regional court, and if necessary the Higher Regional Court, for cases starting at the regional court appeals go to the Federal Court (Bundesgerichtshof). There are, in addition, special courts for juvenile cases and young adult offenders. For convicted offenders, the sentence can be a fine or a prison sentence, especially in cases of restricted or missing criminal responsibility measures of rehabilitation and security can be given instead of, or in addition to, punishment (Jehle 2005).

3.4.7 The probation service

There is also a 'probation service' in the German system but its role is different to, for example, the British system. A convicted person can be obliged to keep in contact with a probation officer after their prison sentence has been suspended. This can happen from its very beginning for sentences of no more than two years imprisonment. Any prison sentence can be suspended after two thirds, under exceptional circumstances after half of the prison time. The intensity of contact is not comparable to the British system, as the offender and probation officer do not meet very often.

3.4.8 Criminal justice interventions for problematic drug and alcohol users

Current legislation allows the courts to impose treatment rather than a prison sentence or fine. The Narcotics Code (BtMG) does not include any provisions for the compulsory treatment of individuals addicted to narcotic drugs although

41 BverfGE 90, 145.

there are provisions within the penal code (§ 64), the *Juvenile Courts Act* (§ 93a) and others by which the Länder operate. These provisions relate to the 'placement in an institution for withdrawal therapy', however, the use of this is very limited (EMCDDA 2005). The German system mainly relies on voluntary treatment, as opposed to that which is enforced by the threat of imprisonment.

3.4.9 Therapy

In addition to the possibility of staying away from prosecution as an exception to the rule, German criminal law allows punishment to be replaced with therapy in cases where prosecution has already taken place. At the end of the trial a judge, with the consent of the defendant and the prosecution service, can postpone punishment in combination with a treatment order. If the treatment order is followed, punishment will be remitted. If an individual known as consumer of illicit drugs by the sentencing court, has already been convicted, there is still a chance to replace a prison sentence by treatment in an outside institution for drug therapy. The sentence will be suspended and the time spent in the institution after a court order will be counted as prison time. Though, as soon as the individual stops attending therapy, the prison sentence would continue (Narcotics Code, paragraphs 35, 36). The prosecution is also allowed to stop proceedings with permission of the court before an indictment, if the accused is in drug treatment therapy, no sentence higher than two years of imprisonment is expected, and rehabilitation is ongoing (Narcotics Code, paragraph 37).

3.4.10 The prison system

The prison population (as at 31 August 2006) is 77,166, which represents a rate of 94 per 100,000 of the national population. Pre-trial detainees constitute 17.1% of all prisoners, 5.3% of the prison population are female, 4% are classed as juveniles (under 18 years) and 28.2% are foreigners. There are 203 prison establishments in Germany and the official capacity is 79,979 (therefore the occupancy level is currently at 96.5%) (World Prison Brief 2006). There are no numbers available for police detention in Germany.

The prison administration and policy is in the hands of the 16 Länder. The *Prison Act*, 1977 (Strafvollzugsgesetz) has also been shifted into state responsibility in 2006. Each of the Länder now has the opportunity to enact penal laws and regulations on its own.

3.4.11 Drug and alcohol use

In Germany, information on problematic drug and alcohol use concerning adults are monitored mainly by Deutsche Hauptstelle für Suchtfragen (DHS), an association of organisations in the field of drug-abuse treatment and prevention; and for juveniles by the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA). Data on drug-related crime as well as deaths in connection with drugs is collected by the Federal Criminal Police Agency (Bundeskriminalamt, BKA).

3.4.11.1 Alcohol use

Alcohol dependence (31/08/2006) in Germany was shown by a national survey in 2000 to be at 3.1% overall (5% males, 1.3% females). This equates to 1.5 million people being dependant on alcohol (Kraus and Augustin 2001). In Germany of all narcotics (Rauschdrogen) alcohol is the most widespread substance (PSB 2001, 206). While in the past only problems of alcohol addiction have been in the focus of attention, there is a recent shift towards the perception of risky or harmful consumption of alcohol as important for research, prevention and treatment.[42] With about 83 million inhabitants in Germany the number of individuals with an alcohol addiction has been estimated to be at least 1.5 million, and of individuals abusing alcohol 2.7 million (both according to DSM IV definitions).

With respect to adults (aged between 18 and 59 years)[43] the proportion of low-risk drinkers (less than 0 to 30g for men and 0 to 20g for women) increased from 65.2% of all individuals having consumed at least one glass of any alcoholic beverage during the last 30 days in 1995 to 71.1% in 2003. This shows a tendency towards lower risk consumption on average (Kraus et al. 2006, 145).

About 10% of all women and 20% of all men in Germany drink more alcohol than recommended by the British Medical Association (20g of pure alcohol per day for women and 30g for men). Although the level for drinking behaviour considered to be risky or dangerous is higher for men than for women, there are still remarkably more men than women involved in any kind of alcohol use that is regarded to be problematic (Augustin and Kraus 2005). While almost 50% of men reported binge drinking during the last 30 days, this applies to less than 20% of women. While binge drinking occurs more often for individuals with higher amounts of alcohol consumption, the mass of alcohol-related

42 According to a press release by DHS on January 11th, 2006 (http://www.optiserver.de/dhs/presse.html).

43 The Epidemiological Addiction Survey changed to the inclusion of only adults (18 to 59) in 1995. Therefore data before 1995 is not available for the same age group (Kraus, Augustin and Röder 2006, 143).

problems in the population is caused by people with a moderate consumption of alcohol on average but who are infrequently involved in binge drinking nevertheless.

In Germany, a national survey in 2000 showed a prevalence of 11.7% for heavy and hazardous drinking (20g to 40g pure alcohol for women per day, 30g to 60g pure alcohol for men per day) (Kraus and Augustin 2001). Heavy and episodic drinking, or binge drinking, was identified in a different survey of 18–64 year olds as prevalent in 14% of males and 7% of females (Gmel et al. 2003). Among the youth population, data from a regional sample in North Rhine-Westphalia (for the HBSC survey) shows an increase in weekly drinking 1993–4 to 2001–2 by 7% for 15-year old girls and 12% for 15-year old boys (Table 1). A smaller increase was discernible at age 13 but no increase at age 11 (Richter and Settertobulte 2003). The 2001–2002 HBSC survey (total sample size *n* = 1,749), showed that the proportion of 15-year-olds who reported ever having been drunk two or more times was 44.3% for boys and 34.4% for girls (Currie et al. 2004).

Table 1: Changes in weekly drinking of juveniles in North Rhine-Westphalia

Age and gender	*1993–4*	*2001–2*
15-year old girls	18	25
15-year old boys	25	37
13-year old girls	4	9
13-year old boys	5	11
11-year old girls	2	1
11-year old boys	3	2
Total sample	**3275**	**3339**

The consumption of alcohol is usually underestimated by half when comparing survey data to statistics on selling alcoholic beverages by the producing industries (Augustin and Kraus 2005, S35). The *per capita* consumption of pure alcohol in Germany was 10.1 litres in 2004[44] as calculated on the basis of national production plus import and minus export of alcohol.[45] It has not changed more than minimally over recent years. After World War II it increased until 1980 (12.5 litres) in Western Germany and until the end of the 1980s in Eastern Germany. Although the *per capita* consumption then decreased during the 1990s it is still comparatively high on a world wide

44 DHS Daten und Fakten: Alkohol, p. 2; Jahrbuch Sucht 2006,7.
45 Wissenschaftliches Kuratorium, 12.

scale.[46] Germany is one of the six countries with a *per capita* consumption of more than 10 litres of pure alcohol a year.[47]

Projection of survey data to the whole population usually lead to between only 40% to 60% of the amount of alcohol consumption measured by *per capita* consumption. This supports the conclusion of serious underreporting in survey studies and that probably individuals with very high consumption are not reached by survey studies at all (Meyer and John 2006, 25ff). If one supposes these aggregate measures[48] to be correct, the extent of underreporting must be considered as enormous. Reliability of an epidemiological survey is thus restricted, particularly as reporting may not be in any known relation to the real amount of consumption.

3.4.11.2 Alcohol-related accident deaths

The number of deadly accidents under the influence of alcohol has constantly decreased (at least) from 2000 to 2004. So did the number of accidents under the influence of alcohol. But in 2004 there were still 22,548 accidents and 704 deadly accidents due to the consumption of alcohol in Germany. The number of deaths overall due to accidents declined more than half since 1953, and was on its lowest point since then (5,900) in 2004.[49] This means, the decrease of deadly accidents due to the consumption of alcohol is part of broader improvements in traffic safety and not a development special to the behaviour of drinkers. While the number of individuals being involved in accidents under the influence of alcohol declined, their medium blood alcohol level stayed constantly at 1.60 to 1.61‰.[50]

3.4.11.3 Alcohol-related offences

In 2005, 11.3% of all suspects of a criminal offence registered by the police were considered by the officers as to be acting under the influence of alcohol. Most (91.4%) of these suspects were male. Rates of alcohol influence are extremely high for resistance against state authorities (61.8%), and violent crime (28.9%), especially manslaughter[51] (36.8%) These statistics do not

46 Wissenschaftliches Kuratorium, 12.
47 According to the Commission for Distilled Spirits these countries in 2003 were Luxembourg, Hungary, Czech Republic, Ireland, Germany and Spain (Jahrbuch 2006, 8).
48 Production of alcoholic beverages in Germany minus exports plus imports based on calculations and estimates of the beer and wine industry, as well as official statistics on alcohol tax (Wissenschaftliches Kuratorium,12)
49 Blutalkohol 42/2005, p.44 according to Statistisches Bundesamt.
50 DHS Daten und Fakten: Alkohol, p. 3; Jahrbuch Sucht 2006,10.
51 Included in this figure is also killing on demand of the victim ("Tötung auf Verlangen").

include traffic offences, because they are usually not incorporated into the official police statistics on crime (PKS 2005).

3.4.11.4 Psychotropic medicine

About 5% of all prescribed medicines are said to have a potential for addiction. Psychotropic medicines in Germany are only allowed to be sold by pharmacies following the prescription of a medical doctor. It has been estimated, that 1.3 to 1.4 million individuals in Germany are addicted to psychotropic medicines, the majority of them to benzodiazepines. About one third of all prescriptions for psychotropic medicine do not occur because of any actual diagnosis but because of an addiction or to avoid symptoms of withdrawal (Sucht 2006; Glaeske 2006).

The study of an insurance company showed that many patients got a prescription of tranquilizers (derivates of benzodiazepine) by their doctors, far exceeding the amount needed for the time period they were supposed to be used. However, it can be observed that, on the whole, there is a slow decline in prescribing tranquilizers over longer periods of time, because doctors increasingly know about the risk of an addiction (Glaeske 2006, 98). The amount of benzodiazepines prescribed decreased by 25% over the last 10 years in Germany. They are often replaced now by 'modern' anti-depressives hampering the absorption of serotonin. Even though they are considered to be without a substance-specific potential for addiction, to stop taking them can lead to symptoms of withdrawal (Glaeske 2006, 99).

3.4.11.5 Illicit drugs

The possession of drugs such as heroin, cocaine and ecstasy is a criminal offence according to German law (Narcotics Code, paragraph 29). Therefore, police statistics reporting cases in which police suspected such an offence might be given are an important, if not the most widely-used, source of data for judging the spread of illicit substances in Germany and trends over time. It has to be taken in account though, that this data reflects nothing but action taken by the police and customs authorities, which may, but does not have to, be connected with patterns of behaviour in the population. While this is true for any kind of crime statistics, it is enormously important as far as drug use is concerned. As usually neither the users themselves nor anybody else reports such an offence to the police, the data rather reflects focus of police attention than patterns of consumption.

3.4.12 First contact with the police in connection with drug use

Since the middle of the 1980s the number of individuals coming to the attention of the police in connection with the use of any illicit drug increased almost constantly until the year 2000 (22,584; 1990:10,784[52]) and declined afterwards until 2003 (17,937). For 2003 and 2004, major data problems occurred, thus comparisons are not possible. In 2005 19,900 cases of first police contact have been reported, indicating that the decline did not continue (BKA 2006, 4). The criteria for being considered as a first-time consumer of illicit drugs by the police has changed several times over the years, making numbers non-comparable.[53] The general figures conceal different developments with respect to various substances. Concerning heroin since the beginning of the 1990s numbers first-time consumer of illicit drugs known to the police were almost constantly declining (1993: 8,377; 2005: 4,637). While heroin used to be the most important substance for first drug-related police contact, it is involved in only one quarter of cases now (1993: 64.4%; 2004: 25.2%). With respect to cocaine, numbers remained almost constant during the last decade. Offences related to ecstasy in police attention were at their peek in 2001 (6,097). Almost steady increases can be observed for possession of amphetamines through the 1990s and up to 2004 (1990: 1,586; 2005: 9,339). While amphetamines were involved in 14.7% of all cases in 1990, it has risen to 43.8% in 2004.

3.4.13 Drug offences (Rauschgiftkriminalität)

In Germany the number of drug offences has steadily increased from 1955 until 2005.[54] Interestingly there is a decline for the first time in 2005. As compared to 2004; 2.5% less cases of drug offence have been registered by the police. However, this decline follows a relatively strong increase of 11% in 2004 as compared to the year before, due to an increase of 40% for amphetamines (BKA 2005). Therefore, it is unlikely to be a continuing decline in the future.

Offences in connection with the consumption of drugs (as opposed to trafficking) at 71% reached their highest proportion ever in 2004. The crime rate (offences per year per 100,000 inhabitants) for drug consumers' in Germany was 243 for 2004, with the highest numbers in the city states

52 PKS 2004, p.228, data from before 1988 is not comparable, because individuals suspected of possessing/ consuming more than one illicit drug were only counted for the one regarded as hardest, since 1988 they are counted more than once.
53 PSB 2001, p.225 referring, for example, to a jump in numbers from 1997 to 1998 caused by changes of criteria.
54 PKS 2004, p.222; PSB 2001, p.223; IMK 2006, p.39. Not all of the data is comparable, the new Eastern states have not been integrated before 2003. But the numbers there are increasingly similar to those in Western Germany (PSB 2001, p.224).

Hamburg (583) and Bremen (449). These two cities are thus places where, comparatively, many consumers of illicit drugs are registered by the police.

The majority of drug consumers' offences in Germany (67%) are in connection with cannabis, and the rise in consumers' offences is due to increases for cannabis (+20%) and amphetamines (+19%). Consumers' offences in connection with heroin decreased (-6%) at the same time. There is also a continuous decrease since the beginning of the 1990s with respect to other reported drugs-related offences (Beschaffungskriminalität) that were committed to gain access to illicit drugs or money to buy them. In 2004, 38% of all suspects registered in connection with drug offences were below 25 years of age, and were registered in connection with the consumption of cannabis. The vast majority (88%) of all suspects registered were male (BKA 2005).

Cannabis is the illicit drug with the highest consumption in Germany as well as in most of the other European countries (EMCDDA 2004). According to epidemiological surveys every fifth woman and every third man between the ages of 18 and 59 used cannabis at least once in their life. However, the use of cannabis tends to be linked with youth. Thus, the portion of cannabis users within the population increases significantly beginning at the age of 15, while from the age of 23 years its portion is continuously decreasing. The majority of cannabis users consume the drug rather occasionally, but 10–15% of all cannabis users are seen as dependent consumers with respect to international studies. Approximately the same results have been found in a German survey, where 9.7% of the women and 18.7% of men reported symptoms of dependency (Tossmann 2006, 74, 81ff).

The experience of Western Germans, aged between 18 and 24, with any kind of illicit drug has almost tripled between 1980 (15.4%) and 2003 (44.2%). These experiences are mainly with cannabis. While lifetime prevalence for opiates and ecstasy are more or less constant over time, there is a notable increase for experiences with amphetamines (1990: 2.8%, 2003: 4.6%) (Kraus, Augustin and Röder 2006,147ff).

Between 1990 and 2003 an increase in the consumption of all kinds of illicit drug can be observed, except for opiates. It is the occasional consumption that increases; when using a drug is stopped after having tried it once or several times, while habitual consumption stays more or less constant. Since 1973, around 5% of all interviewees say that they consume illicit drugs at present (Kraus et al. 2006). It has been estimated that 0.3% of the population aged between 18 and 59 are misusing illicit drugs, and 0.6% to be addicted to them (Jahrbuch 2006,19ff).

3.4.14 National drug strategy

The German government's National Anti-Drugs Plan and the prevention campaigns and model programmes that came from it are based on three main points:

- reducing demand by prevention;
- giving drug addicts different forms of assistance;
- combating drugs-related crime to reduce supply.

A special group appointed by the government comprising the anti-drugs representatives from the government and the individual states, has the responsibility to observe the current drug scene, to set up initiatives and of co-ordinating the measures implemented. In addition to the national government drug strategy, in each state the ministry responsible for drugs creates their own programmes and policies for drug users. The policies in each state can be very different from each other and are not always in complete harmony and, in addition, not all city-level initiatives have state-level support. Services for drug users are also implemented by voluntary welfare associations, specialist clinics, psychiatric institutions and self-help organisations.

3.4.15 Community drug services

3.4.15.1 Drug advice centres

Drug advice centres are available across Germany, more so in the larger cities. In total there are approximately 1250 addiction advice centres in Germany, 150 of which specially cater for drug users. These centres provide access to treatment centres that offer detoxification, substitution treatment and therapy. The range of services provided is dependant on where they are and the number of staff they have. The payment for such treatment varies and is dependant on the measure and legal claim by different authorities, such as pension insurers (Deutsche Rentenversicherung), health insurance companies, and regional welfare associations. The different organisations that can be responsible for treatment costs and provision of services can lead to a lack of clarity of what institution is responsible for provision of services and also to an overlap of provision and in some cases can lead to competition between agencies for resources.[55]

55 see http://www.ac-company.org/

3.4.15.2 Crisis centres

The crisis centres offer counselling and a contact point where urgent medical assistance, hygiene, meals, needle exchange, social education and psychiatric care is provided. In addition clients can be referred onto other institutions that provide services for people with problematic drug use. There are approximately 200 of these centres in Germany.

3.4.15.3 Emergency AID facilities

These are centres that provide short term accommodation that have no prerequisites for people with problematic drug use to be 'clean' and who also provide urgent medical treatment, hygiene and meals.

3.4.15.4 In-patient treatment for people with problematic drug use

There are 5,250 places in Germany for the comprehensive urgent treatment for people with problematic drug use usually lasting for two to three weeks. The treatment that is provided is for:

- the physical withdrawal with or without methadone;
- medicinal adjustment as part of a planned substitution programmes;
- detoxification;
- crisis intervention.

There are a further 50 in-patient institutions which aim to re-integrate drug addicts into society and into working life. However, due to cutbacks by pension scheme insurers, the therapy provided usually lasts six months with an occasional extension of three more months. The régime involves educational, behavioural, group therapy, occupational therapy and psychotherapeutic elements.

3.4.16 Harm reduction

During the last fifteen years Germany has gravitated towards harm reduction and this is reflected in policies and practices. Early in the 1990s the prescription of methadone and needle exchanges were approved. Supervised injection sites and approved heroin trials have been approved more recently. Comprehensive and innovative approaches to problematic drug use have been developed in some major cities, for example in Frankfurt and Hamburg. The political parties in power at the federal, Länder and municipal levels have:

> Influenced and continue to influence the interpretation and implementation of national laws, and the availability of harm

> reduction programs. At the level of the Länder, there has been a north/south split, with the more conservative southern Länder being less supportive of harm reduction approaches. However, cities may deviate from the drug policies of their Länder (for example, Frankfurt in Hesse), and create their own drug policy. Thus, drug policies are created from the bottom up, as well as from the top down (Public Health Agency of Canada 2003).

There are a range of harm reduction initiatives in place in the community in Germany, where Federal Law, in 1992, made needle exchange programmes legal. Substitution treatment is available and the main drugs that are prescribed are methadone and buprenorphine but these can only be used in the context of comprehensive programmes that include psychosocial and medical services and therapy in line with the Narcotics Code (Nickels 2000). Methadone was made available in 1991 and approved by the statutory health insurance system.

In addition to the still prevailingly repressive approach of German drug policy, there are initiatives following a harm reduction approach, such as 'fixer rooms' or medical prescription of heroin for those who suffer most from the consequences of consuming street heroine and who are not expected to comply with a methadone programme. There were for example 15 supervised injections rooms in 2000, made possible by a new provision in the Narcotics Code (paragraph 10a) that serve a client group of approximately 2,600 per day. Such initiatives are always difficult to implement, and some have been completely rejected, such as a model project for selling cannabis in pharmacies with the aim of separating the markets for cannabis and harder drugs. Even once established, harm reduction projects are still a matter of controversy and political symbolism. One example for this is the end of successful needle-exchange programmes in prison. The current debate deals with the medical prescription of heroin.[56] Even though realised as a randomized trial to compare its effects to methadone, and even though results are in favour of heroin, politicians are against changing the Narcotic Act. Thus it is still forbidden to produce and prescribe heroine as a medicine. Even those who agreed to take part in the clinical trial are now, after its end, in danger of being sent back to a methadone programme, which, as a precondition of participation in the study, was not expected to help them.

3.4.16.1 Harm reduction and the police

The attitude of German police to a harm reduction approach is not consistent across all states but in some large cities the police have been actively involved in the development of harm reduction policies and practices, especially in Hamburg and Frankfurt.

56 www.heroinstudie.de/english.html

3.4.17 The healthcare system: differences in standards of health care

There is one important legal difference in the provision of health care in Germany. It is not connected with the kind of detention applied but depends on the citizenship and immigration status of detainees. The majority of the population comply with the obligation to have insurance for medical treatment. This obligation is in force for working people with an income up to €47,250 per year (for 2006), students, pensioners, jobless receivers of earnings-related benefits.[57] Working people with a higher income normally use voluntary insurances as offered by private insurance companies. Some of those with higher income pay for health care on their own without an insurance.

More problematic is the group of people not included in the obligatory insurance system and who can not afford to pay for health care measures on their own. For most of them the state will pay for (at least theoretically but often in reality as well) the same standard of treatment.[58] Nevertheless, a considerable and still growing number of people are excluded from any health insurance[59] and the percentage of those detained by the police who are excluded is much higher than in the population in general.

While Germans are, therefore, with few exceptions, entitled to full medical treatment, foreign nationals are not. For foreigners with a legal status allowing them to stay in Germany the same rules apply as to Germans. Though this is not the case for asylum seekers during their first three years in Germany, and to foreigners staying in Germany without permission. Staying without permission in that sense does, though, not only apply to illegal aliens but also to immigrants who are only 'tolerated' by the authorities, because their deportation is not possible for reasons of law or matter of fact. More than 200,000 migrants live in Germany without an official legal status under German law.[60] For all these immigrants, only a lower standard of health care is provided. Financial support by the state is restricted to treatments of acute cases of illness or states of pain. Any kind of medical treatment in cases of chronic diseases without suffering from pain is excluded.[61]

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57 § 5 SGB V.

58 §§ 5, 264 SGB V: For those able to work at least three hours a day and asylum seekers staying legally in Germany for at least three years this will be paid by the public insurance system, for the others it will be paid from taxes by the social security agency.

59 188 000 or 0.2% of the population according to information by the federal Agency for Statistics with respect to the sample census of 2003. The number has doubled since 1995 and is expected to be rise because of a recent increase in self-employed persons without the financial ability to pay for their (obligatory) insurance and politically induced pressure towards self-employments.

60 BT-Drks. 16/218, p.1.

61 E.g. Nds. OVG, 6.7.2004 (juris); VGH BaWü, 4.5.1998 (juris).

During a prison sentence the costs for health care are taken over by the prison system also responsible for providing medical care. Primarily, prison doctors treat the prisoners; if necessary, doctors from outside can be involved and paid by the prison system. Thus, in practice there is no free choice of doctor for prisoners, at least if they are not able to pay for treatment on their own. During police detention the same system as outside remains at work, meaning the insurance company has to pay if a detainee has got insurance, otherwise the state would pay.

3.4.18 Human Rights legislation: forcible administration of emetics

On 11th July 2006 the Grand Chamber at the European Court of Human Rights in Strasbourg decided in the case of Jalloh v. Germany that the forcible administration of emetics in order to obtain evidence of a drug offence constituted inhuman and degrading treatment prohibited by Article 3 of the European Convention on Human Rights. After two deaths in connection with administering emetics in police detention in Hamburg and Bremen could not convince politicians to stop this practise, they now had to after the decision of the European Court. In Bremen a 'drug-toilet' has been built inside a special cell of the local prison, where those suspected to have swallowed drugs can now be kept until the drugs come out.

3.4.19 Ability to undergo interrogation

It is explicitly forbidden in the Code of Criminal Procedure to influence the ability of the suspect to self-determined decisions, that is, by administering any kind of substances to the body of the suspect.[62] It is especially forbidden to give any psychotropic substances to the suspect, such as alcohol, narcotics or stimulants. Confessions of the suspect or other statements may not be used in front of the court, if this prohibition has been neglected, even apart from the consent of the suspect.[63] The use of substances serving only for refreshment or strengthening is considered to be allowed, such as dextrose or chocolate, as well as the use of coffee, tea, cigarettes and other products from tobacco.[64]

Although it is, on one hand, seen to be irrelevant whether forbidden substances have been administered to or taken voluntarily by the suspect before or during interrogation, on the other hand, suspects under the influence may still be interrogated. Exceptions are only made in cases of severe threats to the

62 § 136 a StPO.
63 § 136 a III StPO.
64 Meyer-Goßner 2005, § 136 a, margin 10, with reference to the constant jurisprudence.

freedom of decision, rejected by the Federal Supreme Court for a blood alcohol concentration of 2ml and accepted by the High Court of Justice in Cologne for one of 4%.[65] Details are still not clear in jurisdiction and a matter of debate in the literature. Some argue for a distinction between substances given to the suspect by the authorities, where one should be restrictive, and the influence of substances used by the suspect by his own choice prior to interrogation. Otherwise, they say, justice would come to an end for a wide range of offences, because of the mass of suspects intoxicated with alcohol and drugs during their first interrogation (Pluisch 1994). While this cannot be an argument to forgo their rights, the argument shows how important it is to deal with the problems of intoxicated people in police detention, where police interrogations usually take place.

Symptoms of withdrawal in itself are not dealt with as unlawfully influencing the suspect's ability to be interrogated. However, they can lead to the same result, a prohibition to use a confession etc. in court, because interrogation during withdrawal can be considered as maltreatment or harassment, forbidden under the same rule of the Code for Criminal Procedure. To give the substance needed to the suspect suffering from symptoms of withdrawal is seen to be illegal even if it is to help him or her regain a subjectively normal state of mind (Puischel 1994, 53). Administering drugs to suspects to help them cope with symptoms of withdrawal can again be considered to be illegal, as decided by a Higher Court with respect to diazepam given to someone addicted to heroin.[66]

3.4.20 Research on health care in police detention

Health care in police detention in general or with specific regard to problematic drug and alcohol use has not been a matter of research in Germany so far. However, research has been done on reasons for death in detention.[67] Another study deals with cases of death *after* police detention. From such an analysis, conclusions can be drawn about problems of medical treatment in police detention.

3.4.20.1 Death in and immediately after police detention

A nationwide study on deaths in police detention has been conducted by the Institute of Forensic Medicine, Martin Luther University, Halle-Wittenberg. The researchers found that the doctors had reacted inadequately in two-thirds of the cases. Mainly they made mistakes with unconscious people and drunken men with considerable injuries to the head. In almost half the cases the police

65 Meyer-Goßner 2005, § 136 a, margin 10, with reference to the jurisprudence.
66 OLG Hamm StV 1999, p.360-364.
67 Ongoing study of the Institute for Forensic Medicine, University of Halle-Wittenberg.

officers' reaction was inadequate. The most frequent mistake they made was not to involve a doctor, although they would have been obliged to do so according to the rules they have to follow. It also happens that they did not make the controls during the specified intervals they were obliged to, in one case a man was dead in the cell for six hours. Other mistakes included improper searching on arrival, which led to a death, because the detainee was able to take a deadly amount of methadone that he had been carrying with him into the cell. Finally, the researchers also found a lack of communication between police and doctor in one third of the cases, especially with the police not telling the doctor what they already knew about the medical aspects of a case, for example, that the detainee was witnessed to having taken many pills. The researchers estimated that one quarter of all deaths would have occurred even if everybody had kept to the rules and taken care. Based on the preliminary results of their study the researchers concluded that not only were there mistakes or omissions by the police but responsibility also lay with the system of medical care and legislation. It has been observed in several cases that unconscious people had been sent to police detention, because hospitals and paramedics had refused treatment of these supposedly totally-drunk people.[68]

Using documents from the Institute of Forensic Medicine in Bonn, the 86 deaths of males in detention occurring from 1949 until 1990 in the area of Middle Rhine have been analysed. Of these, 56 (63%) died of unnatural causes. Among them 51% (44) died of suicide, all but one by hanging, 50% of the suicides were discovered in the morning. Nearly all the suicides were committed under the influence of alcohol and in 6.8% there was a positive drug-test (Steinhäuser 1995). An inspection of cases revealed that in most of them the detainee had slept for several hours and therefore was not subjected to medical examination. During this alleged resting time, they died from suffocation.

Some police officials in this situation, at the end of the 1990s, felt that the police were not the most appropriate institution to deal with this kind of problem, therefore they proposed to take intoxicated detainees (by alcohol or illicit drugs) to hospital instead of keeping them in police detention, but would often be refused admission. An additional problem for the police was that medical doctors at the same time often used to reject an examination of the ability to undergo detention. The often-repeated recommendation was to establish a special sobering up unit in a hospital, as it was known from Hamburg (Greiner 1999). While this proposal was not directly successful for Stuttgart, capital of Baden-Württemberg, in 2001 a 'central sobering up unit' of police detention was introduced there. Located at the police headquarters and staffed with a doctor and nurse in addition to police personnel, all are equipped with CCTV and the presence of a doctor and a nurse is available between 7pm

68 The results are not yet published, but a presentation on preliminary results made available by Steffen Heide.

to 7am.[69] In 2002 3,666 out of 6711 individuals in police detention were brought to the central unit in Stuttgart for sobering up, in 2003 it was 3,595 out of 6,433.[70]

3.5 Hungary

3.5.1 The police

Since the 1980s, the Hungarian criminal justice system has become less politicised, responding to social problems subject to the rule of law and independent of the ruling party. In Hungary the law enforcement bodies are the police, the border guards and the Customs and Excise Authority. The police and the border guards are independent organisations of the Ministry of the Interior and the Customs and Excise Authority is under the direction of the Ministry of Finance. There is one national police force in Hungary. In Budapest there is the Metropolitan Police and 22 district police stations. In addition there are 19 county police HQ and 131 town police stations.

The organisation of the police is based on a militaristic hierarchy, with the National Police Administration at the top. The head of this organisation is the Chief Police Commissioner, who is responsible for two chief administrative sections: criminal and public security. The following are all part of the National Police Administration:

- the Economic and Information Chief Administration;
- the Republic Guards;
- the Police Troop Force;
- the Special Police Service (anti-terrorist service);
- the Airport Security Service;
- the Special Service against Organized Crime and Drugs;
- the Economic Crimes Police.

In addition, each of the 19 county police organisations and the Budapest police headquarters is directed by a police commissioner. There are 198 provincial police stations, which function as subordinates to the territorial police headquarters. Each of these provincial stations is directed by a police superintendent.

Police officers are required to undergo secondary schooling and, to become a higher-ranking police officer, three years of higher education training. The initial and ongoing training programme for police and border guard staff

69 http://www.polizei-stuttgart.de, Polizeigewahrsam und Zentrale Ausnüchterungseinheit.
70 http://www.polizei-stuttgart.de, Polizeigewahrsam und Zentrale Ausnüchterungseinheit

contains legal training, social studies, psychological studies, human rights and investigation techniques (CPT 2006).

3.5.2 Police detention in Hungary

There are different forms of detention by the police in Hungary, depending on their assessment of suspects' offence and also whether they need to be detained further during the investigation and pre-trial processes. The types of detention include the following.

1. *Short-term arrest*: Police can arrest persons who cannot identify themselves in a credible way (with an ID card with photo or by a person who has an ID card), who are suspected of committing crime, who are suspected of abusing drugs and should be tested, underage persons escaped from home or from educational institute, persons who violated the rules of their probation, persons who do not stop activities that are considered *administrative* offences by law and persons against whom a warrant is issued (*Act XXXIV of 1994 on the Police*). Arrested persons have to be informed about the reason for arrest and the expected duration of detention by the police, so they can inform their close relatives about the arrest. During this period they cannot have visitors. The duration from the point of arrest cannot exceed eight hours, this can be prolonged by four hours if this claim is well founded. During the interrogation stage, the presence of an attorney can be requested. A complaint can be issued against the arrest within eight days, which has to be considered by the police within 15 days. In case of physical abuse or other forms of abuse by the police, detainees have the right to sue the officers, under the offences of 'maltreatment during arrest' or 'unlawful arrest'.
2. *Custody*: If a police officer has reason to suspect that the offender (who is suspected of committing a crime which is punishable by imprisonment by the law) will attempt to escape detention, or on release will hide from the police, they can be taken into custody for maximum of 72 hours (*Act XIX of 1998 on the criminal procedure*). If the person taken into custody is responsible for the care of a child, the child should be taken and placed in the care of relatives or to a 'public trustee'.
3. *Pre-trial detention*: Detention at this stage can only be granted by the courts, and must be initiated by the prosecutor. As an alternative to detention in pre-trial custody, home custody can be ordered. The maximum length for pre-trial detention is one month but this can be extended by the judge from three months, up to one year maximum, from the first day of detention. In addition, Regional Courts can prolong pre-trial detention by an additional two months. Pre-trial detainees have to be kept in correctional facilities but in certain cases

> they can be kept in police jails for maximum 60 days (if the investigation requires and the prosecutor requests so).

The new Code on Criminal Procedure[71] (CCP) in force since 2003 and the 1994 Act[72] on the police provides the legal provisions that govern the detention of criminal suspects by the police. The maximum length of time that a suspect can be kept in police custody[73] is 72 hours. After this time the person must be released if the court has not made a decision regarding pre-trial detention. In the CPT Reports of 1994, 1999 and 2003 concerns were raised about keeping remand prisoners in police establishments. However, this situation has changed due to Section 135 of the Code on Criminal Procedure coming into force on 1 January 2005, which stated that detainees can be held in police detention places for a maximum of two months then they should be transferred to correctional institutions:

> According to this Section, remand detention must, as a rule, be carried out in a penitentiary establishment. However, in exceptional cases, persons remanded in custody may be held on police premises for up to 30 days upon the decision of a court, and may be sent back twice to police establishments, each time for a maximum of 15 days, in exceptional circumstances justified by the investigation and upon the decision of a prosecutor. In other words, the cumulative maximum a remand prisoner may spend in police custody is 60 days (CPT 2006).

3.5.2.1 Communication with the outside world

Pre-trial detainees have to make a request to the prosecutor or judge dealing with their case to contact and receive visits from relatives. There is no time limit for the permission procedure in the *Act XIX of 1998 on the Criminal Procedure*. Detainees can contact their lawyer from the first day of arrest and detention. If the request is approved by the judge or prosecutor, the detainee can accept visitors once a month, up to two adults for a duration of 30 minutes. Detainees are allowed to receive and consume food from relatives during these visits, but not drinks, and are allowed a maximum of five kilograms per month sent from outside. Detainees can also contact their relatives by letters, which can be checked by the prison or police detention staff, and also by telephone. The use of telephones varies according to the institutional regulations but, for all detainees, the only private contact they can have is with their lawyer.

71 Act No. XIX/1998
72 Act No. XXXIV/1994.
73 Section 126 (3) of the CCP

3.5.3 Access to healthcare services in detention

Detainees have right to free health care in police custody and they must have a full medical check (by a doctor) prior to being detained in the cells. The report of the medical investigation has to include if there is any sign of physical injury, any signs of illicit drug use or addiction to drugs or alcohol.

According to the *Ministry of Home Affairs Decree no. 19 of 1995 on the Order of Police Detention Places* the conditions of health care have to be established by the Chief of the police detention facility. For example, with regards to problematic heroin users this decree makes it possible for the Miskolc Police to take detainees who are clients of the local methadone programme to access their treatment, on a daily basis by being escorted to the clinic. This is however, an isolated police practice in the country, and most heroin users have no access to substitution therapy during time spent in police detention.

According to the decree, the doctor has to decide if the withdrawal symptoms are life-threatening or significant enough to transfer the detainee to hospital. The in-patient treatment of drug addiction takes place in the hospitals of the correctional system. Detainees with serious withdrawal symptoms are transferred to detoxification centres. According to police practice in Budapest, heroin-addicted detainees are often transferred to the Forensic Observation and Psychiatric Institute (IMEI) to receive medical treatment (usually sedatives, tranquillizers).

The confidentiality of medical examinations of detainees in police custody is compromised when police officers are present as is often the case in Hungary (CPT 2006):

> The Committee [CPT] has serious misgivings about the presence of police officers during the medical examination of detainees. It acknowledges that special security measures may be required during medical examinations in a particular case, when a security threat is perceived by the medical staff. However, there can be no justification for police officers being *systematically* present during such examinations; their presence is detrimental to the establishment of a proper doctor-patient relationship and could discourage a detained person who has been ill-treated from saying so. Alternative solutions can and should be found to reconcile legitimate security requirements with the principle of medical confidentiality. One possibility might be the installation of a call system, whereby a doctor would be in a position to rapidly alert police officers in those exceptional cases when a detainee becomes agitated or threatening during a medical examination.

3.5.4 Arrest for people with problematic drug use

Arrested drug users usually undergo a urinalysis in order to test for use of illicit drugs during detention by the police. According to the most recent Police Act, only drivers can be forced to undergo drug (including alcohol) testing, however, urinalysis became a standard procedure for the police as a measure against suspected drug users. Aside from seized drugs, positive drug-test results are also used as evidence in the criminal procedure. The police are criticised for this practice by human rights organisations like the Hungarian Civil Liberties Union, as well for stopping and searching people on the street without a well-substantiated reason. In the spring and summer of 2005 the police raided disco clubs several times in various towns and villages throughout Hungary. During these raids hundreds of young people were body searched and their pupils were observed by doctors with a flashlight. As a result, many were arrested and forced to undergo urinalysis, however the results of this only confirmed the findings from the 'quick pupil test' in a couple of cases. No drug dealers were arrested during these raids only those found in possession of small amounts for personal use. It is also common for the police to ask for a warrant to search drug users' cars and homes.

The management of people with problematic drug use during withdrawal was highlighted by the latest CPT report (2006) 'in view of the fact that the prescription of medicines to relieve such symptoms was not tailored to meet the individual's needs'. Concerns were also raised about the treatment of detainees known to be HIV-positive who were segregated and had to use a separate shower and toilet, which demonstrates a serious lack of information amongst police staff about HIV and transmission of blood-borne viral infections and about harm reduction methods to limit the risk of infection (CPT 2006).

3.5.5 General conditions of police detention

According to the *Ministry of Home Affairs Decree no. 19 of 1995 on the Order of Police Detention Places* detainees have the same rights as prisoners (regulated by the *Ministry of Justice Decree no. 6 of 1996 on the Rules of Imprisonment and Detention*). The regulations include separating males from females, those on police arrest from those on a custodial sentence or in police custody, those with mental or physical health problems from those without, young people (under 18 years) from adults, and smokers (tobacco) from non-smokers. In addition, prisoners have to undergo a medical investigation before being released back onto the community and any complaints they report have to be investigated.

All detainees have the right to be kept in cells with $10m^3$ airspace and $4m^2$ floor space, with all necessary tools for eating and sleeping. Detainees can also ask for clothes but can wear their own clothes, if they wish. They also have the

right to request basic hygiene equipment, such as a towel, toilet paper, toothbrush, tampons, razors, and to have at least one shower per week with warm water (and in case of those prisoners who work in hard-working conditions, this should be allowed on a daily basis). Detainees can also request the services of a hairdresser once per month.

3.5.6 The courts

The courts of the Republic of Hungary are independent of any political body. They are supervised by the National Judicial Board. The court system includes: Courts of Labour, Municipal or District Courts, County Courts and the Metropolitan Court, the Supreme Court, and the Constitutional Court. All courts try both civil and criminal cases, except the Courts of Labour. Appeals are made to the court competent in jurisdiction next in the hierarchy. Sentences are passed by a judge or a board of judges, assisted by lay assessors.

The preparation of a case for trial will involve an investigation by the police or an investigating agency. The majority of cases are prosecuted by the official prosecutor, with the exception of private prosecutions of non-serious crimes. The Prosecution Office is completely independent of the courts themselves, and reports to the Parliament. The key tasks of Public Prosecutors are to uphold the charge in court cases, representing the State; supervise the lawfulness of criminal investigations; ensure the observation of the rule of law; approve and supervise certain policing measures concerning intelligence gathering and measures of constraint; carry out investigations in criminal cases involving law enforcement employees, public administration and political personalities.[74]

Police premises can be inspected by special prosecutors. There is a Division for Supervision of Legality of the Execution of Punishments and Legal Protection based at the Prosecutor General's Office that employs 30 prosecutors who carry out such inspections (usually unannounced and random) who have functional independence.

There are three levels of criminal courts, which include local courts, county courts and the Supreme Court, with no specialist courts for juveniles or military personnel, or for dealing with specific types of offenders such as drug users or sex offenders.

Sentences are passed down by a judge or judicial panel and include:

- imprisonment, that is, deprivation of liberty;
- public labour;
- fines;
- supplementary punishments: prohibition from participating in public affairs; prohibition from driving a motor vehicle; local banishment (a Hungarian citizen may be banished from a city or village); expulsion (a

74 http://www.interpol.int/public/Region/Europe/pjsystems/Hungary.asp

foreign citizen may be expelled from Hungary); confiscation of property; and fines.

3.5.7 The probation service

The development of the probation service in Hungary comes at a time of recognition of the need to find a balance between 'controlling the behaviour of its citizens, whilst crucially also ensuring their freedom, dignity and human rights' (Gönczöl and Lorand 2005). This change is based on the principles of restorative justice, which promotes the human rights of both victims and offenders.

The probation service in Hungary was introduced in July 2003, to supervise and manage those on community sentences and those on release from prison. The significant increases in crime in Hungary in the last 20 years led to a lack of public confidence in the police and the criminal justice systems as a whole, and a need to consider how best to use limited resources more effectively when addressing law and order issues. Therefore, learning from the developments in older democratic societies, specifically those with overcrowded prison populations, and costly measures to address offending, is important. The criminal justice system needs to ensure a balance between maintaining public safety and safeguarding offenders' human rights, while also dealing with the causes of offending, and the probation service has a key role in this.

3.5.8 Forced treatment of problematic alcohol users

Since a 1979 amendment of the Penal Code, judges can order the forced treatment of problematic alcohol users as a supplement to the imprisonment if the criminal offence is related to the 'alcoholic lifestyle' of the offender. However, a criticism often echoed by lawyers is that at the time of imprisonment (sometimes years later than the time of arrest) offenders often no longer need the treatment for their alcohol use, because, as a result of imprisonment, they have already changed their drinking patterns. The 1987 amendment of the Penal Code extended this measure to illicit drug users as well but, as of 2007, this amendment has yet to come into effect.

3.5.9 The prison system

The Hungarian Prison Service is the responsibility of the Ministry of Justice. The current prison population is 15,720 of which 2.7% are juveniles. There are 35 prisons in Hungary and the occupancy level is at 139.6% (World Prison Brief 2006). All prisons have an assessment unit, known as the 'get ready group,' where a range of specialist staff meet the new prisoners. The assessment period lasts for a maximum of 30 days, although the prison director

can extend it for a further 30 days. Maintaining family contact is important for prisoners, and visits are allowed, as in detention, once a month, for 30 minutes. Similarly, prisoners are also able to receive parcels, up to 5kg, from home once a month.

3.5.9.1 Provisional bill on correctional institutes

A new bill was drafted by the Ministry of Justice in 2005, which would replace the 1979 Decree that reflected outdated ideas about the criminal justice system. The aim of the bill is to harmonise national legislation with EU recommendations. The bill contains progressive elements, including:

- regulation of the Office of Probation Officers in order to facilitate the rehabilitation of released detainees and prisoners;
- offering new possibilities for detainees and prisoners to meet with their relatives in uncontrolled settings and outside prison;
- charging prosecutors to dispose of the communication of the offender with relatives at the same time as they order the detention.

Unusually, this draft bill regulates the police detention places (and not the Ministry of Home Affairs). The new legislation adopts the most lenient regulatory rules for persons who spend their detention for administrative offences in police detention places.

3.5.9.2 Overcrowding in prisons and pre-trial detention

Overcrowding is a major problem of the Hungarian correctional system. The socialist-liberal government attempted to tackle this problem by decreasing the overall number of prisoners (by creating more alternatives to imprisonment) and establishing two new institutes to be managed by the private sector. Table 1 illustrates the changes in the prison population since 1997. The rate of overcrowding has also changed, which is in part due to the changing availability of prison places. However, the fact that it is consistently high shows that new legislation to divert offenders away from custody has had little effect.

Table 1: Prison population in Hungary 1997-2006

YEAR	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*
Number of prisoners	13,439	14,131	14,950	15,659	16,713	17,875	17,320	16,716	17,316	15,720
Capacity of prison system	10,325	10,305	10,127	99,89	10,703	11,169	11,256	11,400	11,400	11,260
Overcrowding rate	130%	137%	148%	157%	156%	160%	154%	145%	154%	140%

3.5.9.3 Police investigation officers

As a result of a national agreement between the Ministries of Justice and the Interior there is a 'police investigation officer' in all prisons. This investigator caries out investigations of criminal offences committed by prisoners in prison and prior to their imprisonment and gathers information pertaining to prison security. The police investigation officer is not subject to the prison management. In order to carry out this role the investigators have free access to prisoners and can interview prisoners, have unrestricted access to documents held in the prison and can influence such decisions as allocating prisoners to cells. According to 'Section 346 of the draft new Prison Code, the tasks currently performed by these police investigation officers would apparently be assigned to prison staff' (CPT 2006). The CPT Report (2006) argues that this practice of police investigation officers is worrying as their practice could be:

> detrimental to the safeguarding of inmates' rights. It is also arguably contrary to Rule 58.1 of the European Prison Rules, according to which the prison administration must ensure that every institution is at all times in the full charge of the director, the deputy director or other authorised official.

3.5.10 Trends and statistics in problematic drug and alcohol use

In Hungary, those groups considered to be socially excluded include the disabled, the elderly, single mothers, drug users and the Roma gypsy community. Often, the notion of 'social exclusion' is clear when looking at the lifestyle of people with problematic drug use, who can be homeless, suffering poor health, unemployed and uneducated. These factors can either lead to recreational drug and alcohol use becoming problematic, that is, affecting health and social welfare, or can be a result of this. However, there is still limited information on the extent of problematic drug and alcohol use and its links with social exclusion in Hungary.

Data on all crime in Hungary is collected by the Uniform Criminal Statistics of Police and Prosecution, which is managed and co-ordinated by the official statistical services, the Ministry for Foreign Affairs and the Public Prosecutor's Office. Drug-related crime decreased by 29.3% while total crime revealed decreased by only 1.8%, which can in part be explained by the amendment to the Criminal Code in 2003 and the entry into force of the new Act on Criminal Procedure. This targeted drug users offering alternatives to prison and better regulation of existing community sentences (EMCDDA 2004).

According to the World Health Organisation (WHO) 'Health for All' database, Hungary is one of the biggest alcohol consumer countries in the world. Consequently, the alcohol-related morbidity and mortality is also very high: in 1995 the rate of alcohol-related mortality among men was 7.5 times higher in

Hungary than the average level of the European Union (EU). This trend is slowly decreasing, as in 1998 the alcohol-related mortality was 'only' 2.5 times higher than in the EU. According to the National Alcohol and Drug Epidemiology Survey (ADE) 8.6% of the adult population between the ages of 19 and 65 can be defined as problematic alcohol users. As a direct result of their alcohol use, they encounter more health and other problems, compared to the general population, relating to accidents, work productivity, conflicts etc.) (Elekes 2002).

The first estimate for the prevalence of problem drug use was conducted in 2003, however, the scope of this research was limited to the capital only. The sample of this study included 80 IDUs who were either clients of substitution or needle-exchange programmes. Researchers used a nomination technique and estimated that the number of heroin users is 4,000 in Budapest and more than 90% of them are injecting users.[75] However, this study covered only a high-risk group of IDUs (60% of the sample were unemployed, 20% were homeless). It is possible that there is a more hidden, more socially integrated IDU population (Gyarmathy 2005). A Rapid Assessment and Response (RAR) research study estimates the overall number of IDUs in Hungary is between 10,000 and 15,000 (Rácz and Ritter 2003).

The monitoring of problematic alcohol use belongs to the National Institute on Alcohol (Országos Alkohológiai Intézet), the monitoring of problematic drug use is the responsibility of the National Focal Point (Drog Fókuszpont) of the EMCDDA in Hungary.[76] Since 1 January 2004, the latter works within the framework of the National Centre for Epidemiology (NCE) of the National Public Health and Medical Officers Service. Beside the annual report of the Focal Point the Ministry of Youth, Family, Social Affairs and Equal Opportunities also releases its annual reports on the drug situation.[77]

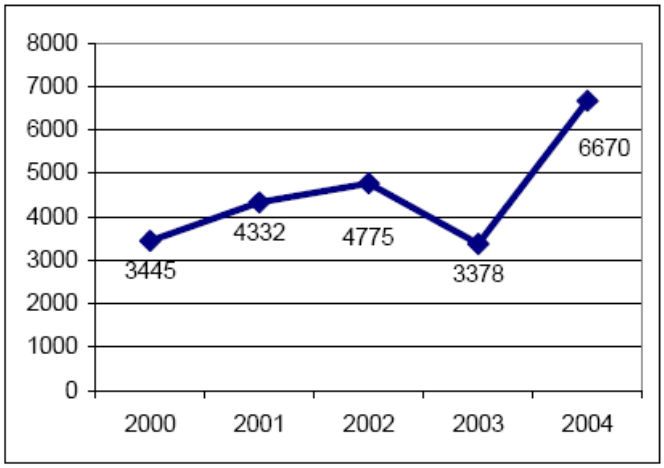
3.5.11 Alcohol- and drug-related crime

According to police statistics, in 1995 there were 429 detected cases of drug- or alcohol-related crime. In 1997 there were 943, and then it almost tripled and reached 2,068 in 1998, 2,860 in 1999 and 3,445 in 2000. Between 1998 and 2002 the number of people arrested because of drug- or alcohol-related crimes tripled again, with 4,775 people under criminal prosecution because of 'abuse with illicit drugs' in 2002. In 2004 this number was 6670. The increase in the rate peaked in the second half of the 1990s (around 40% per year) and slowed down at the turn of the century (20%), by which time it stabilised and in the past couple of years, the prevalence of drug use has fallen into line with the average trends of the European Union. The figure below illustrates the

75 National Focal Point Annual Report 2004, 35.
76 www.drogfokuszpont.hu
77 www.icsszem.hu

changing trend in drug- or alcohol-related crime as measured by the police from 2000 to 2004.

Figure 1: Number of revealed offences of misuse of narcotic drugs



Source: ERÜBS

In 2004, among those arrested by the police for drug offences, 91.7% were prosecuted only for possession, and more than 90% of the offenders were below the age of 30.[78] According to the 2002 Annual Report of the Ministry of Youth, 54.7% of the offences involved cannabis and only 10.6% involved heroin.[79] During 2004, of the 4071 persons who committed crime under the influence of illicit drugs and licit medications, 75.6% of these crimes were drug-related offences (an increase of more than 14% compared with 2003). The majority of the remaining offenders in this group committed non-violent offences (e.g. theft) and just 2.2% committed violent crimes.[80]

Alcohol is a major cause of traffic accidents is Hungary, 62% of all traffic-related offences were committed under the influence of alcohol in 2002. Between 1985 and 2001, one out of every four offences were committed under the influence of alcohol and the rate of these alcohol-related crimes increased by 42% in the same period. Alcohol is also strongly associated with violent crime, as more than 30 percent of violent crime is committed under the influence of alcohol.[81]

78 Annual Report of the National Focal Point 2005, 70.
79 GYISM 2002, 33.
80 Annual Report of the National Focal Point 2005, 71.
81 A társadalmi bűnmegelőzés nemzeti stratégiája (The Strategy of the Social Crime Prevention) Supplement to the Parliament Decree 115 of 2003, 13.

3.5.12 National drug strategy

The 'National strategy to combat the drug problem'[82] is the major framework of drug policy in Hungary and was approved by the Hungarian Parliament with full consensus of all parliamentary parties in the year 2000. However, currently, the strategy has no clear timeframe and there is no action plan to translate its directives to concrete actions. The major goals of the strategy are the following:

- to encourage society to be more responsible for drug problems and increasing the capacity of local communities to deal with the drug problems in their area (community, co-operation);
- to enable young people to refuse illicit substances (primary prevention);
- to help problematic drug and alcohol users and their families (treatment);
- to reduce the availability of illicit drugs (supply reduction).

3.5.12.1 Drug coordination system

The National Drug Strategy emphasises the need for a drug coordination system based on subsidiary and community involvement. Therefore, it created a system with different levels of decision making. The 'Drug Coordination Committee' (established by the 1039/1998 (III. 31) government resolution) represents the highest level, co-ordinating the work of related ministries and professionals. It has many sub-committees in specific areas (such as legal, epidemiological, social and health). At the local level 'Drug Coordination Forums' (KEFs) are responsible for the implementation of the National Drug Strategy. These forums are supposed to include all key stakeholders from the local areas (in the field of prevention, treatment, harm reduction and law enforcement). According to recent statistics there are 97 KEFs in the country and 75% of them work in line with the provisions of the National Drug Strategy. In addition, the police are actively participating in the work of KEFs but there is currently no data available regarding the contribution by professionals from correctional institutions.

3.5.12.2 Harm reduction and the national drug strategy

Harm reduction is integral part of the strategy (6.3.2) as:

> the only efficient and cost-effective way of HIV (and Hepatitis) prevention among intravenous drug users.

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82 *Nemzeti stratégia a kábítószer-probléma visszaszorítása érdekében* (National strategy to combat the drug problem) Budapest: ISM, 2001.

One of the shorter-term aims of the strategy is to introduce and develop harm reduction services and substitution therapy and needle-exchange programmes are explicitly mentioned as recommended measures. Another short-term aim of the strategy is to provide substitution-treatment centres in all regions of Hungary (currently the coverage of methadone programmes is still very low and are only available in a few regions).

The strategy does not address the problems of problematic drug use in police detention or in prisons. It includes recommendations to improve supply reduction methods in prisons but it does not mention drug use in prisons in the context of demand reduction or harm reduction.

3.5.13 Changes in drug legislation in regards to drug users and small drug activities

The development of the response to drug use and related issues in the Criminal Code began in 1937, when the first drug law was enacted in Hungary. This was followed most recently by:

- 1993: Amendment to the Penal Code: diversion into therapy for drug users (users and possessors of small amounts of illicit substances can opt for a six-months prevention or treatment programme as an alternative to punishment);
- 1999: Amendment to Penal Code: restriction, diversion into therapy only for addicts;
- 2003: Amendment to Penal Code: diversion into therapy for possession of small amounts of illicit drugs, possession of small amounts for collective use, handing small amounts to underage people by young adults not older than 21 years for collective use in the area of a public institute;
- 2004 December: Constitutional Court Resolution: limitation of the circle of those applicable for diversion into therapy (exclusion of collective use). The resolutions of the Court have legal power in Hungary.

Drug use in itself is not a criminal offence, whereas the purchase and possession of small amounts is under the Penal Code §282. This is punishable by imprisonment up to two years and a fine. For possession of larger amounts, the punishment can be up to five-to-ten years of imprisonment. There is no differentiation between types of drugs, for example as found with the classification system in the United Kingdom (UK), therefore possession, use and supply of marijuana is treated in the same way as possession, use and supply of heroin. According to the Act (1979/5 Law-decree), a quantity is defined as ‘small’ if it contains less than 0.001g (LSD), 0.6g (heroin), 0.5g (amphetamine, met-amphetamine), 1g (MDA, MDMA, N-etil-MDA (MDE), MBDB, 1-PEA and N-metil-1-PEA), 1g (methadone), 0.9g (morphine), 2g

(cocaine), 1g (ketamine), 1g (codeine), 0.8g dihidrocodeine, 1g (petidin), 1g (tetrahidro-kannabinol, THC). To establish if charges apply for 'larger' amounts, generally, police officers and prosecutors need evidence that the offender possessed 20 times that defined as small amounts. In addition to these codes, there are more specific guidelines for drug dealing and supply, especially for those found dealing near schools and cultural institutions.

3.5.14 The healthcare system

After the end of Communist rule, the healthcare system in Hungary transformed into a more de-centralised model, making use of contracts between local government and providers. It is funded primarily through social insurance, the Health Insurance Fund (HIF), which collects premiums at the national level and allocates funds to 20 county branches. State budgetary assistance is provided for capital costs and to cover areas of under-funding. The coverage of healthcare is universal, for all citizens regardless of employment status; the unemployed and pensioners are covered by government contributions. Employees pay 3% of their wages towards health insurance, and employers add 15% of the employee's gross salary plus a lump sum tax or 'healthcare contribution'. Funding also comes from local and national income tax, which helps to finance the investment costs of health care.

The Ministry of Health is the main regulatory body, with the national policy framework drawn up by the government, who also debates bills and proposes amendments. Local municipalities own primary care and outpatient clinics, and municipal hospitals provide secondary care. County-level governments run county hospitals, which provide secondary and tertiary care. The majority of pharmacies are privatised but the overall role of the private sector is currently minimal. Despite the principle of 'universal care', there still exist gaps in accessing healthcare services for particular socio-economic groups, such as the Roma community and, more generally, those living in rural areas (Ferguson and Irvine 2003).

3.5.15 The prevalence of communicable diseases

3.5.15.1 Prevalence of HIV/Hepatitis among general population

According to official data there is a relatively low prevalence of HIV infection in Hungary among the general population. There were 1,155 cases registered officially, up to 2004 (71% are men engaging in homosexual activity) and 65 new infections were registered in the past five years. The UNAIDS study

estimates the number of HIV-positive people in Hungary to be 5,500. The estimated number of hepatitis C-positive people is around 70,000. [83]

3.5.15.2 Prevalence of HIV/Hepatitis among IDUs

There has been no national research on HIV/AIDS prevalence among IDUs in Hungary, aside from a sentinel surveillance survey that has been conducted annually, since 1997, among clients of a Budapest methadone centre and a detoxification clinic with small sample of 300–600 participants. This survey indicates that HIV prevalence is low among IDUs (0-2%), but hepatitis C prevalence is increasing and tripled between 1997 and 2003 (30%).[84]

3.5.15.3 Screening and education

HIV screening is voluntary, anonymous and free in Hungary since 2003 (prior to this, it was not anonymous). Testing for hepatitis C is also now anonymous and voluntary, but not free (one HCV test costs around €6). According to a survey conducted by the Public Health Institute (ÁNTSZ) of Jászberény in 2004, HIV education does not work effectively in Hungarian schools, high school students know less about HIV today compared to 15 years ago. In addition, there is no systematic testing and HIV education at needle-exchange sites and treatment facilities.85

3.5.15.4 Access to treatment

ARV treatment is available for all HIV-positive and AIDS-symptomatic people, and the costs are covered by health insurance (including those who, according to available information, have no insurance). However, there is only one HIV treatment site in Hungary where those diagnosed as HIV-positive or symptomatic can get access to general and dental health care (St. Laszlo Hospital, Budapest). The cost of interferon-ribavirin treatment is also covered by the state but treatment is not available for hepatitis C-positive drug users, including clients of methadone programmes. According to a treatment protocol, drug users must prove that they have abstained from all illicit and licit substance use within the last six months, in order to access such treatment. This

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83 UNAIDS 2004 Report on the global AIDS epidemic. URL: http://www.unaids.org/en/geographical+area/by+country/hungary.asp

84 Eszter Ujhelyi, *HIV/Hepatitis fertőzöttség előfordulása az intravénás heroinfogyasztók körében* (Prevalence of HIV/Hepatitis Infections among Intravenous Heroin Users), Research Report KAB-KT-02-18. 2004.

85 V. Anna Gyarmathy, József Rácz, Alan Neaigus and Eszter Ujhelyi, „The Urgent Need for HIV and Hepatitis Prevention in Drug Treatment Programs in Hungary," *AIDS Education and Prevention* 16 (2004): 276-287.

is despite the fact that access is also limited for those who do not use illicit drugs. Methadone was registered as an official medication covered by health insurance for drug addicts in 2002 (before it was available only as a pain killer), so is now more widely available.

According to the 2004 survey of the National Institute for Addictology (OAI) there are approximately 400 treatment providers in the country. The report identified different types of treatment sites, the most important forms are in-patient treatment, out-patient centres and methadone substitution.

In-patient treatment occurs in psychiatric or addiction departments of hospitals, for which there were 1200 beds available for addiction treatment.

Some outpatient centres belong to in-patient departments of hospitals, some of them are special centres not belonging to hospitals. The network of the TÁMASZ care centres provide treatment for both problematic alcohol and drug users, but in certain areas the lack of professional infrastructure does not allow the efficient and mass treatment of drug users. The most prevalent drug-free treatment forms are psychotherapy, mental hygienic consultation, crisis intervention, consultation, social case management, group methods, family therapy and social therapy. 69% of treatment sites provide services for clients referred to alternative treatment by the criminal justice system.[86]

Methadone substitution was introduced in 1992. Before 2002, when the appropriate legal regulation on substitution therapy was adopted, there were very few programmes available, and coverage is still very low.[87] Currently, there are eight methadone treatment sites in Hungary and all of them operate in six major towns (two were opened in 2004). Demand is still much higher than supply and there are several regions with significant heroin use that are not covered at all. The total number of clients in methadone treatment is increasing slowly, up to 757 at the end of 2004 and 80% of them were treated in Budapest.[88] According to media reports, the implementation of substitution therapy is sometimes inconsequent and contradicts the principles of maintenance therapy. Buprenorphine is not available, only methadone.

3.5.16 Needle-exchange programmes

There are ten needle-exchange services operating in eight towns (Budapest, Debrecen, Gyula, Kecskemét, Miskolc, Pécs, Veszprém, Szeged). In the capital there are two mobile units (operated by Blue Point and Street Front of the

86 EMCDDA Annual Report 2005, 44.
87 Balázs Dénes and Anna Nyizsnyánszky (Ed.), Harm Reduction Programs in Hungary (Budapest: HCLU 2003).
http://www.drogriporter.mool.hu//download/HCLU%20-%20Harm%20Reduction%20in%20Hungary.pdf?id=13435&time=1105695152&op=cont
88 EMCDDA Annual Report 2005, 47.

Baptist Charity Service), one automat (at the Nyírő Gyula Hospital) and four fixed needle/syringe exchange sites. There are fixed sites in Veszprém, Debrecen and Kecskemét as well. In two towns (Gyula, Miskolc) there are only needle-exchange automats. The South-Hungarian Harm Reduction Association operates a needle-exchange site and street outreach service in the city of Szeged. There is a need for more street outreach work because most injecting drug users (IDUs) are not accessing any other treatment of the healthcare services. Needles are available in pharmacies but often staff are hostile to IDUs and sometime refuse to serve them.

Table 2 presents details of the rates of needle provision and return during 2003, throughout Hungary. These figures demonstrate the higher rates of exchange of needles in urban centres, such as Budapest, where injecting drug use may be higher compared to more rural areas. However, as a whole, there is clearly a demand for such services outside major urban centres.

Table 2: Needle exchange traffic in Hungary, 2003[89]

Location	*Needles provided*	*Needles returned*
Budapest	26,914	14,630
Rural areas	25,000–30,000	13,000

3.5.17 Alternative treatment for drug offenders

For those offenders arrested for possessing small amounts and using illicit drugs, it is possible to undergo up to six months of treatment as an alternative to criminal prosecution and possible custodial sentence. The prosecutor can decide to suspend a case for ten months, in which time the offender has to certify that they have attended a treatment programme. According to official statistics almost 5000 offenders went through this process during 2004. There are three kinds of alternative treatment available under this legislation, including a prevention and education programme for occasional users, a treatment programme for addicts and others.

According to an impact analysis of the alternative treatment programmes in Budapest more than 70% of the clients participating in these programmes were cannabis users and heroin users constituted only 13.6%.[90] This study also emphasises that offenders have to wait a disproportional amount of time (10 months in average) before starting the treatment. This data reveals the

89 EMCDDA National Focal Point, Annual Report to the EMCDDA (Budapest 2004), 59.

90 Ildikó Ritter (2005) Elterelés a büntető útról kábítószerbűncselekmények esetén (Diversion from the Criminal Prosecutin in Case of Drug-Related Offenders) National Institute of Criminology (OKRI), Budapest.

inadequacies of the system regarding the effectiveness of the treatment and the issue whether programmes focus on problematic users who really need treatment or occasional users who do not. This is a very significant question because people with problematic drug use have very limited access to effective voluntary services due to the lack of financial resources of these programmes (including life-saving services like needle exchange or methadone substitution). There is a need to revise the system with special regard to human rights and cost-effectiveness: this needs the further amendment of the Penal Code (which is under process but was delayed because of the parliamentary elections in April 2006).

3.5.18 Detoxification centres

Offenders under the influence of alcohol arrested by the police should be transferred to the closest detoxification centre, according to a 1988 government decree (*Ministry of Home Affairs and Justice Decree no. 2 of 1988*). This decree was repealed in 2005 and it was not replaced by a new regulation. The Hungarian Civil Liberties Union suggested an amendment to the new Public Health Law in order to create a new regulation,[91] however, this did not occur. In the capital there are two detoxification centres (one in the Jahn Ferenc and one in the Nyírő Gyula Hospital). The government does not have a full national register of these centres. In some bigger towns (like Pécs) the detoxification centres were closed for financial reasons, which resulted in a protest by doctors and hospital workers who claimed that they are not capable of treating violent drunken persons. The head of the Nyírő Gyula detoxification centre, Dr. Sándor Funk suggested that patients should be requested to pay for the detoxification service (5,000HUF per night) and for the transfer (600HUF per kilometer).

In the capital there is also a special department of the Péterfy Sándor Utcai Hospital that receives seriously intoxicated persons (by poisons, alcohol or other mind-altering drugs). The head of this department is Dr. Gábor Zacher, who reported that during the day they treat more people suffering from licit drug intoxication while in the night the number of illicit drug overdoses are higher. They use methods like gastric lavage, kiss of life and pace setting to stabilise patients.

91 Hungarian Civil Liberties Union, 'Az egyes egészségügyi tárgyú törvények módosìtásáról' TASZ Álláspont 26.

3.5.19 Human rights legislation: violations of detainees' rights

Hungary joined the European Convention on Human Rights in 1992 and signed the treaty on the prohibition of torture and inhuman treatment. According to the Penal Code, unlawful arrest is punished by five years of imprisonment and forced confession by the police can lead to eight years of imprisonment. However, there are very few instances in which such cases lead to prosecution and conviction. In 1992 there were 796 cases against police officers, but investigation proceeding by the prosecutor only occurred in 131 cases (this rate was 1,246:151 in 1993 and 1,183:107 in 1994). In contrast to this, the rate of investigations leading to prosecution of violent offences against law enforcement officials was 90%.[92]

Hungarian authorities have received warnings from the European Court of Human Rights for violating the rights of detainees on three occasions:

- Kmetty vs. Hungary (December 2004): a violation of Article 3 (prohibition of inhuman or degrading treatment) of the European Convention on Human Rights;
- Balogh vs. Hungary (July 2004): a violation of Article 3;
- Maglódi vs. Hungary (November 2004): violation of Article 5 § 3 (right to be brought promptly before a judge).

There are two major human rights organisations monitoring the human rights of detainees in Hungary: the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the Prison and Police Cell Monitoring Program of the Hungarian Helsinki Committee. This project has been working on a base of an agreement between the Helsinki Committee and the National Prison Administration (BVOP) and the National Police Headquarters (ORFK) since 1996.[93]

As the consequence of the first visit of CPT in Hungary in 1994, 21 police detention centres were closed due to reported inhuman conditions. The Office of the Prosecutor General also issued an investigation in 1994 and ordered the reconstruction of police jails. In 1996, after an agreement with the Liberal Minister of Home Affairs, Gábor Kuncze, the National Police Headquarters launched a circular letter in which it was ordered that local police stations must allow the observers of the Helsinki Committee to investigate and observe the situation of detainees without any interference.

> According to the 2005 report of the Hungarian Helsinki Committee (based on a survey conducted in 16 police detention centres and 10 correctional facilities among 500 detainees),

92 András Mink ed. (2005) 'Alperes: az állam' (*Respondent is the State*) Magyar Helsinki Bizottság, Budapest, 211.
93 English website: http://www.helsinki.hu/eng/indexm.html

17% of detainees stated that they were beaten by the police and that in most cases the complaints against the police are rejected. In addition, the survey found that one third of arrested offenders were not allowed access to legal representatives.

3.5.20 Policy changes after joining the EU

The application process to the European Union included a twinning project with the Trimbos Institute from the Netherlands. The aim of this project was to evaluate the implementation of the Hungarian National Drug Strategy and point out the gaps and controversies in the system.

The 'Special Committee on Preparing the Harmonization of the National Drug Strategy with the European Union Drug Strategy' was mandated by the Parliament in April 2005 to interview all key stakeholders of Hungarian drug policy and identify the main successes and barriers of the implementation of the National Drug Strategy. The report of the Committee (released in the beginning of March) points out that the National Drug Strategy is fully in line with the balanced approach of the drug policy of the European Union, in that it stresses the need for science-based prevention and harm reduction programmes and limits the scope of the criminal justice system to supply reduction.

However, the implementation of the strategy faces serious barriers, especially the lack of financial resources and political commitment. The Committee opposes the distinction between licit and illicit drugs in the field of prevention and harm reduction and calls for the creation of a National Institute on Drug Use with a standard professional scope. The report also calls the government to organise a multi-disciplinary conference to advise political decision makers on the reform of the drug-related articles of the Penal Code. The documents states that 'the drug problem is a social issue – not solely and not even mainly criminal or medical problem – so the management of this problem should be social as well.'

3.6 Italy

3.6.1 The police

The Italian legal system is based on written laws and the criminal procedure is adversarial in nature. The behaviour that is perceived as criminal and the minimum and maximum penalties for such behaviour are defined by the Penal Law.

There are three main state police forces in Italy:

- the State Police (Polizia di Stato);
- the Carabinieri;

- the Guardia di Finanza.

In addition there are the Corpo Forestale dello Stato and the Polizia Penitenziaria (who also guard prisoners in the cells at court while they wait to go before the judge). The sixth police force are the Polizia Municipale and Polizia Provinciale who are limited to their local area but who also have the same powers as the national police.

The most important are the State Police under the responsibility of the Ministry of the Interior (the Ministry that ensures public order) and the State Police are responsible for all functions listed in the United Nation's definition of police (prevention, detection, investigation, and apprehension of alleged offenders) and the Carabinieri are under the responsibility of the Ministry of Defence. The Guardia di Finanza are responsible to the Ministry of Finance. The structure of these police is variable where the:

> State Police and the Carabinieri have a pyramid-like structure with the lower level ranks grouped into provincial territories (each provincial capital has a police headquarters and a provincial Carabinieri command office), with the Head of the Police and the Commander of the Carabinieri at the top. These are responsible to their respective Ministries in regard to bureaucratic and organizational matters and to the Ministry of the Interior for public security affairs. The Prefect is the highest internal administrative organ with control and inspection under its jurisdiction (Manna and Infante 2000, 29).

To become a senior officer or executive in the State Police, a Masters degree in law is required. Police in the Carabinieri and Finance Guard are required to attend the Military Academy and the Scuola Ufficiali. In addition the Scuola di Perfezionamento per le Forze di Polizia is the provider of high-level specialist courses for police officers from all the police forces.

3.6.2 Prosecutors

The prosecutor office is entitled to prosecute any criminal offences. Once the prosecutor office has been informed about a criminal offence then the offence has to be recorded ‘nobody including the prosecutor themselves has the power to stop or discontinue the proceedings’ (Avocats Sans Frontieres 2002). Only a judge can stop or discontinue the proceedings. All crime reports have to be sent to the prosecutors’ office in the area where the crime took place and may be lodged in any police station in Italy. The crime report must be signed by the complainant. If the complainant wishes to be kept informed of the proceedings they have to expressly ask for this.

When the prosecutor receives detailed and specific details about the occurrence of a criminal offence the preliminary investigations start. This period has a fixed time limit:

> The time limit does not start on the day the offence is reported, however, but on the day when the offender is identified: in other words, from the moment in which a given person is investigated for a certain offence. The time limit set to investigate a specific person is six months, which can be extended to a maximum period of two years in the case of more serious offences (Manna and Infante 2000, 17).

The police after making an arrest in the case of both mandatory and facultative 'arresto' or 'fermo' must immediately notify the Public Prosecutor, the defence attorney and the suspect's family (Code of Penal Procedure, Art. 386, 387). The judge responsible for the preliminary investigation must be requested to fix a hearing to confirm the arrest within the first 48 hours of the arrest otherwise the arrest will lose its validity (Code of Penal Procedure, Art. 391).

The Code of Penal Procedure provides the framework for the continued process of the person arrested through the criminal justice system. After the initial hearing all subsequent decisions are taken by the judge or prosecutor. The pre-trial investigation is the responsibility of the Public Prosecutor who either carries out the investigation or uses the investigating police. The pre-trial investigation establishes whether there is sufficient evidence for penal action within a legally fixed period of time.

Similar to a judge, the Public Prosecutor is a career official (public servant) considered to be a part of the Bench although the prosecutor is not a judge. The prosecutor and the judge are both considered magistrates. The Italian magistry is divided into the inquiring magistry (magistratura inrequirente o magistracy), who are the public prosecutors, and the judging magistry (magistratura giudicante), who are the judges. The prosecutor is in charge of conducting the investigation and prosecution while the judge passes judgement on the case and imposes a sentence. The terms magistrate and magistracy refer to all judges and prosecutors, independent of their level, competency and jurisdiction.

The pre-trial phase is conducted under the control of the judge for preliminary investigations (GIP), a judge who controls the work of the public prosecutor and guarantees the rights of the person being investigated, in other words, when there is a need to collect the evidence in advance. The preliminary judge has the task of adopting measures restricting personal freedom if this proves necessary during the investigation. He or she also decides whether it is necessary to extend these measures, following a request by the public prosecutor. In addition, at the request of the parties the preliminary judge decides whether to admit taking evidence during the pre-trial phase and presides over the proceedings (Manna and Infante 2000, 19).

6.3.6 The courts

There are various judicial bodies in the Italian Criminal Law system that includes, at the first level, the lower court (Pretura), then the Tribunale and

then the Court of Assizes. Despite a few minor differences the procedures are the same in all three courts. Low-level offences are tried by Giudici di Pace, established in 2002, which deals in the main with petty offences (21 from the penal code and 17 offences prescribed by general legislation) and does not have the power to sentence defendants to prison. This court is presided over by one lay judge only.

Depending on the seriousness of the offence the Tribunali has one or three judges. The Corti di Assise deals with the most serious offences (e.g. murder) and has two professional judges and six lay judges. In the case of failure to reach an agreement then the two professional judges will decide. In addition to these three courts there is also a judge who monitors the activities of the prosecutor during the preliminary investigation—the Giudice per le Indagini Preliminari. In Italy only a judge can deprive a person of their liberty by issuing a warrant of arrest or passing a sentence following a trial. In some circumstances for serious offences the prosecutor can order the arrest for not more than 96 hours.

The investigative and criminal procedures commence:

> when an offence is reported, and is completed when a decision by a court is given. It is divided into two phases. These are the investigative phase (indagini preliminari), which precedes the trial and in which the public prosecutor has an important role, and the court hearing during which the contending parties put evidence before the court (Manna and Infante 2000, 17).

In the Italian Criminal Code, there are clear distinctions between criminal sanctions and penalties and security measures. The latter refers to those deemed as 'socially dangerous' who may commit crime and the former to those actually found guilty of committing an offence. This is referred to as the 'double track' system.

Penalties are divided into main and collateral penalties. The main penalties are imprisonment, with the length of sentence decided by the judge, or fines. Collateral penalties are applied when responsibility for the crime has been confirmed and are added on to the main sentence. They are intended to have preventative and incapacitating functions.

In 1981, Law 689 introduced penalties to act as a diversion from short custodial sentences, which can be applied to sentences of less than one year. This involves supervised release and work in the community and can also include treatment for problematic drug and alcohol use. These sanctions include probation, house arrest, semi-custody and early release.

3.6.4 The probation service

Sanctions through the Probation Service can be applied to those offenders sentenced to less than three years, or who have three years left of their current

prison sentence. They aim to rehabilitate offenders, and must be carried out under the supervision of the social services. If this measure is successful, then the offenders' penalty is cancelled but if they breach the conditions of this measure, it is revoked and offenders are sent back to prison to serve the rest of their sentence.

3.6.5 Alternative measures for problematic drug and alcohol users

In the case of problematic drug or alcohol users who have a sentence of less than four years, and who have participated in a rehabilitation programme for drug addiction, it is possible to request the intervention of UEPE (Office for the External Execution of a Sentence) in order for the person to continue the programme or to undertake it outside prison. The rehabilitation programme must be agreed with the professionals of the Local Health Service and of the Services for the Drug Addiction (SERT). The request for an alternative to prison can be presented by the prisoner with the necessary documentation, to the Director of the prison who sends it to the Probation Court and to the supervisory magistrate who has agreed the alternative. If the sentence remaining to be served is within the limits, the judge orders the release of the prisoner.

The requirements for this measure are:

- a sentence no longer than 6 years;
- the sentenced person must be a drug addict or alcohol dependent who is already in a rehabilitation programme or who is going or willing to start one;
- the therapeutic programme must be agreed with the health service, sometimes, be in accord with other private agencies specifically identified by law (art.115 D.P.R. n. 309/90);
- drug addiction or alcohol dependence must be medically supported and the suitability of the programme itself for the rehabilitation process must also be medically supported. The benefit of the alternative to prison for drug or alcohol dependence can only be granted on two occasions.

The option of alternatives to prison are often denied by judges for prisoners who are in methadone therapy, because abstinence is considered in relation to whichever opiate the prisoner may be using, thus judges often confuse methadone therapy with the use of a drug. Moreover, alternatives to prison are often revoked because of relapses (again considering compliance to the programme only on the basis of abstinence), showing an insufficient consideration of the real problems and a substantial closure in relation to alternatives to prison. It is important that the use of methadone is recognised as

an appropriate means to prevent drugs use, and that staying in therapy is considered a successful alternative to prison (Berto 2006).

3.6.6 The prison system

The Prison System, which is under the direction of the Ministry of Justice, is divided into regional offices that control the activities of individual penal institutions located in each regional territory. At the time of the research (20,060 the prison population was 61,721, with 35.9% on pre-trial detention. Foreign prisoners make up 33.2% of the overall population, and the number of establishments is 225 (163 remand prisons, 36 institutions for the execution of prison sentences, 8 institutions for the execution of security measures, 18 penal institutions for juveniles). The official capacity of the prison system is 42,959, therefore the current occupancy rate is 138.9% (World Prison Brief 2006).

Along with security staff and officials, personnel in each prison include the correctional police corps (to maintain the order of the prison), social service staff, educators and healthcare staff. Rehabilitation of prisoners is done through educational, work, religious, cultural, recreational and sporting activities as through well as ensuring prisoners maintain regular contact with their family and the outside world.

At the end of June 2005, there were 59,125 prisoners in the Italian prisons, of these, 40,054 were Italians and 19,071 non-Italian nationals. In all, 16,179 were people with problematic drug use (15,511 men and 668 women) of these, 3,016 were non-Italian national prisoners with problematic drug use (2,935 men and 81 women). (Further details on problematic drug users in custody are presented in the next section). Amongst the imprisoned people with problematic drug use 1,525 were HIV-positive in 2005. As the test for HIV is voluntary this number could be underestimated. It is interesting that within Italian prisons, every prisoner can access a certain amount of alcohol, despite all the problems related to alcohol use (security between the prisoners and with the guards, alcoholism, violence).

3.6.7 Drug and alcohol use

In Italy, as in many countries, the real number of people with problematic drug use is difficult to estimate. The only definite number of problematic users are the clients of the Services for the Drug Addiction (SerT). Data from the Annual Report to Parliament on the Situation of Drug Addiction in Italy (2001) show an increasing number of clients from 140,307 in 1998 to 150,327 in 2001 who are receiving treatment. In 2004, the number of clients receiving treatment at SerT was 171,724, of which 17,143 clients have been sent to rehabilitation organisations.

Approximately 15% of those in the general population who visit their GP have alcohol-related problems, and 5% are alcohol dependent. Although it is difficult to appraise, scientific data estimates that mortality rates attributable to alcohol are between 30,000 and 50,000 each year, and 30% of road accidents and 10% of incidents in the workplace are alcohol-related. An additional important aspect is alcohol consumption among young people, who mostly abuse alcohol by 'binge drinking'.

The use and the abuse of alcohol is also very common in prison and it is often used with pharmaceutical drugs. People with problematic drug use in prisons often replace their primary drug with alcohol and pharmaceutical drugs. Often the beginning of alcohol use or the increase of alcohol consumption corresponds with a period of imprisonment. Epidemiological data about prescribed drug and alcohol use in prison is lacking, one survey on the drug- and alcohol-dependent prisoners was carried out by the Ministry of Justice, which identified 1.3% alcohol-dependent prisoners.

At the end of June 2001, according to the survey of the Ministry of Justice, there were 55,261 prisoners in Italian prisons, among which 15,173 were people with problematic drug use equating to 27.46% of the prison population (data collected on voluntary screening). Without relevant variations from the previous three years, the drug addicts entering prison in 2004 were approximately 29% of the total number of prisoners (Annual Report to the Parliament year 2005).

Drugs users aged between 35 and 44 years old are particularly represented among patients in methadone treatment programmes, while young adults (23–34 years old) are represented in higher percentages among the patients of the Therapeutic Communities (Relazione Annuale *2004)*. Psychological treatments provided by drug services represent approximately 49% of all treatments, and this percentage has increased from 2001 to 2004. In these four years, detoxification treatments with medications have decreased, from approximately 3% of all pharmacological treatments in 2001 to 1% in 2004. 82% of pharmacological treatments involve methadone. From 2001 to 2004 there was an increase in the number of long-term therapies, compared to a slight decrease in the number of short-term therapies. Prescription of buprenorphine has been increasing in recent years. In 2004, compared to the previous years, a reduction in the use of naltrexone has been registered; residential treatment continues to be very common for heroin dependency and a great number of clients in therapeutic Communities have a history of poly-drugs use or cocaine dependence (Relazione Annuale *2004)*.

The IPSAD Study (2001–2003) shows an increasing rise in the consumption of cannabis (compared with 2001) for all ages. Among men, the highest percentage of consumption is between 25 and 30 years olds. Among women, the highest percentage of consumption is among the 24 and 25 years olds. In 2003, 5.4 % of respondents interviewed reported having used cocaine at least once in their lifetime and 1.5% in the last 12 months (IPSAD 2001–2003). The use of cocaine has shown a substantial increase between 2001 and 2003.

Cocaine is used more commonly by young people (15–24 years) compared to adults (25–34 years), however, the greatest increment, in recent years is shown by young adults (25–34 years) and by adults (35–44 years). Heroin use once or more in a person's lifetime is reported at 1.2% of the population aged between 15 and 44 years in 2003, while 0.25% of the population report using heroin in the last 12 months. The use of heroin at least once in a lifetime, in comparison with the 2001–2003 data, shows an increase in use by 25–34 year olds, and even more of an increase in the 35–44 age group. A decrease in the number of young people who refer to heroin use once or more in their lifetime has been observed. In the last 12 months (2006) heroin use has reduced to half of the frequency found in 2001, showing a significant reduction. There is a decreasing trend (2001–2004) in the use of cannabis and heroin, whereas there has been a significant increase in the use of cocaine and the quantity of amphetamines being used has stabilised (Relazione Annuale *2005)*

3.6.8 National drug strategy

In Italy the law regulating the sentences for the sale of illegal drugs is Testo Unico (TU) 390/90. A new law was approved on 21st February 2006, n°49[94] that integrates and modifies DPR 390/90, article 4 regarding the execution of preventive jail sentences for drug addicts in recovery programmes:

> Anyone, without the authorization referred to in article 17, who cultivates, produces, extracts, refines, sells, offers or puts on sale, yields, distributes, trades, transports, provides to others, sends, passes or sends, delivers any part of drugs or psychotropic drugs can be punished with imprisonment from six to twenty years and with a fine from 26,000 Euros.

In the case of people with alcohol dependence there are no regulations, since alcohol is a legal substance, except for the rules applied to drink driving or in the workplace, or violations of the law under the effects of alcohol.

3.6.9 Harm reduction and other treatments

Policies of harm reduction financed primarily by the National Fund remain fragile, mainly due to a narrow interpretation limited to health interventions. Such strategies in Italy mainly relate to tertiary prevention or rehabilitation treatment. As a result, the interventions are occasional, fragmented and feeble; they depend on the individual commitment of professionals or specific services. Harm reduction initiatives are supported by occasional funds for

94 Published in the Official Gazette n°48 on 27th February 2006 - Ordinary Supplement n°45.

particular projects and what harm reduction projects there are differ greatly between what is available in the north compared to the south of Italy.

The major misunderstanding on a national basis is that harm reduction policies are considered to be of a lower priority compared to the 'real objective' of drug policy, which is abstinence and self discipline. Harm reduction is a complex strategy[95] that contributes to strengthening the abilities of self-determination in those who use substances, and to acknowledge the related risks, such as; diseases, marginalisation, imprisonment and mortalities. It is important to highlight that between harm reduction policies and demand-reduction policies (prevention and rehabilitation) there must be mutual support and strategic interdependence. Available data provides support to the fact that that it is necessary to implement initiatives aimed at the reduction of mortality, diseases, marginalisation and imprisonment. The political will to play a cultural and education role is essential. In explaining harm reduction interventions to citizens, four major motivations are emphasised:

- harm reduction interventions are helpful for the individual;
- there are public health interventions that limit infections and diseases that are beneficial for the entire population;
- harm reduction interventions have a positive impact on public order and contribute significantly to the safety of the cities;
- harm reduction interventions are an economical way to reduce the spread of communicable diseases.

It is important to highlight that adequate strategies of harm reduction require investment toward:

- an acknowledgment of the right to cure and the therapeutic freedom (methadone therapies and experimentation of substitutive therapies);
- an increase in investments for social integration, without which, health interventions are going to be reductive and ineffective;
- the acknowledgment of the importance of social rehabilitation within working activity;
- empowerment policies, such as the active involvement of clients, based on their will to be recognised, integrated and emancipated;
- possible options to shorten prison sentences and improve the quality of the time when people leave prison and are continuing to wait for community interventions.

In 1999, the advisory commission for the re-organisation of the health care system in prisons proposed to provide syringes and condoms for prisoners. The Ministerial decree sent to the regions and to the prison institutions on 29th December 1999 says that 'among the priorities in this field there is the increase

95 Starting from a cultural dimension of tolerance of the consumption and of decriminalisation of the consumer

of the prevention, information and education activities for the reduction of the risk from pathologies due to drug use';

The Regional Decree n. 1588, dated 11 April 2000, of the Regional Committee of the Veneto Region includes the *Guidelines for the prevention and the treatment of overdose and the acute effects of ecstasy.*

In November 2000, the *Guidelines on Harm Reduction* were published by the Ministry of Health. In the section 'Harm Reduction and Detention', it underlines the risk behaviours that are particularly related to promiscuity, and to the lack of syringes and of correct procedures of sterilisation of injecting equipment. Also common under these circumstances is tattooing, usually under unsafe conditions, which can often lead to the spread of communicable diseases (HIV, hepatitis). Under these circumstances, it is appropriate to conclude that serious consideration must be given to harm reduction interventions, especially those that are not yet provided systematically in the current activities within prison institutions.

Public opinion in Italy supports the concept of abstinence as the response to problematic drug or alcohol use. This is reinforced by campaigns on public safety that stress the relationship between problematic drug use and crime with the result that abstinence is the major objective of treatment interventions resulting in further marginalisation of people with problematic drug use and of increasing social anxiety. The absence of an effective drug reform strategy coupled with the lack of a serious harm reduction strategy are leading to a potential increase in problematic drug use and increasing spread of communicable diseases. In an attempt to address the perceived 'need for public safety', policy makers implement further repressive and punishing measures for people with problematic drug use.

3.6.10 The healthcare system

In 1998, the reorganisation of the National Health System began to include the reorganisation of prison health care. All prisons are under the control of the local health system and all prisoners are registered in the National Health Service and do not have to pay health insurance. Foreign prisoners during their imprisonment also have the right to the same health care as those in the community, regardless of their legal permission to live in Italy (Articles 1–5, legislative decree 22nd June 1999 n.230).

The Ministry of Health plays a key role in providing guidelines for and coordinating the health service in prisons. The regional health authorities also have a key role in provision of services in the local area and manage of and provide of services for prisons. The SERT, the community drug agency that is part of the National Health Service, has the responsibility of care and treatment for problematic drug and or alcohol users. The financial resources, included in the budget of the Ministry of Justice for prison health care, are to be transferred to the National Health Fund (Article 7 of D.Lgs. 230/1999).

In Italy, since the introduction of Law 230 of the penal code introduced in 2000, drug treatment for prisoners has been provided by SERT. SERT can start drug treatment in the prison with prisoners who have had no previous contact with the SERT in the community. In addition SERT can arrange drug treatment in the community as an alternative to staying in prison and many prisoners with problematic drug use benefit from this.

SERT has no formalised agreement with the police to work with problematic drug and or alcohol users in police custody. There are some local initiatives such as the presence of SERT in the Milan courts that provide individual programmes for drug users prior to their court hearing that offer an alternative to the individual being sent to prison. Another initiative is that provided by Villa Maraini in Rome who work closely with the police in every police station. The police notify staff at the Villa Maraini, who go to the police station to attend to the needs of the prisoners with problematic drug use.

3.7 Lithuania

3.7.1 The criminal justice system

The Lithuanian legal system, principally based on the legal traditions of continental Europe, has undergone significant reforms since independence from the Soviet Union in 1989. For example, in 2001, the new Civil Code came into effect and during 2003, changes were made to the Criminal Code, Code of Criminal Procedure and Penal Procedure Code, which had implications for the organisation of the criminal justice system and the execution of its role. The procedures of the criminal justice system in Lithuania are governed by the Code of Criminal Procedure, which prescribes that criminal cases must be investigated by an pre-trial investigator, prosecutor or court representative (judge), based on evidence presented by individuals, the reports of state institutions or officials, or legal professionals.

3.7.2 The criminal justice response to drug and alcohol use

The Law of the Republic of Lithuania on addiction care aims to reduce the harms associated with problematic drug and alcohol use, including those experienced by the patients, their close relatives and their local community. It regulates services covering the personal health care of persons abusing alcohol, narcotic, psychotropic and other substances. The law sets the conditions for the prevention of addictive diseases, early identification of illnesses, health care and integration into society.

3.7.3 Training for criminal justice professionals

In 2004–2005, at the universities of Vilnius, Kaunas and Iauliai, compulsory and optional subjects related to control and prevention of the use of psychoactive substances, rehabilitation and integration of persons dependent on psychoactive substances were taught to criminal justice professionals. In addition, separate disciplines cover topics about the control and prevention of the use of psychoactive substances, psychological aspects of addictions, provision of medical, psychological and social services and rehabilitation. To implement the national drug control and drug use prevention strategies (see 3.7.15 below), there are training programmes for the police and other law enforcement institutions (public and criminal police, customs, state border protection office). This training is included in the Plan of Programme Measures, which in 2005, was carried out by the Police Department under the Ministry of Interior, Customs Department under the Ministry of Finance and by the State Border Protection Office under the Ministry of Interior. There were 14 programmes in total, eight programmes were prepared by the Police Department, four by the Customs Department and two programmes by the State Border Protection Office. In all, 537 Lithuanian officers attended this training to improve their knowledge about the issues of drug search and recognition, drug control and drug use prevention.

3.7.4 The police

The police service in Lithuania is managed by the Ministry of Interior. The police service is responsible for public safety, state border protection, state aid during emergencies and civil protection and the control of migration processes, among other administrative functions.

The Lithuanian police service consists of territorial police commissariats, police education and training institutions and specialised police divisions. Order No. 88 of the Minister of Interior of the Republic of Lithuania of 17 February 2000, 'Concerning the Regulations for the Activities of Police Custodies' sets the following provisions.

- 31. Persons kept in police custodies have the right to receive state guaranteed (free) health care services;
- 80. Persons kept in police detention should be provided the same quality and level of treatment as those whose freedom is not restricted;
- 81. A medical nurse working in a police custody must:
    - 81.1. provide first aid to the persons kept in police detention in accordance with professional requirements and instructions of the Ministry of Health Care of the Republic of Lithuania;
- 85. In case of a sudden dangerous illness or an accident, first aid to the person kept in police custody must be provided

immediately by detention officers and staff within their competence.

The temporary detention of an offender suspected of committing a criminal act may not last longer than 48 hours. If the detained person is to be arrested, then within 48 hours he or she has to be brought to the judge who takes the decision about the duration of arrest. A family member of the arrested person or a close relatives is immediately informed about the detention. Furthermore, persons who have been taken into custody (arrested) and convicted persons who have received 15 days imprisonment are kept in a detention centre.

The detention of a person prosecuted under the administrative code may not last longer than five hours, except in those special cases when the laws stipulate other terms of administrative detention. In some cases persons may be detained for up to 48 hours.

There are 46 police detention centres in Lithuania, in which there are 24 medical posts. A paramedic at the detention centre provides first aid to the detained persons. If there is a need, the administration of the detention centre calls specialists from health care institutions to assess the state of health of the detained person in custody.

Persons, who have a doctor's certificate confirming that they are in need of treatment at the health care institution and that their detention in custody may be dangerous to their life, are not taken into custody. This also applies to persons who are drunk, intoxicated with drugs or other toxic materials or strong medicines. If the persons detained declare that they are addicted to opiates, they are taken to the doctor who has the right to provide detoxification. Harm reduction programmes are not carried out in custody, except for talks on a healthy way of life, including the topic 'damage to health from smoking, alcohol, drugs and other addictions'.

The control of the activities of the police detention administration is carried out as stipulated by the laws of the Republic of Lithuania by the Seimas (Parliament) ombudsmen and prosecutors, who investigate the complaints.

3.7.5 Role of prosecutors in police investigation

The Prosecutor's office helps to ensure legality and helps the court to carry out justice. The Prosecution Department consists of a Prosecutor General's office and territorial prosecutor's offices. Territorial Prosecution Department include district prosecutors' offices and local prosecutors' offices.

Prosecutors organise and carry out pre-trial investigation, lead the pre-trial investigation and control the procedural activities of pre-trial investigation officers. They support charges on behalf of the state in criminal cases, control of implementation of sentences in compliance with the Criminal Code, Penal Procedure Code, Penalty Implementation Code and in accordance with the

procedure set by the Law on the Prosecutor's Office. Prosecutors and pre-trial investigation officers must comply with the recommendations approved by the Prosecutor General as well as other normative legal acts, setting the control procedure for pre-trial investigation, state charges and implementation of sentences.

3.7.6 Human rights issues for police detainees

In 2005 many problems arose because of the unauthorised handling and use of data in various information systems and databases. The danger to the protection of data is increased by the fact that the system of databases is centralised in Lithuania, all stored data is quite easily accessible to third parties, and the population is still not well-informed about the areas of data collection, storage and use.

Inadequate staff policy, bad working conditions in police stations, insufficient payment to the lower- and middle-level officers contribute to a low level of professional ethics, violations of human rights and population's distrust of the police. Representative surveys show that, in 2006, only 38% of the Lithuanian population trusted, 53% distrusted while the police.

Low salaries and the lack of adequate working conditions and tools (officers in town and regional departments are often forced to work in shabby premises experiencing constant lack of paper, petrol, office equipment, etc.) force them to look for other jobs. Statistics show that about 50% of citizens' complaints about police unlawful activities were confirmed. In 2005, there were several cases when police officers, due to alcohol abuse, committed criminal acts against the property and person of the citizens. The Minister of the Interior and the Police Department Office also acknowledged that some police officers drive when drunk.

Police officers often fined offenders without informing them about the content of the written documents and consequences arising. There were cases when citizens found out about the fine from the bailiffs' notice, which urged them to pay the fine. In some cases the sum to be paid had increased two or three times because of the expenses of the bailiff's office.

In 2005, the Ombudsmen's office stated that the number of violations of human rights, including violent behaviour of police officers, is not decreasing in Lithuania. Violent behaviour of police officers has been recorded during police custody as well. There is a suspicion that arrested persons are exploited. Attempts have been made to draw attention of the authorities to the necessity to modernise detention centres and to ensure the safety of detained persons. Though there is some observable progress, many problems remain unsolved. Out of 46 police detention centres only ten can claim to have adequate conditions. According to the Ombudsmen's Office, some of the police detention centres should not be used at all because the conditions there are humiliating and beneath human dignity.

3.7.7 The courts

The courts in Lithuania deal with civil and criminal matters under general jurisdiction in the Supreme Court and Court of Appeals, and since 1999, have a system of specialised administrative courts, at a national and district level. In addition, there is the Constitutional Court which decides whether the laws and other legal acts adopted by the Parliament are in conformity with the Constitution and legal acts adopted by the President and the Government, do not violate the Constitution or laws.

The judicial system is managed by the National Courts Administration, which conducts a range of functions, such as analysing the activities of courts and providing recommendations on the working conditions of the courts.

There are 54 district courts, five regional courts, the Court of Appeal of Lithuania and the Supreme Court of Lithuania. Criminal cases are heard at regional courts, the Court of Appeal of Lithuania and the Supreme Court of Lithuania. In the first instance, cases are heard at the district and regional courts, and depending on the nature of the offence and subsequent proceedings, can then go on to be heard at the Court of Appeal and Supreme Court. The main rules on jurisdiction are contained in the Code of Criminal Procedure and in the Law on Courts.

Under the Penal Code, the main punishments are life imprisonment, imprisonment, correctional work and a fine. Additional punishments include confiscation of property, fines and deprivation of the right to a certain job or to perform certain duties. In addition, the Penal Code also stipulates coercive medical measures, which can be applied to the mentally ill who have committed an offence, and usually involves placement in a psychiatric hospital. There are also special provisions for juveniles, such as placement under guardianship, home supervision, reparation to the victim or community-based work.

3.7.8 The probation service

The Probation Service in Lithuania has been running for eight years, and is primarily responsible for supervising offenders on release from prison and those on community sentences. It also offers social assistance or referral to other agencies to meet the needs of clients, who can be placed under three different categories of supervision:

- parole (after prison sentence);
- postponed/suspended sentence;
- limitations of freedom (curfew ordered by courts).

For those on suspended sentences, many are required to undergo treatment for alcoholism, drug or toxic abuse or sexually-transmitted diseases as a condition

of their release back into the community. The probation service is also a part of the Correctional Affairs Department (Prison Department) but with its own agencies under the police units of each region. This close relationship with the police is important in supervising offenders in the community, in order that any breaches of the conditions of their sentences are reported and dealt with back in court.

The main functions of the probation service are:

- keeping personal records of persons on suspended sentences or conditional release from imprisonment;
- helping clients to gain employment;
- supervising and monitoring clients;
- instigating disciplinary measures and incentives;
- locating conditionally-released persons who do not declare their address.

The Probation Service actively encourages links with volunteers and non-governmental organisations (NGOs) in supporting its activities, however, currently, there are very few NGOs who can offer assistance (for example, the Prisoners Aid Association).

3.7.9 The prison system

Decisions about the necessity to transfer a detained, arrested or convicted person from police custody to prison and back under convoy are taken by a pre-trial investigation officer, prosecutor or court. In exceptional cases the decision is mad by the Prison Department or heads of institutions under Prison Department, whose authority is established by the Penal Procedure Code, Penalty Implementation Code, Law on Imprisonment and other legal acts.

The prisons department and judicial system is co-ordinated by the Ministry of Justice, based in the capital Vilnius. The current total incarcerated population is 7,983, as of November 2006. The official capacity of the prison system is 9,444, within 15 prison establishments throughout the country (World Prison Brief 2006).

The main problems of the prison system in 2005 were inadequate conditions and failure to ensure human rights in incarceration institutions, inadequate implementation of the right of convicted persons to access health care, and insufficient social integration when these persons come out of prison. The absence of an independent institution that could carry regular visits to places of incarceration without advance notice was not helping to secure the rights of the convicted persons. In 2005, Lithuania lost a case concerning the living conditions of incarcerated persons at the European Court of Justice. The Court stated that an extremely small living space (1.5 sq. m), unsanitary conditions, insufficient time for walking in the yard (an hour per day) and insubstantial

food violated Article 3 of the Convention prohibiting torture, inhuman treatment and loss of dignity.

The press has repeatedly criticised the lack of social rehabilitation centres in prison establishments, especially for drug rehabilitation. There are only a few initiatives by some prison authorities to establish drug-free zones where incarcerated persons, willing to give up drugs, are taught social skills and prepared to live out of prison.

3.7.10 Prevalence of drug addiction in places of incarceration

The number of persons addicted to narcotic and psychotropic substances in places of incarceration has risen between 1998 and 2004, although peaked in 2002 (Table 1). According to the data of the Prisons Department under the Ministry of Justice for the year 2005, out of 8,155 persons kept in places of incarceration, 18.1% (1,476 persons) were dependent on narcotic or psychotropic substances. At the beginning of 2004, there were 15.6% such persons (1,265 persons). In 2005, about 1,940g of narcotic and psychotropic substances were confiscated either from persons kept in places of incarceration or from handovers to these persons, which was almost three times more than in 2004 when about 680g were confiscated. A total of 61 pre-trial investigations of crimes related to illicit trade of narcotic and psychotropic substances in places of incarceration were initiated.

Table 1: Prevalence of drug use among incarcerated populations, 1998–2004

Year	*Number*
1998	704
1999	1072
2000	852
2001	1301
2002	1464
2003	1148
2004	1256

Source: Drug Control Department, Annual Report 2005.

Opiates remain the main drugs used in places of incarceration. During the last five years, however, a considerable decrease in the use of opiates has been observed. This observation was confirmed by the numbers of convicted and arrested persons registered for follow-up medical care. In 2004, 55.5% of such persons admitted using opiates, down from 78.8% in 2000. In places of

incarceration a growing number of young people were found to be addicted to narcotic and psychotropic substances. It is important to note that the great majority of drugs are injected, which raises serious concerns regarding the spread of infectious diseases.

3.7.11 Drug and alcohol use

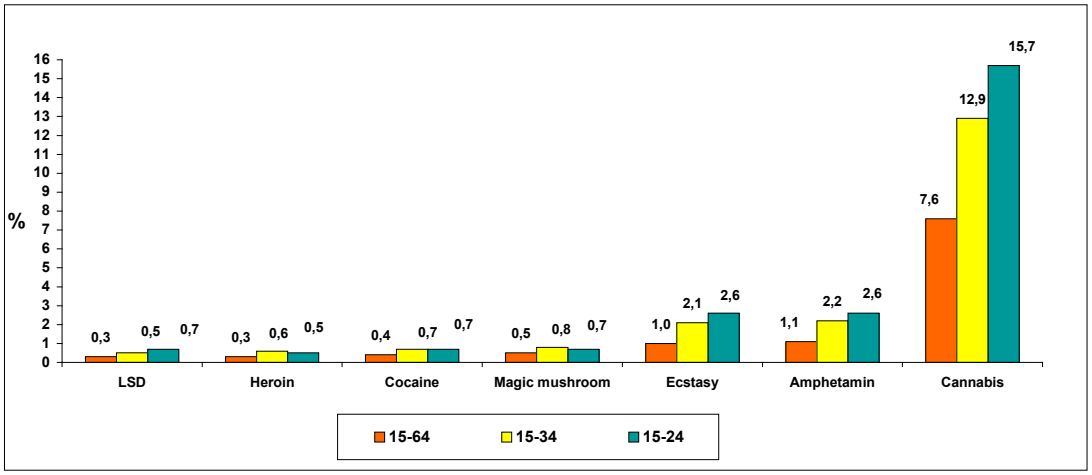
Until 2005, Lithuania was one of the few countries where the prevalence of drugs among the general population had not been investigated. The investigation of harmful habits among the general population in Lithuania carried out at the end of 2004 provided a lot of valuable information about the prevalence of the drug problem and other harmful habits – the use of alcohol and smoking—in the country and revealed the major risk groups, their socio-demographic characteristics, and the attitude of the Lithuanian population toward drug addiction.

3.7.11.1 Prevalence of drug addiction among general population

At the end of 2004, a representative survey of the prevalence of harmful habits among the country's population aged 16–64 was carried out in Lithuania for the first time in accordance with the European methodological requirements of the Drug Addiction Monitoring Centre (Figure 2). The results of the research revealed that 34.8% of the Lithuanian population smoked tobacco, 65.1% drank alcoholic drinks and 8.2% of the Lithuanian population had tried drugs at least once in their lifetime, mainly cannabis: 7.6% of the Lithuanian population had tried this drug at least once in their lifetime.

The findings also showed that men (13.1%) had used drugs more often than women (3.8%), younger persons (aged 15–34) used narcotic and psychotropic substances much more frequently than older people (aged 35–64) (14.4% and 4.5% respectively).

Figure 2: Distribution of Lithuanian population who have tried drugs at least once according to their age (percentage)



Source: Drug Control Department, Annual Report 2005.

All indicators of cannabis prevalence were higher among men than women, and among younger than older respondents. The percentage of those in Lithuania ever using cannabis was 3.7 times higher among the younger respondents (aged 15–34) than older respondents (aged 35–64), 12.9% and 3.5% respectively. Cannabis was also the most frequently used illicit drug in the larger towns. This difference was especially striking in the distribution of those who admitted having smoked cannabis in the last 30 days.

Apart from cannabis, the most widely used drugs in Lithuania were amphetamine and ecstasy. The prevalence of their use was very similar. 1.1% of the Lithuanian population have tried amphetamine at least once, 1% tried ecstasy, 0.5% tried 'magic mushrooms' (the most widely used hallucinogenic drug), 0.4% tried cocaine, 0.3% tried heroin and 0.3% tried LSD.

3.7.12 Alcohol use

Research shows that alcohol use is widespread among the Lithuanian population: 16.7% of respondents indicated that in meetings of friends or relatives alcoholic drinks are always or almost always used, a further 22.6% indicated that alcohol is more often used than not and 58.4% said it is used sometimes, eg. during the holidays. Only 1.9% said that in meetings of friends or relatives alcohol is not used.

Men use alcoholic drinks more often than women: 39.2% of men and 13.9 % of women use alcoholic drinks (including beer) at least once a week. Men of different age use alcoholic drinks (including beer) equally frequently, however younger (aged 15–34) women use alcohol more frequently than older (aged 35–64) women (18.7% and 10.5% respectively). Although the percentage of younger (aged 15–34) and older (aged 35–64) women who used alcohol in the

last 12 months was similar, a greater proportion of younger women claimed having used alcohol in the last 30 days (65.7%) than older women (55.5%).

The data reveal that the greatest use of alcohol is among the Lithuanian population with a university degree or unfinished university education, and the smallest use of alcohol is among those with basic or unfinished basic education. The greater spread of the use of alcohol was noticed among the Lithuanian population with the highest income.

The comparison of alcohol use between the country and the town showed that at present alcohol use is more prevelent in major cities (Vilnius, Kaunas, Klaipėda), alcohol is least used by the country people (71.5% and 64.25% respectively). These differences could be explained by the different social demographic structure of the population, that is, in the countryside there are more of older women who have a lower level of alcohol use. There is an obvious trend that the population of major cities (Vilnius, Kaunas, Klaipėda) use alcohol more often than the population of rural areas and smaller towns. In major cities, in comparison with rural areas and smaller towns, alcohol is used slightly more often by older (aged 35–64) people and much more often by younger (aged 15–34) people.

According to the survey, on average, the Lithuanian population starts using alcohol when they turn 18. Half the respondents started using alcoholic drinks before they turned 18. One quarter of the respondents started using alcohol when they were under 16 and three-quarters had begun using it before they reached 19 years of age. By 22 years of age, more than 90% had started using alcohol.

3.7.13 Crimes related to drug and alcohol use

In 2005, almost 4% fewer criminal acts were registered in Lithuania than in 2004 (89,815 and 93,419 respectively). In contrast to the general crime trend, the number of criminal acts related to narcotic and psychotropic substances and their first category precursors is growing. In 2004, 1,552 acts were registered, which rose to 1,818 in 2005, an increase of 17%. Overall, criminal acts related to the illicit possession of narcotic drugs accounted for 2.02% in 2005, 1.7%, in 2004 and 1.2% in 2003. More than half of the registered criminal acts related to the illicit possession of narcotic drugs were drug distribution cases, out of which 12% was distribution of large quantities of drugs.

It can be claimed that the trade of drugs is increasing, the main drugs are amphetamine-type substances and cannabis, the illicit trade of heroin is growing and the role of Lithuanian citizens in the international market of illicit drugs remains significant. According to the Criminal Code, in force since 1 May 2003, criminal acts are divided into crimes and misdemeanours. Misdemeanours in the area of illicit drug trade are defined in Part 2 of Article 259 of the Criminal Code. Disposition in this part coincides with the disposition in Part 1 of Article 44 of the Administrative Code, that is, until

2003 these acts were not included in the official statistics. A slightly increased number of registered misdemeanours show that pre-trial investigation institutions in the country focus their work on revealing and destroying the drug trade network.

According to the statistics for 2005, provided by the Informatics and Communications Department under the Ministry of Interior, out of the 1,818 criminal acts related to the illicit possession of narcotic and psychotropic substances recorded there were 808 cases of illicit possession of narcotic and psychotropic substances without the aim of their distribution (832 in 2004); 977 cases of illicit possession of narcotic and psychotropic substances with the aim of distribution (673 in 2004); 2 cases of illicit possession of the first category precursors of narcotic and psychotropic substances (8 in 2004); 6 cases of seizure of narcotic or psychotropic substances (3 in 2004); 2 cases of making equipment for the production of narcotic or psychotropic substances (2 in 2004); 8 cases of illicit growing of poppies or cannabis (22 in 2004); 2 cases of distribution of narcotic or psychotropic substances to minors (4 in 2004) and 14 cases of drug trafficking.

The major trends characterising the illicit trade of drugs in the country have not changed but when setting the priorities for the work of law enforcement institutions, greater attention should be paid to the threats posed by this phenomenon, that is, the rapidly increasing supply of drugs among young people and the increasing supply of heroin and amphetamine-type stimulants. To stop drug trafficking and unmask organised groups, law enforcement institutions should strengthen international cooperation and, in order to reduce availability of drugs to the youth, should more actively cooperate with educational and training institutions. In 2004, 60 cases were known when citizens of the Republic of Lithuania were detained for illicit drug trade abroad (in 2003 there were 62 such cases). The majority of detentions were registered in Germany accounting for one fourth of all detentions of citizens of the Republic of Lithuania abroad for illicit drug trading.

3.7.14 Public attitudes towards problematic drug and alcohol use

In a survey of the general public's attitudes towards drug and alcohol users, it was found that 4.1% see drug users as criminals, 61.5% treat them as patients, 7.3 % perceive drug users neither as criminals nor as patients, 20.2% see them as both criminals and patients, and 6.8 % said they don't know or haven't decided (Drug Control Department 2005).

The majority of Lithuanian population positively assesses their knowledge about the possible consequences of drug use. Almost half of the population (46%) think that they have sufficient information, almost one fifth (18%) claim that they are very well informed, and 22% of the population think that they are informed but would like to learn more about the possible consequences of drug

use. Young people (aged 15–34) more often than older people (aged 35–64) say that they are very well informed about the possible consequences of drug use (21% and 15% respectively). Young people (26%) more often than older people (19%) claim that they are informed but would like to be better informed about the possible consequences of drug use. Younger women (30%) would like to find out more about the possible consequences of drug use. The majority of the population (82%) think that people smoking marihuana or hashish cause great risk to themselves, 12% see it as medium risk. The population thinks that the least risk to physical and mental health is caused by using five or more 'doses' of alcohol at weekends.

The majority (86%) of Lithuanian population think that drivers should not only be tested for the amount of alcohol in their blood but also for drug use. The majority of the population think that punishment of a penal nature should be applied in cases of drug use and that stricter penalty would reduce the use of drugs: 74% of the respondents absolutely agree and agree with the statement 'punishment of a penal nature should be applied in cases of drug use' and 70% of the respondents absolutely agree and agree with the statement 'stricter penalty would reduce the use of drugs'.

The majority of the population think that services which help to withdraw from drug use should be provided free of charge: 71% agree with the statement 'methadone treatment should be free of charge' and 60% agree that 'drug users should be provided with free syringes in order to stop the spread of AIDS, HIV and other infectious diseases'. People have a negative attitude toward drug traders: 61% agree with the statement 'life imprisonment should be introduced for drug traders', 62% disagree with the statement 'existing punishment for drug traders is strict enough'.

3.7.15 National drug strategy

Lithuania is carrying out a consistent drug-control and drug-addiction prevention policy, which is a component of the country's foreign and domestic policy. One of the main long-term priorities of state development listed in the Long-term Development Strategy of Lithuania, approved by the Parliament of the Republic of Lithuania, is the creation of a safe society. The National Strategy for Drug Addiction Prevention and Drug Control for 2004–2008, approved by the Resolution of the Government of the Republic of Lithuania, sets the priority of the state policy for drug control and drug addiction prevention, which is the primary prevention of the use of drugs in the family, among children and youth.

The National Programme on Drug Control and Prevention of Drug Addiction 2004–2008, adopted by the Parliament of the Republic of Lithuania, sets the strategic aim to reduce and to stop the spread of drug use, to set and implement the main guidelines of state policy and activities in the area of drug addiction prevention and drug control, to increase the effectiveness of drug use

prevention in Lithuania. This programme foresees state coordinated and operated policies in implementing drug addiction prevention and drug control through legislation, education, health care, and penal policy. Active cooperation with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Europol, Interpol, United Nations' International Narcohes Control Board (INCB) and other international organisations is maintained.

The use of opportunities provided by membership in international organisations is sought and as well as positive experience of other countries in drug addiction prevention and drug control. The measures of the National Programme on Drug Control and Prevention of Drug Addiction are approved every year. The aims and objectives of the programme basically coincide with the provisions of the EU Strategy for Action against Drugs for 2005–2012. In 2004, the Prime Minister of the Republic of Lithuania appointed the representatives of Lithuanian institutions to the Horizontal Working Party on Drugs of the Council of the European Union and to the monitoring committee on the trade of certain materials used for the production of illicit narcotic and psychotropic substances.

The present programme of the government envisages strengthening the prevention and control system of drug-related violent crimes as well as juvenile offences by carrying out an active employment policy and developing social assistance measures. Therefore, the government is planning to design models of healthy living for different communities so that they could choose the most suitable one for them.

In 2004, the Minister of Justice approved the strategy for Drug Addiction Prevention and Drug Control in places of incarceration. Its purpose is to stop and to reduce the expansion of drug addiction and to prevent the illicit drug trade in places of incarceration by consistently removing the causes and conditions for the rise and spread of drug addiction and by using financial and human resources in a rational way. In 2004, the Minister of Justice also approved the order for information exchange with municipalities about persons released from places of incarceration who have addictive or infectious diseases. This order regulates the procedure and conditions for the information provision to municipal institutions and any other subjects under the regulation of the municipalities providing health care and rehabilitation services to persons with addictive or infectious diseases, in order to ensure the sustainability of health care, rehabilitation and integration into society for such persons.

In 2002, the Government of the Republic of Lithuania approved the strategy of the combat against the trade of illicit narcotic and psychotropic substances. Specially-authorised state institutions are authorised to implement the strategy, including the divisions of the Ministry of Defence, the Ministry of the Interior, State Security Department of the Republic of Lithuania, Special Investigation Agencies of the Republic of Lithuania and the Customs Department under the Ministry of Finance. These organisations exchange information concerning illicit drug trade, carry out joint operations, coordinate the protection of secret

information and co-operate in other ways. The Police Department under the Ministry of the Interior was commissioned to coordinate the strategy of the combat against illicit trade of narcotic and psychotropic substances.

3.7.16 Policy information on harm reduction and other treatments

In 2004, there were 3,606 registered drug-dependent patients of which 3,992 (79.7%) were dependent on opiates and 614 (12.3%) dependent on several drugs. On 1 January 2005, a total of 436 opiate-addicted patients in Lithuania received substitution treatment, which accounts for about 10% of all registered opiate-addicted persons. Methadone substitution treatment was available in Vilnius, Kaunas, Klaipėda, Panevėžys and Druskininkai.

Apart from legal measures reducing the circulation of drugs, the policy of drug control includes elements of prevention and rehabilitation as well as social reintegration or re-socialisation. The purpose is the psychological and social rehabilitation of drug addicts and re-socialisation of former drug addicts. There are two long-term in-patient rehabilitation divisions funded by the state and municipalities in Lithuania: at the Vilnius Centre for Addictive Diseases (12 places) and the Lithuanian AIDS Centre (13 places). In addition, there are 19 NGOs that have established rehabilitation communities for persons addicted to drugs.

In 2004, 611 persons addicted to drugs participated in various projects. The majority of participants of those projects received psychological assistance (89% of all participants, of which 75% received this assistance in groups, and 95% received individual assistance). Medical assistance was provided to 49% of all participants. Work therapy services were provided to 46% of participants, and temporary accommodation was provided to 41% of persons addicted to drugs. 36% of all participants received help in solving education, re-qualification and employment problems, and 23% of all project participants received legal assistance.

In 2004, the 19 projects organised 1,978 events (lectures, seminars, trainings, leisure events) which involved 4,232 persons (persons addicted to drugs, their family members, and other participants). A total of 128 volunteers and 156 specialists (psychologists, social workers, medical workers, lawyers, etc.) participated in the implementation of the projects. Project managers cooperated with 68 partners (enterprises, institutions and organisations) during the implementation of the projects. Two out of 19 project managers had no partners for the implementation of the projects. A small majority (58%) of project managers claimed that their project achieved its purpose and 42% claimed that the purpose was partly achieved.

The implementation of harm reduction programmes started in Lithuania in 1995. Since 199, programmes have been carried out which give the possibility

to injecting drug users to receive consultations anonymously and exchange syringes and needles. Harm reduction is carried out by state health care institutions and non-governmental organisations. Since 2001, Vilnius Centre for Addictive Diseases has established a mobile syringe and needle exchange outlet called 'The Blue Bus'. The "Blue Bus" follows a schedule and drives to the gathering places of drug users and sex workers and persons willing to participate in the programme are given a participant card. Participants receive service once a day, syringes are exchanged according to the ratio 1:10 (new to used syringes), but the maximum number of syringes during one visit is 30. In 2004, the mobile outlet was visited by 2,825 clients. The number of new clients per year is 1,485. The programme is funded by Vilnius municipality and Open Society Fund Lithuania. In Lithuania, needle and syringe exchange programmes are carried out in Alytus, Druskininkai, Klaipėda, Mažeikiai, Vilnius, Biržai and ŠIauliai. Since 2002, in Mažeikiai the project 'Let's block the road to drugs' is being carried out by the Police Department of Mažeikiai region. Needles and syringes are exchanged on the premises of the Club of Anonymous Alcoholics 'Aura'.

3.7.17 Institutions monitoring information on problematicdrug and alcohol use

The Drug Addiction Prevention Commission, established by the Seimas (Parliament) of the Republic of Lithuania in 2004, has 11 members. The main long-term aim of the Commission is to ensure the state interests and to create favourable conditions for the implementation of state policy oriented towards drug addiction prevention and drug control. The National Health Board is an institution co-ordinating health care policy and accountable to the Seimas (Parliament). The main aims of the National Health Board are to improve public health and to ensure the participation of the public in solving health-related issues, to coordinate the cooperation of non-governmental organisations, state and municipal institutions, to analyse disease prevention processes and to carry out examinations, to participate in the formation of health care policy and its priorities, provide conclusions and proposals concerning the improvement of the work of environmental and health care agencies.

The State Mental Health Centre carries out epidemiological tests of mental illnesses, alcoholism, drug addiction and other addictive diseases at the national level and analyses the data (as outlined by the Centre's regulations). The data concerning the numbers of persons who approach health care institutions about their addiction to narcotic and psychotropic substances, statistical data concerning the treatment of such persons, their morbidity, ailments and deaths are presented to the Drug Control Department. The Drug Control Department under the Government of the Republic of Lithuania, established in 2004, organises observation of the prevalence of the use of narcotic and psychotropic substances, stores, analyses and provides

information to the institutions concerned with the prevention of drug use and implementation of drug control measures, local and international trends, consequences of use of narcotic and psychotropic substances and prepares methodological guidelines.

3.7.18 The development of Drug Control Commissions

Drug control commissions were established in municipalities of towns and regions in 2004 to administer the programmes of drug control and drug addiction prevention at county and municipal level. In 2005, out of 60 municipalities only four had not established drug control commissions.

The bureau of the Nordic Council of Ministers in Lithuania administers exchange and support programmes and projects of the Nordic Council of Ministers. The bureau of the Nordic Council of Ministers carries out the Action Plan for the Drug Addiction Prevention. It is a project support programme whose aim is to assist in reducing the spread of drug addiction in the countries of the Baltic Sea Region by implementing measures approved by the Nordic and Baltic ministers responsible for drug issues who signed a letter of intent for cooperation. In carrying out drug addiction prevention non-governmental organisations pay the greatest attention to the development of healthy living and organise occupation for children and youth. While carrying out the projects they provide psychological counselling, organise training for social skills development, give lectures, conduct seminars, and inform the society about the preventive activities via the media.

3.7.19 Links with NGOs

Since 2004 the Open Society Fund Lithuania no longer supports separate projects but pays the greatest attention to drug and HIV/AIDS prevention policy and carries out the Drugs and HIV/AIDS Policy Programme. On 2 February 2004, twelve non-governmental organisations established a representative coalition of vulnerable social groups called ‘I Can Live’. In addition, the public organisation ‘Parents against Drugs’ is a member of two international organisations, the Euro-Mediterranean Partnership against Substance Abuse (EMPASA) and Nordic Alcohol and Drug Policy Network (NordAN). At the end of 2004 they joined the Lithuanian ‘National Association of Families and Parents’.

3.7.20 Healthcare services response to problematic drug and alcohol use

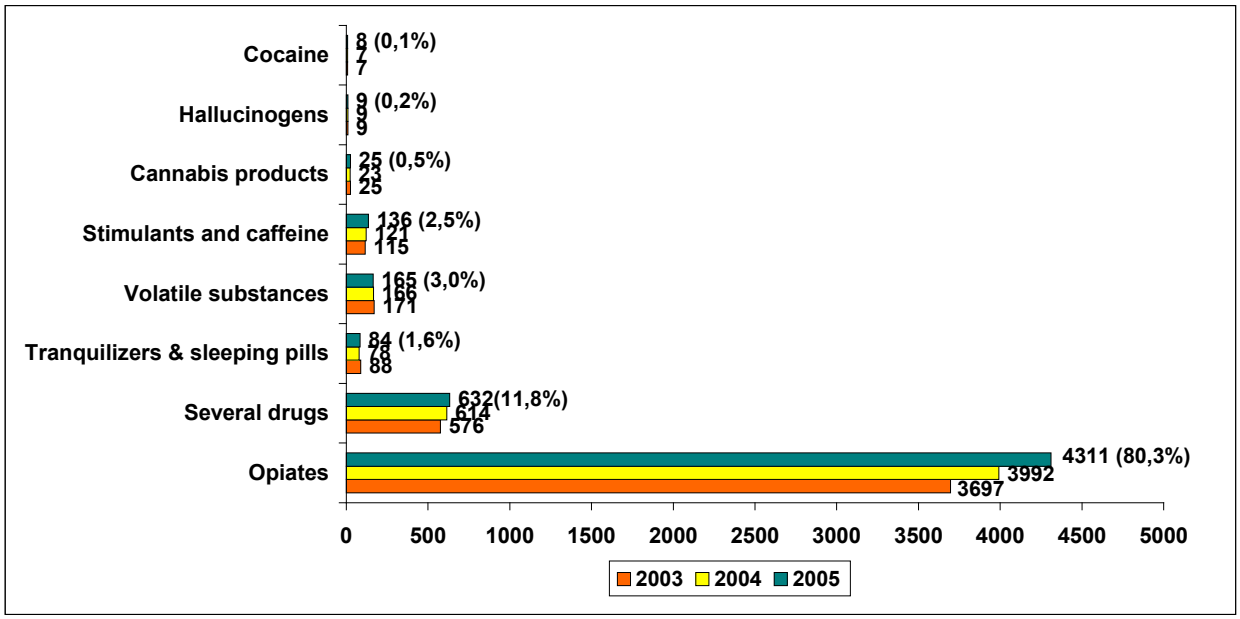
The healthcare of persons with addictive diseases is carried out according to the procedure set by the Ministry of Health Care in accordance with the treatment and rehabilitation standards approved by the Order No. 204 of the Minister of Health Care of 3 May 2002 on 'The Treatment and Rehabilitation Standards for Addictive Diseases'. There is also a provision in Lithuanian legal acts that imprisoned, detained or arrested persons have the right to receive health care services of the same quality as other Lithuanian citizens. Most patients with abstinence symptoms get into the investigation cell and from there to the psychiatric ward of the prison hospital where they are treated. The duration of in-patient treatment is 2–4 weeks. Such patients get individual treatment at the hospital, and later this work is continued by the psychiatrist at the place of incarceration.

In the Lithuanian health care system, the health care of persons with addictive diseases is part of the system of mental health care, therefore, statistical indices of prevention of addictive diseases, morbidity and ailments at the national level are coordinated by the State Mental Health Centre. At the municipality level, mental health care is ensured by mental health centres, of which, from December 2004, 65 were established throughout the country. On suspecting an addictive disorder the general practitioner refers the patient to a psychiatrist for a more exact diagnosis. The general practitioner, in cooperation with a psychiatrist (or a psychiatrist for addictive diseases), can participate in designing and implementing an individual plan for the patient's treatment. In accordance with the regulations of mental health centres, the team of specialists organises mental health care and social support. In-patient treatment services for persons with addictive diseases are provided in five regional centres for addictive diseases and psychiatric hospitals. It is widely believed that in-patient treatment at the specialised centres for addictive diseases better suits the needs of problematic drug and alcohol users.

According to the data of the State Mental Health Centre, institutions of personal health care had 68,653 persons with psychoactive drug dependencies (alcohol and drugs) registered on 31 December 2004: 378 persons fewer than in 2003. 5,011 of all the registered persons were registered as having narcotic drug dependencies. The number of persons registered for narcotic drug dependencies is increasing every year.

In 2004, 81.7% of all persons with drug dependencies registered in institutions of personal health care were men (4,094 persons) and 18.3% were women (917 persons). In 2004, 94.1% of the persons with drug dependencies registered in institutions of personal health care were town dwellers and 5.9% were rural dwellers. Almost half, 2,159 persons (43%) had previous convictions. Opiates predominated although about 12% of dependents used several drugs (see Figure 1).

Figure 1: Distribution according to groups of narcotic and psychotropic substances of patients treated for drug dependency in 2003–2005



Source: Drug Control Department, Annual Report 2005.

In 2004, specialised centres for addictive diseases provided out-patient treatment services including abstinence-based treatments, out-patient day centre and other treatment programmes. Some specialised centres carried out additional social consultative or 'low threshold' programmes, prevention programmes and harm reduction programmes. Institutions providing out-patient and in-patient treatment and rehabilitation services are accredited by the Ministry of Health Care of the Republic of Lithuania and have licences to provide psychiatric services or psychiatric services for addictive diseases. Therefore, the institutions have to meet the set requirements and to ensure the quality of the specialised health care services they provide. According to the data of the State Accreditation Agency for Health Care Activities under the Ministry of Health Care, in 2004 there were 30 private institutions licensed to provide addictive disease treatment services and 80 private institutions licensed to provide psychiatric services.

3.7.21 Impact of joining the EU

Ever since the preparation for accession and after the accession to the EU, Lithuania has been actively implementing the EU standards and applying the best practice in the areas of drug control and human rights protection. In the preparation of the National Strategy on Drug Addiction and Control 2004–2008 and the National Program on Drug Control Prevention of Drug Addiction

2004–2008 in Lithuania alternative EU strategies, programmes and action plans were taken into account and their recommendations were used. At the moment, while implementing the national policy and strategy of drugs control in Lithuania the following documents are taken into consideration: the EU Strategy Against Drugs 2005–2012, the EU Action Plan Against Drugs 2005–2008 and recommendations of other EU documents. For example, taking into account the Decision 2005/387/TVR of the Council of Europe of 10 May 2005 concerning the information exchange about new psychoactive substances, their risk assessment and control. On 17 January 2005, the Drug Control Department approved of the Procedure of Information Exchange about the Emergence of New Psychoactive Substances and obliged the responsible institutions to exchange information promptly. The Drug Control Department registers, analyses and summarises information that is then presented to the European Drug and Drug Addiction Watch Centre, and the Police Department provides information to Europol. Since the accession to the EU, Lithuania is co-operating, exchanging information and participating in the initiatives of various levels of European institutions concerning the issues of drug control.

3.8 Romania

3.8.1 The criminal justice system

The Romanian Criminal Justice System is based on a combination of the inquisitorial and accusatorial models, with the preliminary phase primarily regulated by the inquisitorial system, and the trial phase by the accusatorial one, however the two systems are often interacting. Currently the present Criminal Procedure Code is being reformed, with the key aims of bringing the court system and police investigation procedures in line with the standards imposed by the European Convention of Human Rights, and the jurisprudence of the European Court of Human Rights.

3.8.2 The police

The Romanian Police (*Poliţia Română*) is the national police force and main civil law enforcement agency and it is under the control of the Ministry of Administration and Interior. The central structure of the Romanian Police is the General Inspectorate which is under the command of a General Inspector appointed by the Minister of Administration and Interior. The General Directorate of the Police is in Bucharest and there are 41 territorial inspectorates, corresponding to each county (*judeţ*).

Before 2002, the National Police had military status and a military ranking system. In June 2002, the national Romanian police became a civil police force as one of the first police services in Eastern Europe to do so. According to

Romanian commentators (IHF Report 2006) the police have remained a conservative and closed institution and how they operate barely shows any effects from the formal demilitarization of the police force in 2002. In particular, 'the disproportionate use of "masked" squads during police operations made the identification of abusive officers difficult' (IHF Report 2006).

3.8.3 Arrest and detention

According to the law, preventive arrest is from 24 hours up to 180 days. During the first 24 hours the detainee can be held by the police if the person is caught (e.g. selling drugs) or due to a warrant issued by a prosecutor. After 24 hours, a warrant is required by a judge for a further 5 to 30 days maximum with the possibility to be prolonged up to a further maximum of 180 days. Theoretically, in this time, the investigation is finalised and the decision made by the judge.

There are 26 police precincts in total, with 12 having detention houses. There are 296 cells across the 12 precincts. Outside Bucharest, the detention centres are located in the local regional or county police headquarters.

The rules governing police detention are largely the same as prisons. Prior to 1981 they had the same rules but in 1991 the prisons were handed over to the Ministry of Justice. The rules taken from the Ministry of Interior say that it is mandatory that detainees have a medical examination within 24 hours including blood samples and x-rays. At arrest, detainees are visited by the doctor within 24 hours. During the 24 hours an assessment is made as to whether detainees are drug users or alcoholics. If they are drug users and the police see needle marks the detainee is handed over to the treatment centre or national institute for psychiatry for detoxification. The police doctor decides what treatment is required and treatment is ensured through availability of 24 hour medical service. The number of doctors employed to look after detainees is one doctor and three nurses in Bucharest. For the counties it is proposed that there should be three nurses in the detention houses. Forensic medical care in Romania for people under police arrest and for inmates in prison is provided by the Forensic Medical Institute. The Institutes decide whether or not people can be imprisoned, taking into account their health status. Medical assistance is offered during police arrest, by the medical staff at the point of arrest who are employed by the Ministry of Interior and Administration. The police medical staff do not provide any harm reduction information or substitution treatment.

The police do not, as such, have a formalised policy response to problematic drug and or alcohol users at the point of detention. In theory, all those arrested have a medical examination and should also screened for TB prior to being sent to prison. People detained by the police for different offences and who are drug problematic users are taken under guard to hospital to determine their health status, where they will be recommended medical treatment for, in effect,

enforced detoxification. If detainees are experiencing withdrawal they are admitted to Ministry of Health clinics or Rahova Prison Hospital where they can be observed and properly medically treated.

3.8.4 Roma community

The relationship between the police and the Roma community raises concerns, and was highlighted by the Helsinki Committee report. They found that Roma were often subject to violent attacks including police brutality during raids targeting Roma communities. In addition they reported many incidents of torture and ill-treatment in police custody, as well a racist intimidation and harassment by police, and use of excessive force and firearms against Roma. In addition, Roma victims who filed complaints faced retaliation (IHF Report 2006).

3.8.5 Conditions of police detention

According to article 23 paragraph 3 of the Romanian Constitution, detention in police custody must not exceed 24 hours. In addition, the period of arrest must be warranted by a magistrate (judge or prosecutor) and must not exceed 30 days. The criteria for detaining suspects is based on the seriousness of the offence, personal circumstances of the offender and clear evidence linking the offender to the offence.

Romania was visited by the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 8 to 19 June 2006. This visit focused on the treatment of persons detained by the police and the conditions of detention in a number of police establishments and detention facilities for foreign nationals.

3.8.6 The courts

According to the Romanian Penal Code, problematic drug and alcohol users are not punished for drug or alcohol use, but for drug possessions for consumption (article 312 ‘Drug trafficking’). They are punished for drug possessions for consumption and crimes committed under the influence of drugs or alcohol and according to the seriousness of their crimes.

Romania, since the ratification of the Treaty of Accession (2005) with the EU, has focused on judicial reform. Romania has not as yet implemented all of the necessary political reforms that will aid the process of judicial co-operation between Romania and EU member states. The court system in Romania consists of four tiers: local courts of law (*judecatorii*), county courts (tribunals), courts of appeal and the Supreme Court of Justice. The basis of the

Romanian judicial system is formed by approximately two hundred local courts of law that are established in most Romanian cities. There are a total of 41 tribunals, including those in each county and in the municipality of Bucharest. These tribunals exercise legal control over the decisions ruled by the local courts as well as dealing with certain categories of litigation of medium importance. There are 15 appeal courts that cover several tribunals in their districts. Decisions made in the appeal courts can only be challenged by the Supreme Court of Justice. There are no special courts to deal specifically with alcohol and drug use offences. However, the large urban courts in larger cities and port cities are more aware of drug use and associated crimes.

All judges and prosecutors in the general court system are considered as 'magistrates' and are members of the magistracy. The prosecutors establish who is to be detained for 24 hours and they also draw the indictment to be presented for preventive arrest based on evidence obtained by the prosecutors provided by the police. In the first phase of a trial, the investigation, the prosecutor has a key role and works closely with the police. The prosecutors are in charge of collating evidence and safeguarding the rights of the accused such as access to a lawyer.

In 2005, the three laws on the judiciary were amended to improve the independence of the judiciary, but two areas of concern were identified by the Romanian Helsinki Committee (APADOR-CH):

> That the general prosecutors and their deputies are to be appointed and revoked by the minister of justice (a system that was abolished in 2004) and the military courts and military prosecutors were still not disbanded, their role being only minimized. Some of the amendments were declared unconstitutional by the Constitutional Court, including the provision that allowed the judges to hold seat also after they reach retirement age. During 2005, the Supreme Council of Magistrates started to function. Although the launch was difficult and marked by a tense relationship with the minister of justice, there were indications that the council was willing to take over its duties in ensuring the independence of the judiciary (IHF Report 2006).

3.8.7 The probation service

The probation system in Romania was implemented for the first time in 2000. The Romanian probation service mission statement does not make any reference to the role of probation in the pre-trial phase, nor to other substantial probation activities, such as early help, prevention and aftercare. This is mainly due to the fact that the probation service in Romania, like in many other countries, is created in order to reduce prison overcrowding (Council of Europe 2005). By mid-2005 there were 41, probation officers (one within each county

court) employing in total 184 probation staff. 102 probation officers are employed in 28 teams. They usually have to cover the work generated by one county court and, on average, four local courts. There are no official requirements for the size of probation officers' caseloads.

3.8.8 The prison system

The Romanian General Directorate of Penitentiaries is part of the Ministry of Justice. There are 45 prison institutions including 36 prisons, six prison hospitals and three centres for young offenders. The prison population was 33,927 in January, 2007 (Walmsley 2007).

3.8.9 Transfer from police detention to prison

When being taken to prison by the police, the detainee has a personal file in which the offence is recorded and a medical file in which, in some cases, drug-use status is noted. At admission to prison, the prisoner has a medical examination and this can reveal injuries consistent with intravenous drug taking. The prisoner is asked about his or her drug-use history. The evidence that a prisoner is a problematic drug user is based on self-declaration as it is not possible to carry out drug tests in the prison system except at Rahova Prison Hospital where a special system for drug testing was purchased from the Global Fund. Cases are referred to a hospital in the community if it is established that a problematic drug user requires therapy.

3.8.10 Healthcare services for drug users in prison

Currently, only detoxification treatment is available within the prison system. However, an EU PHARE project, in partnership with Spanish experts as part of Romania's pre-adherence entry to the EU, has been developed on the medical health care for prisoners with problematic drug Use. The project started in 2007 with a key aim to make substitution treatment available in prison and to prepare the ground for the introduction of a prison needle exchange to meet the needs of increasing drug use in prisons.

During 2006, in the wider context of HIV prevention, the prison department carried out a series of discussions with prisoners about their attitudes towards condom distribution in prison with the aim to implement condom distribution in the future. As part of the same programme some prisons will receive drug analysis kits so that they are able to identify those prisoners with problematic drug use. The prison service is also developing closer contact and cooperation with the police where it is hoped that eventually at the point of arrest the police will complete a proforma about the detainee's drug use and treatment. This

proforma will accompany the drug user when they are transferred to prison. This will enable the therapeutic plan established during police detention to be continued after transfer to prison.

3.8.10.1 Training for prison staff

There has been a series of training for prison staff about drug addiction and problematic users and the need for treatment and to challenge negative stereotypes of drug users. This training of staff from the prison system has been developed through programmes financed by external organisations such as the Global Fund and PHARE twinning programmes.

3.8.11 Drug and alcohol use

The data available to show trends in drug use and related communicable diseases have been improved due to better partnership amongst state institutions and a better methodology to collect the data. According to the National Anti-drug Agency and Romanian Monitoring Centre for Drugs and Drug Addiction Report (2005) the key trends in drug use are that heroin continues to be the drug causing the majority of admissions to treatment. Estimates of problem drug use based on admission to treatment can be made only for heroin, as the number of cocaine or amphetamine treatment admissions is too low to evaluate. The prevalence of infections hepatitis B, hepatitis C and HIV among IDUs has not significantly changed in relation to previous years.

In order to estimate the number of people with problematic drug use in Bucharest two rapid assessments were made in 2003 and in 2004 by the Anti-drug National Agency (ANA), which is co-ordinated by the Ministry of Interior and Administration. The estimates were done using the:

> capture-recapture method, based on databases from needle and syringes exchange programs, treatment centres (including Emergency Rooms) and police files. Each of the estimation mentioned above was performed by crossing data from only two independent sources and not by crossing data from all three databases simultaneously. The crossing was performed by an external expert, as NFP staff did not have access to the NGO database. Because crossing the following databases (police data with treatment data; police data with Emergency Room data and treatment data with Emergency Room data) resulted in very wide CI (confidence intervals) and also the age group distribution differed from one data source to another (negative dependence between treatment data and police data and between Emergency Room data and police data; positive

> dependence between treatment data and Emergency Room data), the use of multipliers method was suggested. (Reitox National Focal Point "ROMANIA" 2006, 34).

The number of injecting drug users (IDUs) is growing fast and is estimated to be 25,000 in Romania with approximately 80% in Bucharest (UNAIDS, Bucharest 2006). The Anti-drug National Agency (ANA) is also responsible for the monitoring of national programmes of drug use control (prevention, treatment and rehabilitation services, drug supply reduction) using specific defined indicators and for conducting research related to problematic drug use in Romania. The main barrier encountered by programme implementers (public or private) is a lack of concrete data regarding the total number of drug users, their social and demographic characteristics and the prevalence of risk behaviours among this population.

A study carried out in 2004 (Romanian Observatory for Drugs and Toxic Manias 2005) showed that problematic alcohol use was higher amongst males in both the younger and older age groups:

Table 1: Prevalence of alcohol use by age and sex

Age	*Male (%)*	*Female (%)*
15–34	61.6	23.0
35–64	71.7	13.8

Illegal drugs are more widely used by young people; among the population over 65 years of age there were no registered cases. The most commonly-used drug is cannabis.

Table 2: Drugs used by age groups:

Substance	*Age group (years)*	
	15–24	25–34
Cannabis	2.7%	3.0%
Cocaine	0.4%	1.0%
Heroine	0.3%	0.5%
Ecstasy	0.8%	0.3%
Amphetamine	0.3%	0.6%
LSD	—	0.6%

3.8.12 National drug strategy

The National Anti-drug Strategy 2005-2012 was adopted in 2005 together with its Action Plan, in line with the provisions of the European strategy in the field. The National Anti-drug Agency (NAA) is the institution appointed by the Romanian Government to coordinate initiatives in the drugs field at both the national and local level. At the local level, the 47 Drug Prevention, Evaluation and Counselling Centres (6 in Bucharest and 41 in the regions) are responsible for the implementation of the drugs strategy, as decentralised structures subordinated to the NAA.

In addition, the local authorities have also accepted their role in preventing drugs use and trafficking, and are actively participating in programmes in the drug field by providing financial resources. A problem with the current drug strategy is that drug use is not a penal offence in Romania and because of this all drug traffickers declare that they are drug users to avoid arrest and subsequent charges (Qaramah and Parausanu 2006).

A key response to the emerging drugs phenomenon in Romania was the reorganisation of the special units to create the network of Drug Prevention, Evaluation and Counselling Centres (DPECC) that were extended at the national level to set up special Integrated Addiction Care Centres to provide, in the future, adequate and standardised medical, psychological and social services for drug users.

A multidisciplinary, multifactor, integrated and comprehensive approach to drug users was promoted to improve the quality of the interventions. This approach was designed for policy makers, programme coordinators and programme implementers to provide a methodology to refer cases from the probation services to the DPECC so as to provide medical and psychological assistance to drug users under probation.

In 2004, the National Anti-drug Agency lobbied for Law no. 143/2000, which specifies the fight against illicit drug trafficking and use to be changed to incorporate the possibility for people with problematic drug use to access voluntary treatment. The resulting new law[96] enables drug users to be included in social assistance programmes including medical, psychological and social services. Drug users arrested by the police who have not committed penal offences, are admitted into specialised medical services for detoxification.

3.8.13 Harm reduction

Harm reduction policy is a part of the Anti-drug National Strategy. The overall objective is to ensure that drug users have access to harm reduction services, by promoting and developing adequate programmes and policies available in the

96 no. 522/2004 and with the GD no. 860/2005

National Health System, and in the prison system. During the period of the Strategy (2005–2012) it is envisaged that there will be improvements to the legislative framework that will enable syringes for single use to be bought from pharmacies. These services will be developed in big cities where drug use is high. NGOs have conducted most of the harm reduction initiatives by organising centres for syringe distribution and by organising activities during the summer where they distribute syringes, for example in seaside resorts, which are visited by many young people.

3.8.14 The health care system

The reform to health care in Romania began somewhat later than in other Central and Eastern European countries due to several factors: a poor economic situation, a market-oriented view of consultants from the west, the existing power of the hospitals, the lack of a democratic structure and an unclear vision about how health care in Romania should develop. The changes to Romanian health care are similar to those in other Central and Eastern European countries regarding the implementation of privatisation and introduction of an independent insurance system. Romania, though, experienced more constraints to changing the health system than other countries in the region due to a history of under-financing during the previous régime under Ceausescu resulting in the need for more investment and reorganisation than in other countries (Ionilã 2003).

The Ministry of Health and Family (formerly the Health Ministry), the Doctors' College in Romania (founded in 1995) and the National Fund of Health Insurance (established in 1998) are the three institutions that currently play a major role in the organisation of the health care system. Primary assistance is based on the family doctor, who is an independent professional practitioner and can guarantee access to medical services (MacDonald 2004). People not earning a steady income (that is, children, youth, retired persons and military conscripts) have free access to public health services. The Health Insurance Fund pays for medical services (National Human Development Report 2001–2002).

In Romania, people are required to have medical insurance in order to access all medical services. In order to be insured:

> people must have identification papers, must prove that they pay health insurance and that their employer also pays their contribution. People under 18 years old, high school and university students, people with disabilities, retired persons and the spouse of a person who is insured (if they do not have their own income) are all automatically covered by health insurance. Those who do not have medical insurance only have access to emergency health care and health services for communicable

> diseases[97]. A problem for the delivery of medical support is the critical condition of many hospitals today, because of a lack of medical equipment and poor infrastructure[98] (MacDonald 2004, 87).

The process of constructing a privatised medical insurance scheme is not easy and in Romania due to a lack of administration skills, planning and a reliable registration scheme resulted in the Ministry of Health taking over the tasks of health insurance once more.

A phenomenon that was identified during the research was the 'under-the-table payment' for health care, which was not seen as unusual, but as a sign of gratitude and a means to access adequate services or treatment when it is needed. In addition:

> In Romania, the latter is forbidden by law but no sanctions are mentioned. In 2002, 22% of the respondents offered money and gifts as under-the-table payment. Of those, 10% stated that they were asked to do so. Additionally, 61% of the respondents involved in under-the-table payments considered that it was necessary to offer them in order to get medical care or medications[99] (Ionilã 2003, 95).

3.8.15 The impact of joining the EU

Becoming a member of the EU is anticipated to have a positive impact on Romanian civil society, political and medical environment, governmental and non-governmental institutions (including prisons and police detention). Romania will be encouraged and, hopefully, determined to make great steps towards changing old ways and helping its less fortunate citizens, and will be supported by the EU, by offering consultancy and financial help to improve the quality of life, health care standards and human rights standards. During the process of joining the EU involving the implementation of PHARE projects

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97 Emergency order of the Government No.150-2002 regarding the organisation and functioning for the health insurance system.

98 Until 1993, the hospital maintenance expenses had been financed by the central budget. Then they were transferred to local budgets. And, more recently they are managed by the County Health Insurance Funds.
A law from 1999 granted hospitals larger autonomy, especially in budget-related decisions and also stipulated that each hospital must have a managing board appointed by the hospital owner. Gradually, most financial matters will be transferred to local councils although major capital investments are necessary. Financing and an effective allocation of resources are still a priority (National Human Development Report 2001-2002).

99 Center for Politics and Health Care Services (CPSS). Public Opinion Barometer for Health Care Services 2003. Available from URL: www.mmt.ro/Cercetari/ Barometru_ sanatate_martie_2003. Accessed: May, 2003.

has favourably influenced the attitude towards the provision of medical care for prisoners in general and in particular the services for drug users in prisons.

Chapter 4: Discussion of the Country Profiles

Using the information and data presented in the profiles of the sample countries, this section discusses each country's approach to dealing with problematic drug and alcohol use and the role of the police.

4.1 The organisation and role of the police

In Bulgaria, Estonia, Hungary, Italy, Lithuania and Romania, the police are governed by the Ministry of Interior/Internal Affairs, in England and Wales by the Home Office and in Germany by the Ministry of Justice. The governance of the police in each country varies slightly, however there is some similarity in the division of roles and the type of police who deal with problematic drug and alcohol users in police detention. Generally, the responsibilities of the police are designated to specific forces which address organised crime, border controls and the protection of public order. The latter of these roles in each of the countries usually falls to state police, as opposed to military or other specialist police forces, and a key element of their responsibilities is to address offending related to problematic drug and alcohol use and deal with detainees in police custody. In all the countries, security issues including drug trafficking and supply fall to national police forces, who work in co-operation with other countries and with international organisations such as Europol. Police officers working at more local levels are divided into different geographical areas, for example, prefectures in Estonia, federal divisions in Germany and territorial commissariats in Lithuania.

Generally the organisation of the police corresponds with militaristic hierarchical models, even though in all eight countries the police are either separate from the military (who have their own special police force), or are moving away from strong links with the military. For example, there is one national police force in Hungary, with separate forces for each district of the capital, Budapest, and each county. Italy has three main state police forces, including the State Police (Polizia di Stato), who are considered the most important as they are responsible for the prevention, detection, investigation, and apprehension of alleged offenders, including problematic drug and alcohol users. Police officers working at the community level are also increasingly becoming engaged in demand-reduction strategies to address problematic drug and alcohol use, such as prevention programmes in schools and referring users to treatment. For example, in England and Wales there is formal legislation in place to establish partnerships between the police, social services and healthcare and drug-treatment organisations to address offending relating to problematic drug and alcohol use, as well as addressing the needs of users. The role of the police in implementing harm reduction remains limited and sporadic in practice, often dependent on individual police forces establishing links with NGOs (e.g. Villa Maraini in Italy), or are implemented on a pilot basis.

In each of the participating countries, the police act as gatekeepers to the criminal justice system and are often the first point of contact with the criminal justice system for offenders. Therefore, the treatment of detainees at this stage can determine how they respond to further criminal justice interventions, whether in the community or in prison.

Training of police officers for their general duties is done in-house in all the countries, with some variation in the qualifications needed to join the police (from secondary/high school level education to university degrees). New initiatives implemented by the police require training from external organisations, for example, in Bulgaria, NGOs and representatives from the Roma community have been brought in to raise police officers awareness of the needs of this group. In England and Wales, an organisation called HIT UK specialises in providing training for all criminal justice staff, including the police in harm reduction and the needs of people with problematic drug use.

In each of the countries, prosecutors work closely with the police during the investigation of detainees' cases, and have varying degrees of power in determining the length of detention for suspects, and how the case will proceed beyond police detention. Their close role with the police can sometime act as a hindrance, for example, in Estonia prosecutors can have a significant role in directing an investigation along with senior police officers, and this 'double leadership' has caused problems.

4.2 Legislation relating to police detention

In all eight countries, there is legislation in place stating the length of time suspects can be held without charge during an investigation of their offence. Generally, this period ranges from 24–48 hours, with any extension requiring a court order or request by the prosecutor. However, in some countries, police detention can last up to 15 days (Lithuania), or longer as suspects are held in separate arrest houses for up to 30 days while their case is investigated (Estonia, Bulgaria). Romania also has detention houses for the prolonged detention of suspects, which can last up to 180 days, and are run in a similar way to prisons. In Hungary, there are different forms of arrest depending on the circumstances of the offence. Detention can last for 8 hours for those suspects unable to identify themselves, suspected of using drugs and those aged less than 18 years, up to 72 hours for those suspected of committing an offence which is punishable by imprisonment and up to three months in a pre-trial detention centre, pending investigation of their case.

Detainees are also granted similar rights in each country, in that they should have access to legal counsel, medical care and some contact with the outside. For those identified as problematic drug and alcohol users, or charged with an offence related to substance use, there are additional measures, such as in Bulgaria, where suspects are required to undergo psychiatric examination, as part of determining the nature of the offence (possession or supply) with which

the suspect should be charged. The rights of detainees are generally based on international standards of care set at the EU level, with a basis in the Human Rights Act (1998). In addition, the treatment of detainees is subject to reports by organisations such as the CPT, which has led to some countries taking important steps to ensuring the welfare of suspects in police custody. For example, in Estonia, in response to the CPT visit (2003), arrangements were made with local physicians and medical assistants were employed by the police to work in detention centres to ensure detainees had access to healthcare.

There are also national guidelines in place in the sample countries, such as in England and Wales, where police officers must abide by the code of practices stipulated in the Police and Criminal Evidence Act (PACE 1984). British Medical Association guidelines stipulate that all detainees be tested for drug use with the purpose of referring users to specialist staff (arrest referral workers) to help engage them into treatment (BMA 2004). Compliance with international standards is particularly important for those countries experiencing overcrowding in prisons, such as England and Wales and Estonia, as frequently police cells are used to accommodate prisoners, even though they lack the necessary facilities for long-term incarceration.

The difficulties in dealing with problematic drug and alcohol users in detention are apparent in all eight countries, even when the detention period is relatively short, that is 24–28 hours, compared to 30 days. Withdrawal from drug or alcohol use can present problems for police officers during detention and such detainees also present a range of other problems requiring medical intervention. International standards of care and the Human Rights Acts have provided a means for detainees to make formal complaints against police officers who do not adhere to the basic rules of detention. In addition reports by the CPT have in each country, revealed police detention cells in poor condition, with a lack of basic hygiene facilities, which is particularly problematic in those countries where the detention period can last up to 30 days or more (Lithuania, Estonia, Hungary, Romania, Bulgaria).

4.2 Healthcare in police detention

There are various arrangements in place across the eight countries to provide healthcare services for problematic drug and alcohol users in police detention. Preliminary screening of detainees, for example testing for drug use is usually done by staff employed in house, for example paramedics (felchers) in Estonia, psychiatric staff in Bulgaria and forensic medical examiners in England and Wales and Germany. The purpose of medical examinations at this stage is to ensure detainees are fit to undergo interrogation or further detention, as stipulated by human rights legislation, specifically in relation to those identified as problematic drug and alcohol users.

Treatment for detainees beyond these initial assessments, in most countries, is provided through links with state healthcare provisions, either directly

employed by the police working in the police station (for example, custody nurses in England and Wales), or being called out as necessary by police officers. In Hungary, drug users detained by the police must undergo urinalysis, and positive drug tests can be used as evidence in the criminal case. Detainees in Romania must undergo a medical examination within 24 hours of arrest, where they will be tested for drug and alcohol use and assessed if they are in need of further treatment. These services are provided through the Forensic Medical Institute, who also present reports to the courts regarding whether or not suspects should be imprisoned.

Depending on the needs of detainees, treatment can be administered in police detention. However, there are situations where health problems require referral to hospitals, or other settings to deal with drug or alcohol withdrawal (for example sobering-up centres in Germany). However, treatment beyond managing withdrawal symptoms in police detention can be very limited, such as in Estonia, as there are no formal links made between the police and drug-treatment agencies. As found in prison systems of many countries, healthcare for drug users is limited to pain management, with no provisions for substitution treatment, even if a detainee is on such a programme in the community. An exception to this is found in Miskolc in Hungary, where police officers will take detainees registered on methadone treatment programmes to a clinic outside the police station so their treatment is not disrupted.

Conditions of detention are also an important issue, and again, in all eight countries there are guidelines, some on the basis of national policy, some based on EU protocols and recommendations by external organisations such as the CPT. In Bulgaria, instructions from the Ministry of Interior established minimum standards, such as having a bed, natural light and continuous ventilation in police cells. In England and Wales, guidelines from the BMA state that detainees must be accommodated in a warm cell with clean bedding, have food and exercise regularly and at least eight hours rest in every 24-hour period. In Hungary, all detainees have the right to be kept in cell with $10m^3$ airspace and $4m^2$ room, with facilities for eating and sleeping, as well as having access to basic hygiene equipment, such as towels and toothbrush.

It is important to understand the governance of the police and other criminal justice agencies, as in all the sample countries, the healthcare of detainees in prisons and police custody is the responsibility of separate ministries or departments. There is some difficulties, for example, in Estonia where medical care is not integrated with criminal justice interventions meaning there is a lack of equivalency of care for detainees. In addition, medical staff are unable to work independently from the needs of police officers investigating the detainees' offence. In England and Wales, there are moves towards improving this, by giving responsibility of medical care for prisoners to local NHS trusts, ultimately responsible to the Department of Health. In addition, in Germany, the introduction of a pilot project of sobering-up centres demonstrates concerns regarding the appropriateness of police detentions as a setting for providing healthcare services.

4.3 Trends in problematic drug and alcohol use and offending

The information provided in each of the country reports demonstrates some similar concerns regarding problematic drug and alcohol use, which replicate some of the trends identified on an EU level. For example, poly-drug use among young people is a particular concern in Western, Central and Eastern European states. Across all eight countries there is a concentration of use in urban centres. However, concerns have been raised in some countries regarding increasing problematic use in more rural locations due to the lack of treatment services available compared to major towns and cities. For example in Bulgaria, the Black Sea ports of Varna and Burgas are seeing increasing use, as they are also key points for the trafficking of drugs.

4.3.1 Drug use

In Bulgaria, from 2003–2005 among young people (aged 15 to 25) marijuana, synthetic drugs (amphetamines and ecstasy) and heroin were the most widely used illicit drugs, and there is evidence of increasing experimental use of cocaine. In Bulgaria, Estonia and Hungary, particular attention is being focused on the student population and the use of synthetic drugs associated with the club scene. The prevalence of drug use in the UK has remained relatively stable in the last few years, although concerns have been raised regarding the use of cocaine and ecstasy. Again, young adults are more likely to use drugs, particularly cannabis and alcohol, and specific groups have been identified as at a higher risk, such as young offenders, children in need, care leavers and the homeless young people.

Addiction to 'psychotropic medicines' is becoming an increasing problem in Germany, and they are often used to alleviate withdrawal symptoms. Many users obtain these drugs with fraudulent prescriptions giving them a larger supply than they need. Again, it is recognised in Germany that relying on police statistics to give a comprehensive picture of drug use is problematic, as it does not account for those populations not arrested by the police. Research in Hungary has clearly demonstrated the links between social exclusion and drug use, which is replicated in the other countries and throughout the EU. The lifestyles of drug users, who may be homeless, with poor health, low education levels and unemployed, often lead users from recreational use to problematic, dependent use. Again, the data on drug use is not wholly reliable and is largely based on official police records.

Data on drug use in Italy comes from clients of the Services for the Drug Addiction (SerT), which shows increased use from 2001–2004. For those patients on methadone treatment programmes, the majority are aged between 35–44 years, whereas younger users tend to be involved in therapeutic

community programmes. Again, cannabis use is the highest and young males are the largest group among drug users. There are concerns about increasing cocaine and amphetamine use, which rose substantially in 2001–2003. In Lithuania, measuring drug use is a relatively recent strategy, in line with their membership of the EU in 2004. Among those seeking treatment for drug use in Romania, the majority are heroin users, although it is not possible to assess current trends in amphetamine and cocaine use as information on this is not available. Figures on problematic drug use in Bucharest are based on the figures from needle-exchange programmes, emergency rooms and treatment centres, as well as police records.

4.3.1.1 Injecting drug use

Injecting drug use in most countries, particularly Estonia and Bulgaria, is also of concern, as the majority of users inject more than one substance. This type of use has been linked with an increase in the prevalence of HIV, although this is now also being attributed to increased risky sexual behaviour. Injecting drug users are at risk due to needle sharing, and there was also evidence of a lack of engagement with harm reduction services among this group in all countries, specifically needle-exchange programmes. In addition, in Estonia, a high proportion of IDUs are arrested by the police, and are still not being referred to harm reduction programmes in the community. The use of measures such as ID cards in Hungary which users can display to police officers if they are found with needles, to prevent them being arrested or searched for drugs also appears to have little impact on the treatment of IDUs by police officers. In Estonia, difficulties may also arise due to many IDUs not having health insurance and being from the Russian community and, therefore, unable to access state healthcare.

Heroin is considered to be the most problematic type of drug use in Bulgaria, in part due to the high numbers of heroin users seeking treatment, and also the health problems associated with injecting drug use, compared to other forms of use. However, there have been some indications that the use of needles is decreasing, reducing the risk to health such as contracting infectious diseases. However, as with other countries, data on this type of use is often considered an underestimate, as such users are not likely to seek treatment, or will continue to use drugs in prison, where generally, drug use is not acknowledged at all or played down. There are also concerns about the use of amphetamines as this often involves injecting. In all eight countries, it is clear that there are increased health risks among IDUs, due to injecting drugs but also other risk behaviours such as unsafe sex. This is of particular concern among the sex worker population, as many are engaged in both un-safe sexual practices and are also injecting drug users. Among those seeking treatment for drug use, there is a lack of data on the prevalence of infectious diseases such as hepatitis B and C and HIV/AIDS, although it is clear that the highest rate is among those aged 20–29 years.

Similar concerns about HIV among IDUs are found in England and Wales, the prevalence rate increased in 2003. This may be due to the injecting of crack becoming more widespread, particularly among sex workers. This group is also likely to share needles and find it difficult to access treatment. In Estonia, poly-drug use has been identified in the IDU population, as well as sexually transmitted diseases. Estonia currently has the most rapidly expanding prevalence of HIV in the EU, which is primarily attributed to injecting drug use. Needle sharing is thought to be a major contributor to the spread of infectious diseases in Estonia, especially in the prison population and there are no measures currently in place to address this.

The prevalence of hepatitis C is also of concern in Hungary among IDUs, as it had tripled in recent years, whereas HIV has remained low. Screening for HIV is now free and anonymous, where as for hepatitis C it costs around €6. However, there are concerns about HIV rates as the message about the risks of contracting this through drug use and unsafe sex does not appear to be getting through to young people.

4.3.1.2 Alcohol use

Alcohol remains the most widely-used drug, among all age groups in the eight countries. The impact of problematic alcohol use has also been demonstrated in each country, for example, in England and Wales it is a factor in some types of offending and is also related to poor work performance and represents a significant cost to the health service. Among police detainees, the effects of alcohol include aggressive behaviour towards officers and a need for constant observation and medical checks, which delay the investigative process.

Alcohol use is a particular problem in Eastern Europe, for example in Estonia where 86% of the population (aged 16–75 years) consume high levels of alcohol (Estonian Institute of Economic Research 2003). Young, poorly-educated males are the largest group consuming excessive amounts of alcohol and there is also greater use outside urban centres. There is a disturbing trend of regular alcohol use among teenagers, that is, 14–15 year olds, and such use is attributed to continued problematic use and addiction in later life. A similar pattern is found in Lithuania, although there is also increased use among those with relatively high incomes, and those with a university education. Inhabitants of major cities (Vilnius, Kaunas, Klaipėda) consume the most alcohol, which is attributed to different demographic factors, as there are more older women in rural areas, and this group consume the lowest levels of alcohol.

In Germany, alcohol dependence is more widespread than drug dependence and there is now a focus on the effects of harmful levels of consumption, which has previously been under-researched. Binge drinking is also highlighted as particularly problematic among males, compared to females, and also with regards to related problems, such as offending. For example, 91.4% of those arrested by the police for an alcohol related offence were males, with a high

proportion arrested for violent crime (PKS 2005). Hungary is one of the biggest consumers in Europe of alcohol, which has resulted in health problems, and other problems such as accidents at work, road traffic accidents and violent behaviour. Binge drinking among young people is also an increasing concern in England and Wales, Italy and Romania, especially among males, which has obvious health risks, often related to physical injuries as a result of violent behaviour as well as alcohol poisoning.

4.3.1.3 Drug-related criminality

Offending related to problematic drug and alcohol use also appears to be an increasing problem among young people. For example, in Bulgaria it accounts for 72.6% of all offending. Criminal behaviour among drug users is characterised in each of the countries by acquisitive crimes to fund habits, particularly among heroin users, and there are also clear links with drug use and prostitution.

In the UK, between 2000–2003, drug related offences increased by 14% and there is new legislation in place to reflect this growing problem (*Criminal Justice and Court Services Act 2000*). This enables police officers to test all detainees to get a more comprehensive picture of drug-related offending. Again, strong links have been found with sex workers and drug use, particularly 'hard' drugs such as crack and heroin. Indeed, those who use heroin and crack represent a group who are responsible for a significant proportion of offences. In most countries, there is also clear evidence of links between problematic alcohol users and offending, as those detained by the police constitute a significant proportion of arrestees.

Offending related to drug use in Germany is concentrated in urban centres, reflecting the increased numbers of drug users in these areas. There has been an increase attributed to higher levels of amphetamine use, although the majority of offences are related to cannabis use. Offending related to heroin use has decreased, which may be in part due to wider provision of harm reduction services such as substitution treatment.

Crime related to drug and alcohol use in Hungary has increased over the last ten years, although in the last two years it has stabilised in line with EU averages. Such offending often relates to possession and use of drugs among young people, with the majority involving cannabis. In Lithuania and Romania, crimes related to drug and alcohol use are increasing, including possession and supply of illicit drugs and also offences related to use, such as, violent behaviour and acquisitive crimes.

4.4 Strategies to address problematic drug and alcohol use and offending

The strategies in place in each country to address problematic drug and alcohol use are referred to as 'national drug strategies', but in most cases, they incorporate measures to address problematic alcohol use. However, it appears that more resources are allocated to tackling the supply, demand and harms caused by illicit drug use. This is despite concerns regarding the public health impact of problematic alcohol use and its links with offending, as well as its use with other illicit drugs, especially among young people. Problematic alcohol users are often dealt with to a limited degree compared to people with problematic drug use, in that they are not referred to treatment services to help them cease or reduce alcohol use.

The National Drug Strategy for Bulgaria was developed in accordance with international standards and experiences of countries in Western Europe and North America. At its core is a national programme to promote healthcare reforms to address the harms caused by drug use. This gives healthcare providers a pivotal role in preventing problematic drug and alcohol use through education and early diagnosis and offering short-term interventions to treat drug use. The drug supply and demand reduction elements of this strategy were developed in co-operation with the UK, and in line with the principles of the EU Drugs strategy (2000–2004). A key element is to promote better co-operation and exchange of information between ministries responsible for criminal justice and health, as well as strengthen local government. The focus of treatment programmes in Bulgaria is abstinence and re-integration of dependant users into society, initially using detoxification programmes, followed by 'psychosocial therapeutic approach', available in day centres and residential facilities. In addition to this, in 2003, methadone maintenance was adopted by the Ministry of Health as well as the use of opioid antagonists (e.g. Naltrexone) for continuous treatment of heroin users, after detoxification treatment. Treatment for drug users is also provided through the HIV/AIDS Prevention and Control Programme, which has a network of offices providing anonymous and free HIV/AIDS counselling and testing. There are also various strategies to prevent the further spread of HIV among vulnerable groups such as young people, injecting drug users, sex workers and the Roma community. As part of the prevention strategy, harm reduction training is also in place for those working with drug users, to develop and implement needle-exchange programmes, condom distribution and testing programmes. Those included in this training come from the health sector, that is, physicians, psychologists, social workers and nurses. There remains concern about inadequate treatment for hepatitis C infection, which is prevalent among IDUs, but which can only be administered to those who have not used drugs in the past six months.

In England and Wales, the National Drug Strategy incorporates supply, demand and harm reduction measures, with the main focus on the former two strands, in order to prevent use (especially among young people), make

communities safer from crime associated with drug use and supply, provide treatment for users and reduce the availability of drugs. The strategy also aims to target the most vulnerable groups, such as young people, homeless and sex workers. Harm reduction measures are to be implemented as part of the treatment for drug users, in order to prevent health problems for users engaged in treatment. This strategy has been put in place by the Home Office and Department of Health to promote working in partnership between the various agencies. Partnerships at the local level are responsible for the implementation of the strategy, through Drug (and Alcohol) Action Teams (D(A)ATs) and Crime and Disorder Reduction Partnerships (CDRPs) in England and Community Safety Partnerships in Wales. The police now have a more important role in engaging users in treatment through the introduction of the *Criminal Justice and Court Services Act 2000*, which requires police officers to test all detainees (of 18 years and above) and refer them to treatment, through arrest referral workers if they test positive for drug use. There is also increased effort in targeting the use of heroin and cocaine among young people as this has been identified as having strong links with persistent offending, and for those users in prisons, the CARATS (Counselling, assessment, referral, advice, and care/treatment services) offer treatment and support services to those prisoners who wish to cease drug use. Harm reduction forms an important part of addressing injecting drug use and crimes associated with this, in order to prevent deaths from overdose, the spread of infectious diseases and generally improve the health of users. General practitioners and community drug-treatment providers are to have a key role in providing these services, with a view to engaging users in treatment to cease drug use. A similar strategy is in place to address the harms associated with problematic alcohol use (Alcohol Harm Reduction Strategy for England 2004). This aims to target those users with multiple problems, prevent problematic use among young people, address alcohol related crime (e.g. as a result of binge drinking in city centres) and work with the drinks industry to promote responsible drinking habits.

In Estonia the Ministry of Social Affairs and the National Institute for Health Development is responsible for the implementation of the national drug strategy, with a priority to improve drug treatment in the community and which also includes provisions for prisoners. As with other strategies it also aims to prevent drug use, reduce the supply of drugs and offer treatment and harm reduction services to users. While previously treatment was provided through psychiatric hospitals, There is now a specialised substitution treatment centre in Tallinn, and this has been recently expanded to other towns and also to include provisions for young people. Medical staff in various institutions have also been trained in understanding the needs of drug users and harm reduction measures. Harm reduction is an important element of healthcare in Estonian prisons, although it is still somewhat limited. It was introduced after an outbreak of HIV among Estonian prisoners in 2000. Medical staff in prisons provide pre- and post-test counselling services, and condoms are available for prisoners. In Tallinn, the prison service works with the NGO Convictus to provide training in HIV prevention and harm reduction. As found in Bulgaria,

there are increasing concerns about hepatitis among prisoners and drug users, as testing and treatment is not widely available. Problematic alcohol users arrested by the police are sent to a psychiatric clinic to deal with withdrawal symptoms, or to hospital for more serious cases.

The national drug strategy for Germany also focuses on prevention, treatment and supply reduction, as well as improved monitoring of drug use and co-operation between various government departments. However, the implementation of the strategy is the responsibility of each of the federal states, and it can differ, making co-operation at a national level difficult. State services for drug users are supplemented by voluntary welfare associations, specialist clinics, psychiatric institutions and self-help organisations. Advice centres offer detoxification, substitution treatment and therapy, for those eligible under state healthcare, and crisis centres offer counselling and a contact point for urgent medical assistance, along with hygiene advice and measures, free meals, needle exchange, social education and psychiatric care. In addition, in-patient treatment for people with problematic drug use is available, usually lasting for three weeks, to deal with withdrawal, medical adjustment to substitution programmes, detoxification and crisis intervention. Harm reduction has been available in Germany for 15 years, with the introduction of methadone and needle-exchange programmes in the 1990s. More recently, supervised injection sites and approved heroin trials have been approved, in the major cities. There is a lack of consistency between the states in the role of the police in implementing harm reduction and such initiatives are limited to the cities.

In Hungary, the National Drug Strategy incorporates both supply and demand reduction elements but it is currently lacking a definitive timeframe in which to achieve its goals. The implementation of the strategy is on two levels, first, on a national basis under the 'Drug Coordination Committee' and at a more local level using 'Drug Coordination Forums'. These forums are to focus on prevention, treatment, harm reduction and law enforcement and must include representatives from each field. Harm reduction is, integral part of the strategy, and aims to prevent infectious diseases among IDUs, using substitution therapy and needle exchange programmes, through substitution treatment centres in all regions of Hungary. There is no such strategy currently in place to address drug use and the needs of drug users in prisons or police detention. Currently there are ten needle exchange services operating in eight towns. There is concern about the need for more outreach services to engage IDUs who are not seeking any form of treatment, and also to improve provision in more rural areas. Problematic alcohol users can be forced to undergo treatment by a court order, in addition to a custodial sentence, if the offence was deemed to be related to alcohol use.

The National Drug Strategy in Italy also focuses on supply reduction legislation, treatment to reduce the demand for drugs and harm reduction measures. The implementation of harm reduction measures is problematic due to a lack of consistency of service provision throughout the country and their

dependence on the motivation on individuals or institutions willing to engage with such measures. This is attributed to the current policy being interpreted as putting harm reduction as a lower priority compared to supply and demand reduction. More work is needed to reassure the public and politicians of the value of harm reduction in maintaining the health of individuals and communities. This requires acknowledgement of drug users' right to a range of health care options, the need to assist users in social reintegration and the need to divert users away from custodial sentences where treatment is limited. However, currently, public opinion in Italy supports the concept of abstinence as the response to problematic drug and or alcohol use, which is reinforced by public safety campaigns linking such use with crime, which further marginalises users and leads to more punitive measures against users, as well as suppliers of drugs. The re-organisation of the National Health System incorporated prison health care provisions, under the responsibility of the Ministry of Health. SERT (community drug agency) provides services specifically for problematic drug and alcohol users in prison and on release from prisons, included drug treatment as an alternative to prison. The police work to a limited degree with SERT and also with an NGO in Rome, Villa Maraini, in addressing the needs of problematic drug and alcohol users in detention.

In Lithuania prevention of drug use among young people is a key part of the national drugs strategy, along with supply reduction through improved international co-operation. In developing this strategy, the government looked to the positive experiences and effective practices of other countries. The measures to achieve this were extended in 2004 by the Ministry of Justice, as well as improving information sharing on problematic drug or alcohol users leaving prison. This is in place to contribute to helping local health municipalities address the needs of users on release from prison and help them re-integrate back into their community. Harm reduction measures in Lithuania included substitution treatment for opioid dependent users (methadone), as part of treatment programmes also providing counselling support and social assistance. Needle-exchange programmes have also been implemented since 1995, to allow IDUs to receive anonymous consultation and supply of clean needles, through state healthcare organisations and NGOs. An outreach service also exists, called the 'Blue Bus', to access those users on the outskirts of the capital.

The National Drug Strategy in Romania was adopted in 2005 in line with the EU Action plan, under the responsibility of the National Anti-drug Agency (NAA). Prevention and treatment are the focus of the strategy at the local level, with some responsibility for reducing the availability of drugs. This led to the introduction of a network of Drug Prevention, Evaluation and Counselling Centres (DPECC) and special Integrated Addiction Care Centres to provide standardised medical, psychological and social services for drug users. These centres incorporated a multidisciplinary approach to address the needs of drug users and legislation was introduced to enable users to access social assistance

programmes. For those users arrested by the police, but not detained in custody there is a system of referral to detoxification centres.

4.5 Alternatives to prison sentences for problematic drug and alcohol users

In Bulgaria, treatment as an alternative to prison for people with problematic drug use is available as part of probation orders, which are implemented by probation staff and volunteers under the responsibility of the Ministry of Justice. In theory, any type of treatment programme (inpatient, outpatient, detoxification) should be available to such offenders, but in practice due to lack of resources this is rarely the case. This is offered to avoid the negative effects of imprisonment on drug users but problems do arise in cases of relapse, as it is difficult to monitor users who receive treatment in the community. This is attributed to users continuing with the social networks that led to and encourage drug use, the physical difficulties in ceasing drug use, and the resistance to control from state authorities. Breaching the conditions of the probation order (that is, by using drugs) can lead to a re-trial and imprisonment through the courts.

To implement alternatives for drug users in England and Wales, specialist Drug courts were introduced to offer treatment options to offenders and to make greater use of existing sentence provisions. These services include abstinence-based treatment and methadone maintenance and aim to work with other agencies to address all the needs of users. This has been piloted in Scotland, but currently there are no plans to roll this out on a national level. The probation service, now the responsibility of the National Offender Management Service (NOMS) aims to manage offenders both in prisons and on community sentences from the start of their sentence and beyond, working with other public sector, voluntary and community based agencies to protect the public and reduce re-offending.

The Probation Service in Estonia is a relatively recent development, coming into effect in 1998 and was based on models found in Western Europe to reintegrate prisoners. People with problematic drug use can be referred by a prosecutor to supervision and treatment in the community under the probation service. Probation officers are responsible for meeting with clients, organising other social assistance needs, including treatment for drug use. However, this is limited to those users who have health insurance and are, therefore, eligible for treatment in the community.

In Germany, probation officers supervise offenders whose prison sentence has been suspended, but they do not have the same level of contact with clients as found in other countries, for example, England and Wales. Criminal justice interventions for problematic drug and alcohol users are limited to time in a facility offering withdrawal therapy or voluntary organisations provisions. Alternative treatment for drug offenders in Hungary is offered for those found

guilty of use and possessing small amounts of drugs, through the prosecutor who can suspend the case for ten months, during which time they must demonstrate they have successfully completed a treatment programme. However, before starting such a programme, offenders often have to wait up to ten months for treatment services to become available, and distinctions are not always made between heavily dependant users in urgent need of treatment and occasional users who do not require this. Alternative measures for problematic drug and alcohol users in Italy must be agreed in co-operation with the health service and local SerT, through the probation service and courts. The conditions of this measure also include that the sentence of the offender must be six years or under and they must be identified as drug or alcohol dependant and willing to start treatment. For those on methadone maintenance, judges often deny such measures as this form of treatment is considered not be to be abstinence-based. Such measures can be revoked if offenders relapse.

In Lithuania, as with Estonia, the probation service has been recently introduced and is primarily responsible for supervising offenders on release from prison and those on community sentences. They also offer social assistance or referral to other agencies to meet the needs of clients. The majority of clients on suspended sentences are problematic drug and alcohol users, required to undergo treatment as part of the conditions of their sentence. They have a close relationship with the police to assist them in supervising offenders in the community, in order that any breaches of the conditions of their sentences are reported and dealt with back in court. They also encourage links with NGOs to support their activities. The probation system in Romania was implemented for the first time in 2000, with its main aim to reduce prison overcrowding. Its core functions are not yet clarified but generally refer to having a role in the pre-trial phase of offenders' cases, as well as aftercare for prisoners.

Chapter 5: Research Findings

The key themes from the research are discussed in this chapter. Not all themes were raised in every sample country thus the discussion will draw on the findings from some countries to illustrate each theme.

5.1 Conditions and impact of police detention

A key theme raised in the study was the physical condition of police detention, both the structure of the actual buildings and the facilities. It is important to distinguish between the conditions at the point of arrest at police stations and the conditions of police arrest houses. Estonia, Lithuania, Romania and Hungary have police arrest houses under the control of the Ministry of the Interior. In Bulgaria the police remand houses are now under the Ministry of Justice.

5.1.1 Bulgaria

In Bulgaria detainees can be kept in the remand houses for a maximum of 9 months but every month the detainee can ask the court to review the decision to keep them in the remand house. If the inspector and the police think they should be released then the prosecutor can make the decision but this practice is rare. Usually, a case is finished within six months. In the area of Varna, where the interviews took place, the police cells and remand house were in the same building but in other police stations in Bulgaria there are only police cells. In the police station there are cells and some detainees wait in them but usually no longer than 5 or 10 minutes. The cell shown to the researcher was very dirty with no furniture in it at all but the researcher was told that most detainees were usually kept in the waiting room.

If the person arrested is under 18 years old they are put into separate cells in the juvenile arrest facility where there are good conditions and plenty of facilities (TV etc) (Interview, Inspector, Varna, March 2006).

Under 18-year olds who are arrested are put in a special room in the police station but apart from this the procedure is the same. In addition:

> ‘we have a pedagogue who investigates the cases involving juveniles (he is a retired teacher)’ (Interview with Head of Police Station No. IV, Varna, March 2006).

The inspector said that having the police station and remand centre in the same building made her job easier. If it appears that it will take a long time to gather the evidence for a case then the inspectors can ask the prosecutor to send the detainee to prison as the facilities in the remand house are not good especially

during the summer. There are also pre-sentence cells in prison and the conditions are much better than the formerly controlled police remand houses (Interview, Inspector, Varna, March 2006). The cells in the remand houses are considered to be better than before and they are not currently overcrowded (Interview, Inspector, Varna, March 2006).

The conditions in the remand houses were considered to be poor by most of those interviewed:

> the situation in some of the remand centres are not good but it needs to be remembered that they did not come under the control of the prison system until 1997. Prior to this they were under the control of the State Security Service. There have been some changes (under the law) to allow changes to the remand centres. Some centres have received new furniture and more facilities. The plan is to make 10 new remand houses and to probably close 10 of the worst (Interview with Official, Prison Department, Ministry of Justice, Varna).

People with problematic drug and alcohol use who had experience of police detention interviewed also held very negative views about the conditions in the police remand houses:

> the conditions are poor and very dirty in Bulgaria and the remand centres are worse than the police cells. Although there are showers in the remand centres often there was no hot water so maybe we could shower once per month. In the remand houses one cell is usually for 3 people but normally there are 8 people in it. If you don't have a bed you have to sleep on the floor well this was the situation 1 year or less ago. We would prefer to go directly to prison because the conditions are much worse in the remand centres (Focus Group with PDUs with experience of Police detention, Varna, March 2006).

A doctor of the Emergency Service felt that the conditions in police detention were not very good:

> I think that the police call for the emergency services more than is necessary. Conditions in police detention do need to be improved. Usually, there is one small room with a small bed but more than one person is in the room; the rooms are not clean or hygienic (Interview with Doctor working with Emergency Service, Varna, March 2005).

Interview with two Fathers running a residential drug treatment programme considered that:

> police officers have a negative attitude towards drug users. Conditions in the police cells are very bad. There is a wooden bed fixed to the wall in the cells and a bucket for a toilet

> (Interview with Two Fathers of the Orthodox Church residential drug treatment programme, Varna, March 2006).

5.1.2 England and Wales

The conditions in custody suites in England and Wales depends on the force, for example, in Sussex it is good with modern facilities, Wiltshire and Gloucestershire it is average and in Essex it is poor. In newer buildings, conditions are usually of a higher standard. The hygiene conditions for detainees are usually adequate. It is unusual to find detainees in squalor unless this has been self-imposed (Interview with Forensic Medical Services Manager). The researchers were told that one police detention centre visited in Birmingham:

> the police station was built around 1880, so we are limited in what we can do, because it is a listed building so for example you cannot change toilets or locks but it has its uses [the conditions] in showing young first-time offenders where 'real criminals' are kept and it is worse than Winson Green [local prison]! (Police custody officer, Inner City Police Station).

According to the above custody officer the conditions in this police station were considered to be very good, as the cells are clean, there is food and hot drinks available and an exercise yard. He added that at the time of the interview there was not a problem of overcrowding but he was concerned that with the current prison overcrowding part of the custody suite may have to be used to house prisoners. This would cause problems as it places stress on staff as prisoners have different rights as to what you can and can't do. Although this is not happening in this police station it is already happening in others (Police custody officer, Inner City Police Station).

Those interviewed who had experience of detention had varying views abut their experience:

> you have to wait for them [police officers] to bring you food, to get a drink, or for a cigarette. It is totally unfair for the prisoner but also for the officers they get more stress from people 'kicking off' [getting angry] so it can be awful. The conditions were awful for me, being pregnant, it was cold and uncomfortable, you get a skinny little mattress, I know I've been arrested but you haven't been charged yet. It took me two and a half hours to get a drink and something to eat, and the food is awful, it is diabolical and I threw it all back up. The choice is so limited; it was better when they just gave you a sandwich. You also don't get much privacy in the cell if they have cameras, anyone can watch, its not right for women to be watched liked that (Former female detainee, Birmingham).

> the condition in the police cells were bloody disgusting, there was no mattress, a blanket with holes and stains, just a wooden platform, and no hot water (Former Male Detainee, Birmingham).

> mostly, I have been detained over the weekend, for shoplifting. They explained my rights to me, but the conditions were horrible, smelly, no blanket, even though I asked for one, it took them hours. I was ill as well, so I was freezing. I asked for a shower, his [the police officer] exact words were this" is a f****** cell, not a hotel", so I didn't get a wash the whole weekend, not even before court, nothing for three days (Former Female Detainee, Birmingham).

5.1.3 Estonia

There has been some discussion of police arrest houses becoming part of the prison system in Estonia but the prison system according to one interviewee is not very keen to have them either (Interview with the Police Board, Tallinn). According to the head of probation the:

> movement of prisoners from pre-trial prisons to the arrest houses is a result of state policy of having regional centres and also the distance from the pre-trial prisons from the courts. If there were facilities nearer then the prisoners could go directly from the pre-trial prisons and not be 'stored in the arrest houses' when they go to court (Interview with the Head of Probation, Tallinn).

It was generally acknowledged by interviewees at the Police Board that the arrest houses were often overcrowded and in need of refurbishment:

> we need money from the government to refurbish the arrest houses. It is a problem that those who get a fine can choose to stay in the arrest house rather than pay their fines and this adds to the overcrowding (Interview with the Police Board, Tallinn).

If the court agrees that a crime has clearly been committed then the person arrested can be sent to a pre-sentenced prison within 24 hours where the conditions are generally better than in the arrest houses (Interview with Prison Department, Tallinn).

The prisoners with problematic drug and alcohol use who were interviewed at Tartu prison made the following comments about the conditions in police arrest houses:

> the conditions in the arrest house in Narva were awful with six persons in the room and a hole in the floor for the toilet that was not screened. There were six beds and clean blankets.

> Showers with hot water were available once per week (Interview 1: Young Male Russian speaking pre-sentenced prisoner, Tartu Prison).
>
> I was at Kohtla-Jarve arrest house and the conditions were not good with four people in the cell, a hole in the floor for the toilet, cold water and no window: really basic conditions. In Tartu arrest house, it was very damp with water running down the wall. I could have a shower with hot water once per week but the water wasn't always hot as it would run out (Interview 4: Male Russian speaking pre-sentenced prisoner, Tartu Prison).
>
> there were enough beds and blankets in the arrest house but there was no outside exercise at all. Showers were possible everyday but usually it was once per week. I did get hygiene equipment—toilet paper, soap and a towel. The conditions were terrible overall; the arrest houses are the worst places and I was lucky to get sent here [Tartu prison] almost immediately (Interview 2: Russian speaking pre-sentenced prisoner, Tartu Prison).

5.1.4 Germany

In 2000 the CPT encountered a great deal of variation in the conditions in the police establishments that they visited in Germany ranging from very good in all aspects to establishments that offered poor, or even very poor, material conditions of detention. The problems highlighted in some of the establishments were artificial lighting that could not be dimmed during the night, resulting in some detainees being unable to sleep, and in:

> Frankfurt am Main: many cells were dirty, or even in a squalid state (e.g. a cell with congealed blood on the floor at the Federal Border Police Station at Frankfurt am Main Central Railway Station), were dilapidated and were poorly ventilated and/or lit; further, some cells had inadequate heating. Further, the cells of the Police Detention Centre at Klapperfeldgasse (with a capacity of some 200 detainees) were not equipped with a call system and, as a result, detained persons were obliged to attract the attention of a police officer by banging on the cell door (CPT, December 2000, Section II A, Sub section 3, point 30).

Other issues identified by the CPT report in some police detention facilities were cramped conditions, lack of provision of mattresses and blankets, detained persons not provided with basic hygiene products (e.g. soap, toothbrush and paste, sanitary towels, etc.) and insufficient provision of outside exercise.

The head of the detention centre interviewed was asked, why sobering-up was not supposed to take place in Bremen although it was a new building especially constructed for police purposes. He said:

> probably because it is easier to observe them at the police station during sobering-up. May be it is also a matter of the lack of transport. Sobering-up has to take place locally where people are found. And we do not meet the local conditions for sobering-up here. Our cells are equipped with beds, tables, chairs and toilets. Those detainees in an extremely helpless position have to stay at the police stations and sleep in a cell with only a concrete base and mattress. They urinate and defecate and it is hard to clean the cells after them.

There is a particular unit of police detention for sobering-up detainees with problematic alcohol use called ZAE where people who have health problems, who are drunk or have psychological problems go as they can be monitored while in the cell. However, there are exceptions when the doctor may prefer detainees who are injured, have health problems or who are under the influence of drugs to go to ZAE where they are monitored more regularly than in ordinary police detention. A person with problematic alcohol use who was interviewed said:

> I cannot tell you anything positive about Hahnemannstraße [the name of the street where ZAE is located]. They caught me on the tram after I had fallen asleep there. They woke me up; I did a breathalyser test and had 3.7‰. They took me to Hahnemannstraße and put me in a cell with four men. One of them I almost thought to be dead. Out of the other two, one was a junkie, the other one suffered from cirrhosis of the liver. They banged against the door all night. I couldn't sleep at all. As opposed to this I was at Bürger hospital once for detoxification, and there everything was very good.

5.1.5 Hungary

Overall, the conditions in police cells in Hungary had improved after Section 135 of the CCP came into force. For example since the previous CPT visit in 2003, the CPT visit of 2005 showed that in the Police Central Holding Facility in Budapest the number of detainees had been reduced from 208 to 134 and the average stay of detainees had been reduced to a few weeks (CPT 2006). The CPT summed up the conditions in police detention:

> … as acceptable for the duration of police custody (i.e. 72 hours maximum). However, they were not suitable for prolonged stays, as was the case for remand prisoners (i.e. up to 60 days). In particular, there were no activities, except for

> one hour of outdoor exercise per day, which was taken in small and oppressive yards (CPT 2006:30).

During the 2005 visit, the CPT also visited the 3rd and 6th/7th District Police Stations in Budapest and the Csongrád County Main Police Directorate in Szeged and found that:

> the cells were of a reasonable size for the number of persons they were being used to hold (e.g. one person in a cell measuring 8 m, two in a cell of 10 m). All cells had windows; however, access to natural light and ventilation was quite limited due to the presence of dense grilles on the windows. …The cells were clean and in a decent state of repair, as were the communal toilet and washing facilities. The cells equipment consisted of sleeping platforms and shelves or lockers, and detainees were provided with bedding (mattress, bed sheets and blankets) at night. However, at the Szeged facility, the delegation was concerned to see narrow (some 50 cm) sleeping platforms, of the same design as those criticised in the report on the 2003 visit (cf. paragraph 14 of CPT/Inf (2004) 18) (CPT 2006, 32).

Those interviewed in Hungary who had experience of police detention had mixed views about the experience:

> the older police officers are more humane; it feels like the younger officers are keen to look tough so they treat detainees badly (Detainees in NEP centre, Budapest).

> you cannot sleep at night and during the day the police keep you awake, you cannot cover yourself with the blanket. In the cell there are usually 4–6 people, and some cells only have a bench, not even a table (Detainees in NEP centre, Budapest).

> showers are only available once a week in pre-trial arrest house unless you have a medical reason, so it is difficult to keep clean and your own hygiene is bad (Detainees in NEP centre, Budapest).

> the food is OK [in police detention] but the ventilation in the cells is poor but you do get one hour exercise (Detainee, Budapest Police Detention Centre).

5.1.6 Italy

In Italy the conditions in police detention were considered to be very poor. The Italian Red Cross (2003) has run a campaign ‘highlighting the "medieval" conditions in which they [detainees] are kept in Rome's police stations’. The driving force, the head of the European Red Cross Network on Aids, Dr

Massimo Barra, says it is crucial that addicts are not further marginalised. Interviewees at the Ministry of the Interior also stated that 'the conditions in police cells are awful and they do not meet with international standards of space of four square metres per detainee'. The cells seen by the researcher in a suburb of Rome were very modern and clean with a separate shower and toilet, however, approximately 99% of those arrested are released on bail so they very rarely have people staying in the cells at this police station (Interviews with two police officers, Rome). The management in detention cells of problematic drug users was not considered to be a problem because, in the Questuro, detainees stay for a very few hours and they stay in common rooms with the police and it is unusual for them to stay over night (Interview with State Police, Padova).

All those who were interviewed who had had experience of police detention thought that the conditions on the whole were very bad with 'the Carabinieri and Questura cells being dirty but the finance police rooms being quite clean and the train police cells being the worst cells' (Focus group at therapeutic community, Padova). Some comments from those who had been arrested were:

> the Physical Conditions of the cells that we have been in were small, very dirty with blood and vomit (Focus group at therapeutic community, Padova).

Women who were interviewed who had been in police detention seemed to feel the time they were kept in police detention was very distressing:

> the conditions in police detention were horrible. The cell was very small, with a sort of toilet. It was very dirty. The toilet was very dirty and smelling, you couldn't use it without feeling sick, so I wasn't able to use it properly. They didn't give me anything to eat till Sunday evening, when I started to cry and ask for the chief. They knew, I was going to the court the next day, so the listened to me, in the end. They didn't give me anything, no water... nothing. No soap, no toothbrush... They don't give you sheets, just a blanket. How can you think they give you sanitary materials? It sounds unreal. No, I couldn't have a shower, even. Everybody knows you can't get anything like that in police detention (Interview 1: Female prisoner, San Vittore Prison, Milano).

> I've been in police detention just for two hours. I was on home detention, but something went wrong, so the police came to take me to prison, but they took me to the police station first. I didn't want to enter those horrible cells, they were so dark, so small and so dirty...I asked to stay out, in the waiting room. As I was very anxious they left me there. I don't know how to describe my experience. I was glad it was short. You feel like nobody cares about you (Interview 2, Female prisoner, San Vittore Prison, Milano).

> the cell was very small, very dark and very dirty. I was alone, and I was frightened. You feel abandoned when you are there. I didn't go to the bathroom, the cell was dirty and I didn't want to see what the bathroom was like. They gave me a blanket, no sheets, nothing to eat, no water, nothing for washing myself. It's like you do not exist. They didn't let me call my sister. I'm eighteen years old, I live with her and I knew she was worried. I didn't see a doctor, or a psychologist. I was really worried and frightened, I'd have been glad to talk with someone, but they just left me there alone. It was very bad, I felt lonely and worried, and nobody to talk with, nobody to explain what was happening. I was so glad when they took me to the prison (Interview: 3 female prisoner, San Vittore Prison Milano).

5.1.7 Lithuania

At the point of arrest in Lithuania, detention usually lasts around three hours but detainees can be kept for up to 10–15 days. As detainees need to be sober for the investigation, this was done in the past by force, now space has to be provided and healthcare (Interview with Police Commissariat, Vilnius). Those interviewed who had previously been detained felt that the conditions in police detention were poor and that conditions were better in prison:

> the police need to be more humane, if they find out you are a user they will treat you badly, they have an intolerant attitude. The cells are very small, with a bench, no windows, for 5–6 people, or at night on iron beds (Interview with ex-detainee at Drug Dependency Clinic, Vilnius).

> in police detention there is a bench but you cannot sleep there, you can sit or stand, the police will not let you rest! There are no windows and they will cram in as many people as they can. There is no exercise yard or showers, sometimes a sink. It is still like Soviet times. Food comes once a day, and sometimes you miss it during interrogation (Detainees, AIDS Centre, Vilnius).

> the police are mocking and insulting to users, the conditions are appalling, dirty, sick is not cleaned up, there is no ventilation. I have seen people begging for help but it does not come immediately and it is humiliating to keep asking (Detainees, AIDS Centre, Vilnius).

5.1.8 Romania

The Romanian police also have arrest houses. The Chief of the Medical Service for the Police said that out of the existing 14 police houses two are being refurbished. When asked if the remand houses were overcrowded the response was that they no longer have underground cells as these had been closed down and using money provided by the community they will refurbish the other detention centres. [Both other professionals and focus group participants appear to differ with this as they said that they had been in these underground cells as little as three weeks prior to this interview].

There was considered to be no overcrowding in police detention due to changes to the penal code where most people who have committed misdemeanours are now bailed; this has thus reduced the numbers kept in police houses (Chief of the Medical Service for the Police).

People with problematic drug use who had been in police detention all said that the conditions were bad usually much worse than those in prison:

> 'what happens [in police detention] changes case from case depending on each police station as they are all different' (Focus groups, ColibaŞi Prison and Hospital).

5.1.9 Summary

Detention in police custody can be either a relatively short time in police stations (Italy, England and Wales, Germany) or for longer periods in police remand houses under the control of the Ministry of the Interior (Estonia, Lithuania, Romania and Hungary) and under the Ministry of Justice in Bulgaria. The conditions were not considered to be acceptable in police stations (England and Wales, Italy and Germany) but conditions in police remand houses where detainees in some countries can be kept for up to 9 months were considered to be very poor, lacking in health care, services for drug users, overcrowded, unhygienic, in need of refurbishment and lacking facilities for exercise. In some instances the poor conditions in police detention were due to structural constraints (old buildings; listed buildings; lack of finance). Within countries there is a great deal of variation in the conditions in police establishments. Former detainees who had experienced police remand houses all said that they were glad when they were transferred to prison as the conditions and services improved dramatically compared to the police remand houses.

5.2 Treatment of detainees

In general interviewees in the sample countries felt that there was no difference in the treatment of those with problematic drug and or alcohol use, instead respondents suggested that all those arrested were considered to be treated as criminals. However, it is important to explore this perspective as problematic drug users are vulnerable at the point of arrest, and often require drug services. Other groups are also vulnerable, such as young people, foreign nationals and those with mental-health problems and with different cultural needs (e.g. the Roma community).

5.2.1 Bulgaria

In Bulgaria, the arrestee has to be deemed responsible for their actions to be taken to the courts. In other words, at the time of the arrest, drug users are aware of their actions. The inspectors treat all arrestees as criminals regardless of whether they are drug users or not. If the psychiatric assessment says that the arrestee is *compos mentis* then they send him or her to the cells and the drug users go through abstinence on their own (Interview, Inspector, Varna, March 2006). Another reason for the psychiatric assessment is that many drug dealers claim also to be drug users and it is often difficult to separate users from dealers (Interview, Inspector, Varna, March 2006). In fact, all those arrested undergo a psychiatric expert evaluation because, if this is not done, the court will not accept the case (Interview, Regional Prosecutor, Varna, March 2006).

There was, according to one respondent, a very bad period when drug users and ordinary criminals were not separated and nobody knew what drugs were but now they are more experienced (Interview, Inspector, Varna, March 2006). However, the police and inspectors (investigators) have more experience with problematic drug use now and there is 'a group of them who deal only with drug users and are slowly creating their own expertise by doing this. Usually the police know very little about drugs and drug users and often ask the inspectors many questions about them' (Interview, Inspector, Varna, March 2006). According to a regional Prosecutor who was interviewed, other members of the criminal justice system, for example, 'the Judges have the same understanding of PDUs as the prosecutors' however, the interviewee continued, 'i.e. drug users who commit crimes to fund drug use are treated the same as others, as a crime is crime' (Interview, Regional Prosecutor, Varna, March 2006).

Juveniles under 14 years are not considered to be responsible for their crimes and the process is therefore different. Juveniles under 18 years who have committed anti social crimes can be sent to supervisory hostels (Interview with Head of Police Station No. IV, Varna, March 2006). The average age of juveniles arrested is 16–18 years and their crimes are usually related to drug

use. There is a probation officer at the police station and the police can send the juvenile to them. This often happens as the key aim for the police is to arrest the dealers and not the users (Interview with Head of Police Station No. IV, Varna, March 2006).

There is no treatment provided for drug users in police detention and according to an Inspector who was interviewed:

> the law does not provide the right to help drug users and these were [previously] considered as easy cases—we caught the drug users, left them to go through withdrawal and then took them to court (Interview, Inspector, Varna March 2006).

According to a doctor working for the emergency service, the police call him when an arrestee has problematic drug use and who also have mental health problems or if the person needs to be hospitalised. He considered that the:

> biggest problem with drug users is that frequently they are often pretending to be worse than they are. I make my evaluation at the police station and decide whether the drug user can stay or not and I can also prescribe some drugs to help with withdrawal (Interview with Doctor working with Emergency Service, Varna March 2005).

According to interviewees in the criminal Justice System the police are not violent to those with problematic drug or alcohol use, rather the emphasis is against the drug dealers. The majority of arrestees are those who commit crime to feed their drug habits. Only a few of them are dealers and 'the police need to focus on dealers not users and the police should not use the period of abstinence to get information about dealers from arrestees with problematic drug use' (Interview with Doctor from Centre for Prevention, Varna, March 2006).

However, all members of the focus group said that the police had hit them. They said that there was no violence from the inspectors or above as the more educated the staff were the better they treated them. They said that they had also been hit by the staff on the sections of the remand house (Focus Group with PDUs with experience of Police detention, Varna, March 2006).

The police station visited deals with many people with problematic drug use and also dealers; many of those who have problematic drug use were from the Roma community. To a large extent, it is those with problematic drug use who are responsible for most of the acquisitive crime.

5.2.2 England and Wales

Service providers and those interviewed with experience of police detention in England and Wales felt that the police sometimes had negative attitudes towards drug users:

> some police have negative attitudes to detainees as they resent the fact that detainees have a right to immediate medical care while they may have to wait three days for an appointment. They fail to understand that the key reason for access to doctors is to keep the detainees alive. Senior management of the police are well aware of the need for high-quality medical provision as are many other police who work in direct contact with detainees. There is a need for sustainability re contact with drug agencies as there is often personnel changes in the police—who have a good working relationship with arrest referral and drug workers and all the good work goes when the staff change (Interview with Doctor from Forensic Medical Services, England).

A custody suite manager interviewed made the point that arrestees with problematic drug use:

> bring with them chaotic lifestyles and are often dishonest about their use, health problems, etc. and as a result are difficult to manage while in custody (Police Sergeant, Custody Manager, England).

One of the detainees interviewed had very negative views about his time spent in police custody:

> The food is awful, just microwave meals, and the police officers, their attitudes stink. They have tried to get information from me, one officer dangled a bag of heroin and one of my needles, all the kit to cook up, and he said give me the name of your dealer and it is yours. As if I would do that, it is cutting my own nose off to spite my face! It really shocked me, I was so tempted to give a bogus name, but I didn't, and if I gave them the name, and they found out I would get shot…it is not worth the risk (Male former detainee, Birmingham, England).

The other vulnerable groups that were raised by the interviews were those with problematic alcohol use, juveniles, those with mental health problems, foreign nationals and sex workers.

There are a lot of detainees who are arrested for problematic alcohol use that is often linked to domestic abuse and homelessness and this group is often excluded from access to treatment via the arrest referral scheme:

> I think alcoholics and the homeless get a really rough deal. Even this week I had a DIP form returned to me saying that they couldn't do anything with this guy because they couldn't contact him and when I looked into it the nurse had gone through everything with this guy: he was compliant, he wanted to engage in getting treatment but under his address there was only the name of a derelict place where he pitched his tent, he didn't have any contact details and so they sent the referral

> back saying sorry we can't speak to him, we can't find him. So that sometimes, every now and again you get something that flies in the face of everything and you say, well, what is the whole point of this? Luckily we will capture that guy again because what will happen is that he is known to us. We know who he is and he comes into Maidstone Police Station every six or eight weeks, so we will see him again and we'll find out an address of a friend so we will eventually get an address for him but that's because we know who he is [due to repeat offending] (Custody Nurse Manager, Kent Police).

Juveniles who are arrested are not drug tested and often do not have the same access to arrest referral schemes as adult arrestees. One interviewee pointed out 'that while current legislation and practice does support over 18s, juveniles can be missed out and not access help. I think it is an important role for police to go to schools in a prevention role but I must acknowledge that it is too late for some' (Custody Sergeant, West Midlands Police). This was reinforced as problematic by another interviewee:

> we don't drug test under 18-year olds and in addition we have problem with social services here, its one of the worst in the country; so if a child is taken into care they are the responsibility of the local authority but when they are arrested often there is no social worker available to come to the police station. The local authority are not taking responsibility so we [the police] should be able to test them for drugs so we can meet their welfare needs and so that courts are also aware of the problems. I've known children as young as 12 being addicted to crack. I have also seen the same problem with young alcoholics at 16–17 years old (Police custody officer, Inner City Police Station).

Although the juveniles are not tested they can still have access to a referral worker and given leaflets. In the near future the police will be able to test for drugs from the age of 14 years (Police custody officer, Inner City Police Station). There are also pilot schemes underway for juveniles with problematic drug use who are arrested but at the time of the research there was not a national strategy for dealing with this age group.

Another area of concern for detainees in custody is mental health problems:

> if detainees have mental health problems, masked by drug or alcohol use it is difficult to refer them to other agencies especially if the offence does not warrant remanding in prison, as mental health teams in the community have strict criteria and won't accept problematic drug users arrested by the police (Police Sergeant, Custody Manager).

This group of detainees with mental health problems and problematic dug use were perceived by service providers and the police as being problematic as nobody wants to take responsibility for them:

> those with dual diagnosis, as in mental health really get the bad end of everybody's stick because they fall out of the net as they are labelled as problematic drug or alcohol users and then the mental health services won't take them if they are intoxicated. Drug Treatment services can't deal with them because they don't know whether the person has schizophrenia or what and they haven't got the knowledge to deal with mental health or to deal with a chaotic user who is also mentally ill. 80% of our client group [in police custody] with mental health problems also have a substance misuse problem (Custody nurse manager, Kent).

This group of detainees with dual diagnosis face problems receiving treatment in other agencies as well as the police, for example the Accident and Emergency Department in hospitals and GPs don't want to register this group as a result many of those with dual diagnosis don't have a GP either.

One police custody officer felt that:

> there has been a vast change in attitudes towards the mentally ill, for example, if [the detainee is drunk] they cannot be assessed until they are sober, now we ask for the forensic doctor to assess and ask for assistance from social services; there are different types of mental health problems, for example learning needs or personality disorders. For those with disorders, some are violent and have no fear or don't feel pain and can be a danger to officers; sometimes they are detained for 36 hours as no psychiatric beds are available in the community. Police custody is not suitable for such detainees [who are violent] but if we cannot find them a mental health bed they are released back into the community where they are not monitored and potentially a danger to the public. For some, if they don't fit into certain categories, there is nowhere to put them—but this should not be a decision made at the police station (Police custody officer, Inner City Police Station, England).

Some detainees do self-harm while in custody and the police use a risk assessment form at admission:

> being called out to visit detainees who self-harm is a common request and also those at risk of suicide. The doctor makes the assessment to the level of monitoring that the detainee requires; routine where the detainee is checked every hour up to constant watch in cell or outside cell or CCTV. Using CCTV can be

> flawed as the person watching can get distracted and not see things (Forensic Doctor, Medical Services Manager).

The number of foreign nationals who come into contact with the police has increased; in one inner city police station visited, out of 12 prisoners recently arrested, two were from the UK and the remaining ten were from eastern Europe and Africa. Most of this group were arrested due to drug-related crime. In addition the influx of asylum seekers, who are not allowed to work, commit crime to fund drug habits. As the number of foreign nationals arrested increases so do the costs of interpreters both at the point of arrest and subsequently in court:

> the availability of interpreters depends on the language—it is very important that detainees are interviewed in their first language, as this is part of their rights and they must understand what has happened to them; for example, even though a Georgian can speak Russian, if it is not their first language then they must have a Georgian interpreter (Custody Officer, Inner City Police Station).

5.2.3 Estonia

In Estonia, the police who were interviewed considered that those with problematic drug use who had been arrested were the same as other criminals (Interview with the Police Board, Tallinn). They did not see their role as one of providing harm reduction or drug services.

Normally the probation service starts to work with offenders after the court decision and sometimes with the prosecutors prior to trial. The prosecutor must order social assessments (pre-sentence reports) for all juveniles arrested and they can also request this for adult offenders as well (Interview with the Head of Probation, Tallinn). The main reasons why the prosecutor would ask for a pre-sentence report for adults are if the person has an addiction, or a psychiatric problem or if an alternative measure is to be requested (Interview with the Head of Probation, Tallinn).

The probation officer goes to the arrest house to interview their clients and their report for the court must be completed within 1 month. Usually the probation officer will meet the arrestee twice. The report will contain information about what social services the person has been receiving, information from the police about previous crimes and so on. In the case of juveniles it is also obligatory to interview the parents and a named other key person. If the person agrees, the medical records will also be accessed, along with a resumé from the school or employer and if they have been on an NGO programme (methadone, alcohol addiction) their key worker will also be interviewed. The final report will make an assessment about the trigger factor for the client to commit crimes and the impact of alcohol or drugs on their

behaviour. The report will make recommendations for the prosecutor (Interview with the Head of Probation).

Juveniles are not usually kept in the arrest house as they go directly to the pre-trial prison. A key problem is the continuation of schooling while the juvenile is in pre-trial detention as schooling is not generally available at this time (Interview with the Head of Probation, Tallinn).

Most of those arrested at Tallinn Arrest House:

> are quite young and they have problems at home and most of them have been here many times. I have seen their drug use develop from sniffing glue to injecting (Interview with the Felcher, Tallinn Arrest House).

None of those with problematic drug use who had experience of police detention claimed that they were ill treated, rather, they were very critical of the conditions of some arrest houses. Those interviewed said that:

> The attitude of the police towards drug addicts depends on the arrest house. At one, the felcher is quite OK and she tries to help but the head of the arrest house doesn't care about problematic drug users (Interview Prisoners, Tartu Prison).

5.2.4 Germany

In Germany, the law states that no one may be detained by the police, without seeing a judge, longer than the end of the day following arrest. Those interviewed with experience of problematic drug use who had been arrested by the police on the whole felt that the attitude to drug users was negative:

> they think their [police] life is superior to our life. They think our health doesn't matter, because we take drugs anyway.
>
> I can't tell you anything positive about police detention. Eight years ago they arrested me in at the police station Neustadt, and I got a sound flogging there in the cellar. They only hit me in a way that it is not possible to see it easily later. They only hit me in the stomach. It happened very quickly. All junkies and alcoholics know that this happens at this police station. Sometimes they call an ambulance, then they say the detainee had slipped down the steps. I have already watched this once, it is not just a rumour. I could see a drunken man who came out of the police cell carried by two police officers. They carried him to the ambulance. I suppose they have beaten him up there before.
>
> It was not very nice in police detention. They treat you like the scum of the earth. If one has drunk too much, they beat you up

> with a stick. If one is impertinent, this happens. If you ask for a sandwich or water, you get nothing.

Other groups that were identified as being vulnerable at the point of arrest were those who were arrested and held for subsequent deportation and the homeless. One person was interviewed with problematic drug use who stayed longer in the institution for police detention in Bremen, that is, in detention awaiting deportation. The detention of immigrants was included as this takes place in the same building and it is important for the reason that this kind of detention is longer compared to police detention in the narrower sense and gives rise to further understanding about the treatment experienced by detainees during shorter stays. The person interviewed had been in police detention in Bremen very often, in the detention centre as well as at police stations. He had also been in the detention centre for immigrants four times. He considered that the police were not interested in the problems faced by problematic drug users:

> when I was in police detention at police stations in Bremen they were not at all interested in withdrawal symptoms and things like that. You can tell them whatever you want, they do not respond. You have to be in an extreme state before a doctor is called. It is very hard when you are there.

The interviews in Germany also raised concerns about the treatment of juveniles and homeless people who are arrested by the police. One example was of a 16-year old boy who was stopped by the police at around 2.40am because he swerved on his bicycle and had crossed a red light. A breathalyser test showed a blood alcohol level of 1.8‰ and he was taken to the police station for a blood test. Because he was afraid of the needle, he first resisted against the taking of a blood sample and made some verbal attacks against the police. When he realised that resistance was useless and offered to have it done "voluntarily", it was too late to escape the rude treatment that was already in progress. He said that, all he wanted was to go home. When he was asked what his impression was why they had not done this, he said in the interview: 'they wanted to punish me, to teach me a lesson.

The police kept him in detention until 6.20 in the morning, when they eventually drove him home. His father lives within walking distance, five minutes from the police station, and the father was sleeping at home during the four hours his son spent in detention. The police tried to call his father on his landline but they only got his answering machine. They did not try his mobile phone number nor simply take the boy home immediately. They kept this juvenile in detention for hours without legal grounds and without letting his legal guardian know.

A social worker from the transitional home for homeless men made the following observations when asked if residents after being detained by the police complained about how they were treated:

> No, but this is because they are used to it. Those who live here have experienced so many frustrations in their lives that they

> often do not even object to obvious injustice. They simply accept this as given. Usually it does not mean much to the individuals in police detention for sobering up or similar situations, whether a doctor is present there and so on. This is due to the fact that they do not or no longer care for their health anyway.

5.2.5 Hungary

A range of professional staff interviewed in Hungary felt that the way vulnerable detainees were treated, particularly drug users, was mixed but that there were still many cases of ill-treatment and negative attitudes (Doctor, Methadone Clinic, Budapest). Those with problematic drug use who are using the needle-exchange programme are vulnerable as the police can arrest them for possession of drugs despite the ID card system (saying that they are part of the needle-exchange programme) being in place to prevent this. However, users are still getting arrested. As a result, the clients of the programme mistrust the Needle Exchange Clinic, despite the efforts made by staff from the centre to liaise with the police to stop them patrolling areas where the needle-exchange programmes are based (Staff, Needle Exchange Clinic, Budapest).

In addition, staff at the Needle Exchange Clinic in Budapest argued that:

> one of the key problems for detainees is that they do not get medication to help withdrawal symptoms, or not a high enough dosage. Also there are problems reported by detainees with the attitude from police officers, ranging from being ignored, verbally abuse and humiliated and even in some cases physical abuse. Among younger officers, there may be more tolerance, perhaps as some of them can be [drug] users themselves. Drug users may be exploited during withdrawal in order to clear up offences, confess to other crimes etc. A study by the Russian Institute of Crime in 2005 showed that younger police officers are more open to reform of the police and changes to their role, to view drug users as in need of support, not as criminals (Staff, Needle Exchange Clinic, Budapest).

According to one person with problematic drug use who has been in detention felt that the:

> older police officer are often more humane, as younger officers want to prove themselves as tough and will pick on vulnerable groups, like [drug] users. If you complain the police are very harsh, they will take away what few rights you have, and will humiliate and beat you (Focus group former detainees, needle-exchange programme centre, Budapest).

The police interviewed felt that detainees with problematic drug use display very different behaviour to other detainees, as they can be violent or very subdued, and then can often experience illness (Chief Officer, Police detention centre, Budapest). In addition it was considered to be difficult to manage withdrawal symptoms of those with problematic drug or alcohol use that may need referral to hospital. Often those detainees with problematic alcohol use also tend to have psychiatric problems as well (Chief Officer, Miskolc Police Department, Budapest). A former detainee reinforced the need for referral to hospital as he considered the police to be 'unsupportive and even when they call a psychiatrist those that come are often trainees [and not experienced enough to help]' (Focus group former detainees, NEP centre, Budapest). A doctor interviewed at the Methadone Clinic said that:

> at the clinic services to deal with co-morbidity are available as there are psychologists on staff, and there is an agreement to refer serious cases to the National Institute for Neurology and Psychiatry – where they have both methadone programmes and more specialist care and detainees with such problems need to be referred there (Doctor, Methadone Clinic, Budapest).

This was reinforced by staff interviewed at the Forensic Psychiatric Hospital:

> there is a higher level of care in this institute, compared to detention centres as there are psychiatrist and addiction specialists, who can address mental health problems and problematic drug and alcohol use. This is important as the two are different and must be treated separately (Staff, Forensic Psychiatric Hospital, Budapest).

The Roma community were identified as a vulnerable group as they are subject to more stops and searches by the police, are marginalised in society so, as drug users, they face a double stigma. However, the Chief Officer at Budapest Police detention Centre said that 'they very rarely come into contact with Roma, as many are poor and cannot afford to buy drugs, especially hard drugs, they have bigger problems with alcohol and cannabis' (Chief Officer, Police detention centre, Budapest).

5.2.6 Italy

In Italy problematic drug use is seen as a major problem, not so much the actual drug use but the crimes committed due to problematic use:

> the fight is against crimes, not the drug addicts. The Law is changing from the current situation where to use heroin is not a crime but the new law will make it a crime. The problem is that the amount of heroin that a person has in their possession to be arrested has not been decided and the law is not as yet backed

> up by rules on how to interpret it (Interview with State Police, Padova, Italy).

According to a prosecutor who was interviewed, the police are more correct in their behaviour with detainees than they were in the past, based on the reduction in the number of complaints that he has received from detainees who have problematic drug use (Interview with a Prosecutor, Padova). This was reinforced by the state police who said that arrestees usually only stay a short time in police detention, for only a few hours, and usually in common rooms with the police and not in cells and it was very unusual for a detainee to stay overnight. This was reinforced by those interviewed in one of the prisons in Padova:

> even when they are arrested with the drugs inside them they stay for a short time in police detention and the police give some excuse to the magistrate why the detainee should be transferred to prison. In court, prior to trial, you will see prison guards escorting the detainee as the police don't go: even though this is against the law! This puts added pressure on the prison due to the lack of staff. The police don't want to deal with problematic drug users and issues like withdrawal and overdose and so on (Interview staff, Padova Prison).

On the whole, it was felt by one focus group with experience of police detention that

> the police now were more sympathetic to drug users whereas before they would take advantage of your drug cravings to get a confession. How the police treat you depends on how you behave (Focus group at Villa Maraini, Rome).

The focus group in Padova were more critical about how they were treated while in police detention:

> I was arrested when I went to buy heroin from a dealer and the police had the dealer under surveillance and saw me there. Later, they came and took me from my home. At the police station I waited 3 hours before being questioned. Although I was not hit I underwent psychological violence as the police wanted to know other names of dealers and for me to act as a witness (Focus group at therapeutic community, Padova).

> Once the police found that I had a dose of heroin on and I was arrested and I spent five hours in the police station and they didn't treat me well. The police beat me; they often do this more than they need to. They saw I was in withdrawal and that I felt very bad (Focus group at therapeutic community, Padova).

The point that the police take advantage of those with problematic drug use during withdrawal was made by another member of the focus group:

> you are not given a lawyer until after withdrawal – when I asked the police for a lawyer they just said no and at the end [of questioning] you have to sign a report saying that you didn't want a lawyer. After 8–10 hours with withdrawal all you want to do is go so you will sign anything (Focus group at therapeutic community, Padova).

The police who were interviewed did not feel that there was a problem dealing with migrants as it is unusual to find someone who speaks no Italian. Italian law says that an arrestee can have a translator from the main languages of the world (Interview with a Prosecutor, Padova). In Rome if a detainee requires a translator they are taken to the central police station where interpreters are available (Interviews with 2 police officers, Rome).

5.2.7 Lithuania

In Lithuania, there are five Parliamentary Ombudsmen; the role of two of them is to investigate the work of government institutions including prisons and the police with a wide remit regarding human rights of those detained. In the 2004 Annual Report of the Parliamentary Ombudsmen of the Republic of Lithuania, the investigation of police detention facilities in Lithuanian cities raised a number of concerns: out of 46 detention centres inspected, only ten were found to be adequate and in some cases detainees can spend up to two years in a detention centre.

The deputy Head of the Health Department at the Ministry of the Interior made the point that arrestees who need psychological support should be referred to the relevant hospital and not treated in detention as:

> this is not the right place and the police have limited time. Only basic healthcare can be provided at this point (Deputy Chief, Health Department, Ministry of Interior).

In a survey conducted in 2003 of 300 detainees, 75% said they had experience a rude attitude, aggression or physical abuse from the police. Only 10% said that their rights were not violated and many of the respondents asked 'do we have rights?' (Social worker, Drug Dependency Clinic, Vilnius).

According to detainees interviewed exploitation at the point of arrest still occurs:

> it [exploitation] is mostly against drug addicts, as they are more likely to be ill with withdrawal symptoms, many will sign whatever the police demand after 24 hours, otherwise you can be kept in for two more days (Focus Group former detainees, Demetra Care Centre, Vilnius).

> I have been detained many times, mostly for minor crimes, but I have suffered psychological and physical violence as they

> [the police] see you are a drug user and treat you worse (Focus Group former detainees, Drug Dependency Clinic, Vilnius).
>
> the withdrawal symptoms make you want to admit to crimes, the police tell you to endure it as it is your own fault, even in prison the medication is very weak and does not work (Focus Group former detainees, Residential Clinic, Vilnius).
>
> they [the police] coerce you to confess so they can clear up crimes. Now they know me well, I just admit to it and they are not violent, if you agree with them and behave they will be OK, now I have a 'normal' relationship with them. If you can get through 48 hours then you can survive as the police have to have evidence to keep you for longer than this – I've never confessed to something I have not done, the police have tried to get me on crimes which would put me in prison for six years (Focus Group former detainees, Drug Dependency Clinic, Vilnius).

Another focus group with former detainees argued that:

> if you behave yourself then you will be OK, but if you are aggressive to the police they will use force to restrain you and psychological pressure. Their job is to detain, but they should do more – they do not care, but they could help motivate drug users to give up or get medical help (Focus Group former detainees, Residential Clinic, Vilnius).

The problems that detainees find in police custody are amplified for those from the Roma community as information is not provided in their language although it can be provided in Russian, which some Roma speak (Deputy Chief, Health Department, Ministry of Interior, Vilnius).

Amongst foreign nationals, alcohol was identified as the biggest problem and 'many come to the attention of police as victims of crime. The majority of foreign nationals are from the EU and Russia. (Chief Officer, Police Commissariat, Vilnius).

5.2.8 Romania

In Romania, Bucharest raises special issues for the general inspectorate of police. Of the 5,200 people arrested about 65% of detainees have problematic drug and or alcoholic use (interview with Chief of Police Medical Service, Bucharest). Prior to 1999 Romania had not acknowledged the problem of drug use and, as a consequence, this issue, especially the treatment of PDUs, has not been a major concern of institutions like the police and has impacted on the treatment of and attitude towards those with problematic drug and or alcohol use (Interview Lawyer, Bucharest).

According to one interviewee there have been several training sessions for the police, prosecutors and judges in Bucharest and this has changed the attitude towards problematic drug and or alcohol users to some extent (interview with a Prosecutor, Bucharest). He went on to say that attitudes towards arrestees with problematic drug and or alcohol use are different in the countryside, outside Bucharest, where attitudes tend to be more negative.

However, a lawyer interviewed in Bucharest argued that the measures against drug users are excessive:

> as the law is harsh and doesn't differentiate between problematic drug users and dealers, i.e., friends give a dose to friends then they are considered as dealers. I was horrified in the past (1995) seeing detainees in withdrawal; one arrestee was chained to radiator but now there is better understanding [of problematic drug use] from the police and prosecutors (Lawyer, Bucharest).

Members of one of the focus groups were very critical of the attitude of the police to problematic drug users:

> they [the police] give you [drug users] sedatives only and one man was taken to hospital and was told he was just pretending. The conditions are inhuman and disastrous, one person was withdrawing and they threw water over him. In Bucharest, drug users are sent to withdraw under ground, in one particular remand house, with only diazepam. County police detention was OK, better than Bucharest (Focus group, Giurgiu Prison).

While the treatment of Roma arrestees was not discussed specifically in this study Romani CRISS and other NGOs claim that police used excessive force against those from the Roma community:

> three individuals were physically abused in the gendarmes' van, and the other two were abused in the police precinct. Two of the five detainees were minors; their parents were initially denied access to the police precinct. The chief of the police precinct stated that the gendarmes' official report denied that the five men were subjected to abuse. The alleged victims filed complaints against the gendarmes for abusive behaviour (US Department of State 2006).

5.2.9 Summary

Whereas detainees with problematic drug and/or alcohol use were the main focus of the research other vulnerable groups such as those with mental health problems, young arrestees, sex workers and those from different cultural groups were identified as also requiring different services and treatment. In the majority of the participating countries a lack of knowledge about those with

problematic drug use led to negative attitudes towards them from the police. Detainees from most of the participating countries said that the police exploited them while they were withdrawing from drugs in order to secure confessions or to get information. Physical violence towards detainees though mentioned by some detainees was on the whole considered to have significantly decreased in all of the participating countries with younger police officers being identified as having more sympathetic and positive attitudes towards those with problematic drug use.

The emphasis on strategies and policies regarding problematic drug use was identified as problematic as they tended to deflected attention away from other vulnerable groups such as those with mental health problems, those with problematic alcohol use, foreign nationals, Roma and young drug users (under 18 years).

5.3 Access to drug and alcohol treatment

The availability of drug services for detainees with problematic drug or alcohol use is variable in the police forces included in this study. This section will, where data is available, explore the response to detainees who are withdrawing, the continuation of drug treatment started in the community and links with NGOs and community drug service providers. Treatment for problematic alcohol use was not available in most of the countries in the research although it was mentioned as a problem amongst detainees.

5.3.1 Bulgaria

Arrestees need services at the point of arrest and they should be provided as this is an ideal and practical time to address both alcohol and drug treatment with detainees (Professor Popov, Varna March 2006).

The police use doctors from the emergency services and from the hospital to visit detainees and to provide the assessment for both drug addiction and alcoholism. These doctors work with problematic drug users in the community and are a good link with detainees with problematic drug use when they are in police custody. During the interview with one of these doctors he said that the biggest problem for doctors in Varna is heroin with almost 3,000 IDUs using heroin:

> the age of IDUs when they seek treatment is early 20s. Alcoholics are usually in their 40s. The treatment programmes for alcohol and drugs are here in the hospital [where interview took place] and the approach is the same with some differences in medication. There is a lack of social support and this is often one of the reasons for the relapse and also the period of

> treatment is too short (Doctor for drug addiction and provide Drug Assessments for police, Varna March 2005).

If a drug user is suffering withdrawal while in police detention the police can call the emergency service (Interview, Regional Prosecutor, Varna March 2006) but according to one of the doctors interviewed:

> the police normally don't call the emergency service usually they just leave them [PDUs]; they have to be really bad for the police to call the emergency services. In police cells, they get nothing for abstinence, they are just left for 24 hours (Interview with Doctor working with PDUs and provide Drug Assessments, Varna March 2005).

Former detainees interviewed had very negative experiences of their time in police detention:

> I was kept in police detention and I didn't have my methadone passport and I was beaten by the police. I was caught with cocaine a year ago and I told the police that I was a drug user and needed help and the police answered that they were not interested because they said that as a drug user/dealer I could have given drugs to their children! (Focus Group with PDUs with experience of Police detention, Varna, March 2006).

> the police have a lot of experience with drug users and they think that you won't usually die in abstinence and this is why sometimes they don't let you have the methadone. Police officers can be abusive to us. If you ask for a doctor – whether they call for the doctor depends on the personality of the police officers on duty if they are more open they will do it or if they are less open they won't. The police call the doctor only when it is really serious (Focus Group with PDUs with experience of Police detention, Varna, March 2006).

In the police stations, there are special cells where alcoholics can be watched and doctors are called from the emergency services if required (Interview with Doctor working with Emergency Service, Varna March 2005).

The methadone programme in Varna is funded by the municipally and the National Healthcare Service pays for the methadone. The programme started in 2003 and it currently has 150 clients on methadone. Some professionals do not think this provision is sufficient as in Varna there are approximately 4–5,000 drug users and 75% of them are IDUs (Interview with Doctor and Head of Department for Prevention, Varna, March 2006). There is a waiting list to get on to the 'mental health centre' methadone programme. Under Bulgarian law, methadone can only be provided in licensed centres – NGOs and GPs can't

give methadone.[100] (Interview with Doctor and Head of Department for Prevention, Varna, March 2006).

If a person is arrested while on methadone it is sometimes possible for the detainee to continue the programme if the methadone is brought by the family to the police station:

> if a client is arrested their substitution treatment is put into water and given to their relatives and they go to the police station and give it to the police and then the police give it to the clients. If there is a doctor in the remand centre we prefer to give the methadone to them (Interview Director of the Methadone Programme, Varna March 2005).

The methadone programme has tried to keep good co-operation with police at police stations and at remand centres. Clients have documents saying that they are on the substitution programme and the police in the investigating office know that these people need their substitution treatment everyday (Interview Director of the Methadone Programme, Varna March 2005).

This co-operation with the police does not always work as one former detainee said:

> If you are in the substitution treatment programme you should see the doctor to arrange for the methadone to be brought here [to the police station]; the police will ignore this. Police officers are obliged to inform your parents or the methadone programme that you have been detained. I was kept for 24 hours in the police station and in the morning I showed my methadone 'passport' [this provides proof that the person is on the methadone programme] and said that I needed my methadone and the police said, "Forget it". When we are not able to take our methadone we are easy to be manipulated and to confess. One of my friends said that his mother took his methadone to the police station for him but the police didn't give it to him. Another friend was arrested at 9.00am by the police on his way to get his methadone and he asked the police if he could get his methadone and they refused (Focus Group with PDUs with experience of Police detention, Varna, March 2006).

When an individual on the methadone programme commits a crime and is sentenced and sent directly to prison the court contacts the medical centre and delays the start of the prison sentence until the client has undergone detoxification at the methadone programme (Interview Director of the Methadone Programme, Varna March 2005). Also if a client is in the police remand house:

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100 There is no methadone programme in prison. The dose varies between 60 to 140 milligrams.

> we provide a list of the dose and then decrease the dose while they are in the remand centre. It is very rare that a client on the methadone programme would go directly to the prison without firstly going to the remand centres (Interview Director of the Methadone Programme, Varna March 2005).

Currently there are not well-developed treatment programmes for prisoners with problematic drug or alcohol use and no substitution treatment is available. As one former detainee suggested:

> in the evenings [in prison] you can see the heroin next to you so even if you have treatment during the day you will be tempted to take it. What is needed are alternatives to prison, to be sent to treatment rather than to prison. Some magistrates and prosecutors take drug use into account but say that they have to keep to what the law allows (Focus Group Former detainees, Varna, March 2006).

5.3.2 England and Wales

The forensic medical service provides assistance during withdrawal. The forensic service providers are different in different areas of the country so practice differs regionally. Essex Medical and Forensic Services have established a loose six-hour rule in dealing with problematic drug and alcohol users. This means that they do not prescribe until the detainee has been in custody for six hours as the doctor does not know what drugs the detainee has taken and they want to avoid the risk of overdose. In addition, some detainees may have drugs hidden on their person (anally). Anecdotally, the Forensic Medical Services Manager interviewed had a case where the drug worker argued very strongly for a detainee who was on a methadone programme to be given methadone as he was reliable and doing very well on the programme and that if he said he had not used anything then it would be the case—unfortunately after they did prescribe him methadone he became unconscious as he had taken methadone just before he was arrested.

Also the six-hour rule was adopted to break an assumption that drug users, when arrested, immediately went into withdrawal. In reality, about 70% of those arrested have drugs already in their system. The six-hour rule has now broken this assumption and what they do now is to try not to give any medication during this period but they will visit the detainee and keep going back to monitor and assess whether they are experiencing withdrawal. The interviewee said that he knew that his policy regarding the six-hour rule and not providing methadone is highly controversial with other drug service providers. However, the forensic medical service provider interviewed said that they have treated over 15,000 problematic drug or alcohol users and that there has not been problems of under treating withdrawal (Medical Director, Forensic Services Limited, UK).

The forensic service manager who was interviewed said that:

> contact with community methadone service providers is limited as there is a clear difference of opinion about substitution treatment. The forensic doctors' key function is to prevent death in custody and to assess the fitness of the detainee to be interviewed and kept in custody whereas the methadone providers' key aim is to stop the drug users from using street drugs so there is a culture clash. There is a need for more contact with the drug workers who work in the police stations and this is starting to happen in my area (Medical Director, Forensic Services, England).

In theory, drug users could continue methadone while in custody if administered by a doctor but 'I don't do this as you can never know if the dose that the detainee says they have is correct or not' (Medical Director, Forensic Services, England).

In an inner city police station the custody sergeant said that for withdrawal:

> we provide medication for heroin users, a strong pain killer, and substitution treatment if detainees already had a prescription, which has to be administered by a doctor (Police Sergeant, Custody Manager, England).

A former detainee was not happy with the service she received in police custody:

> They wouldn't let me see the doctor until the morning, within an hour I needed help, I was rattling and shaking, it was 9 o'clock before I got any medication. Normally they give you painkillers, liquid Valium but some doctors question prescribing you drugs if they think it will make you unfit for interview, even if you need it (Former detainee, England).

According to some drug workers and police who were interviewed, the most vulnerable group in custody are problematic alcohol users as there are not the services needed. Even though alcohol is the main problem, the government prioritise drugs and 'there is more risk with alcohol withdrawal than drug withdrawal, and yet there is an eight month waiting list for treatment' (Police Sergeant; Arrest Referral Worker, Inner City Police Station, England). One police custody manager went on to say:

> we have alcohol referral workers, for suspects who are given two week's bail to attend sessions on dealing with problems with alcohol use and then a treatment action plan is presented to the Court. Binge drinking is a particular problem, especially the level of violence police officers experience, but then after sobering up detainees are unaware of their actions. Most would get 3–4 chances, i.e. not charged but given a caution or fixed penalty and referred to the service. It can be useful to nip first

> offenders in bud but if they persist then they must be charged and face court and a tougher sentence (Police Sergeant, Custody Manager, Inner City Police Station).

There is a large discrepancy between the funding available for problematic drug users and those with alcohol problems:

> to put some perspective on it, the Drugs Action Team is actually the Drugs and Alcohol Action Team the DAAT, as far as I'm aware, the amount of funding, bearing in mind the overall funding is about £14 million per annum, the amount of that money that goes on alcohol is virtually negligible, its predominately a drugs treatment commissioning body (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

> I'd like to say that DAAT is very good and the DAAT programme we use is basically for adult drug users but there is still a big void for youth alcohol and adult alcohol and we would agree that we've seen an increase in alcohol consumption in the last 18 months–two years (Custody nurse manager, Kent Police, UK).

> in the case of alcohol the criteria for referrals are more subjective and the protocols are not as strict as those for problematic drug use. The problems are greater when the detainee has alcohol and mental health problems (Police Inspector, Forensic Psychologist North Yorkshire Drug Action Team).

In England, staff from treatment centres and the police (including arrest referral workers) reported problems associated with the lack of treatment facilities for problematic alcohol users, despite the numerous and widespread harms caused. This was also particularly important as, often, drug users would use alcohol as a substitute, and would need additional support because of this. Interviewees raised the need for more information on alcohol and the link with violence:

> there is a lack of literature to help alcohol users understand the risks and impact of excessive use. They need to be informed of how to avoid violence and simply that by drinking so much they are not in control of their actions. While some detainees are often drunk and violent in custody after the sobering up period, they are very apologetic and co-operative (Custody Sergeant, West Midlands Police).

Alcohol and the link with domestic violence was also raised:

> if you look at the complications of domestic violence alcohol is a greater contribution to it than ever drugs have been in my experience. I also know a lot of burglars we used to catch had a significant amount of alcohol inside them in order to have the

> courage to do what they did and they weren't doing it to drive a drug habit (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

Generally, among police officers in England, the point of arrest was seen as a prime opportunity to address the needs of those with problematic drug and alcohol use. It was viewed as part of the 'journey' of treatment, a starting point where users can begin to address their problems. The remit of the police was described by one officer as being to address the cause of the offending and look beyond investigative and legal procedures and follow up enforcement with treatment, or to 'make the episode of arrest' a much richer event.

Police forces in England and Wales have established links with Drug Action Teams (DATs) and Drug and Alcohol Action Teams (DAATs) to reduce drug and alcohol related offending and help offenders into treatment, to prevent further problems. They work together as part of local Crime and Disorder Reduction Partnerships (CDRPs), which are responsible for addressing local problems and issues, using a multi-disciplinary approach to target resources more effectively and efficiently. This initiative is due to be extended to cover all offences, to enable the police to get a clearer picture of the extent of drug use, and is now referred to as 'test on arrest'. One police officer interviewed raised an important issue:

> on the basis that an arrestee with problematic drug use says I want help then we [the police] just want to try and get them in to treatment as soon as possible, because if you look at our experience of drug treatment and testing—yes people fall out of treatment but their offending rate plummets whilst they are in it, so even if we do nothing more than give them a hit of Subutex and keep them straight for more than two days and release them a few hours later, then that's three lots of heroin they haven't got to find potentially and ten lots of offending they haven't got to do to get the money (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

The response by the police and other criminal justice agencies contributes to the 'Drug Intervention Programme' developed by the Home Office to divert those with problematic drug and alcohol use out of the criminal justice system and into treatment. For example, in police custody, arrest referral workers give advice and information to users and refer them to community treatment programmes and, in prisons, Counselling, Advice, Referral, Assessment and Throughcare (CARAT) workers help users with treatment programmes and aftercare services on release.

In England, both police and magistracy staff highlighted one of the major difficulties associated with the treatment of problematic drug and alcohol users as being delays in court appearances, leading to delays in treatment provisions via criminal justice sentences. Among other criminal justice and healthcare participants in England, concerns were raised about the feasibility of treatment

through the criminal justice system, in that users engaged in treatment through court orders can suffer more serious consequences (that is, more severe sentences) if they experience a relapse compared to others accessing treatment through health services alone. In addition the use of Anti-Social Behaviour Orders (ASBOs) in England, often leads to users being banned from city centres, which impacts on their access to treatment services.

In England, more formal links are made with community services and the police through arrest referral workers, who approach users in custody to provide information and referral to treatment services. Police officers were enthusiastic and complimentary about this scheme and saw it as a vital part of addressing the links between addiction and offending. A senior officer described the period of time arrest referral workers spent with offenders as a 'golden ten minutes', illustrating parallels with the 'golden hour' investigating officers use to emphasise the need for immediate action in dealing with a case. Also in England, custody nurses were based in a few police stations to assess and treat the healthcare needs of detainees – this is a relatively new initiative being piloted in the UK. Generally, police officers and arrest referral workers who were asked about the use of custody nurses agreed this would be very useful, particularly when dealing with high numbers of problematic drug and alcohol users in police custody. Some officers raised the issue of the expense of such an initiative, and felt it would be more cost-effective to employ nurses full time only in large police stations serving urban centres, with cover available to smaller stations as necessary.

Some interviewees felt that offering treatment at the time of arrest helped in compliance to treatment:

> treatment through the Criminal Justice System helps compliance for [drug] users, it provides motivation for them to attend and complete the treatment, whereas community treatment which is not subject to legal consequences, may not be as effective in motivating users, there is less pressure (Police Sergeant, Custody Manager).

Another police officer stressed the importance of motivation to stop drug use:

> what you can't get away from is [that] treatment is directly linked to motivation and you can have all the nets there, all the mechanisms, all the sign posts but if somebody doesn't want to get treatment or they are not going to complete their treatment then that is the reality of it. I think there will come a time when all the systems are in place, we're getting there, perhaps not getting everyone. But you see young people, they dabble with drugs when they're 16 and it's not until they get into their 20s that they get to a point or a significant event will happen or they've just had enough, when they turn round and say: "I think I'm ready for this" and it doesn't matter how many times they say they want treatment, the custody nurse is there to help. You need not to lose sight of the fact that this [agreeing to drug

> treatment] comes down to the individual (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

Currently the policy focus on drug use is treatment and this was considered to be important by most interviewees but one officer did suggest:

> that you shouldn't put all your eggs in one basket, I don't think treatment is the only answer. I mean we've discussed this long and hard—there were three aspects, education, enforcement and treatment and no one is more important than the others. My own view is if we could get into children in schools more consistently and deliver a more consistent message, not only drugs, but things like teenage pregnancies and alcohol and all those sort of issues then that would have a knock-on effect, albeit that it is a fairly long strategy. Enforcement is important because if you don't have people out there, if there's no deterrent then they keep taking drugs and there will be suppliers and then treatment is important as well, all of this is important (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

5.3.3 Estonia

The methadone programmes in the community impact on the non-availability of methadone in police detention. In Estonia methadone treatment is linked to psychiatric services and methadone is seen as suitable for 'hapless cases', in other words, a high threshold service. Here the aim of the methadone programme is to finally prepare the client to go onto treatment similar to the Scandinavian models (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn). In addition, the methadone dosage outside of prison is set too low so the clients continue to use other drugs as well. There are 600 methadone places available in Estonia provided by NGOs and some private hospitals. The majority of places are free and only a few charge drug users for their methadone (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn).

There is a joint working group with the prisons and the police about substitution treatment but there is not an easy working practice. In fact, there is 'a conflict of ideology amongst the groups in the criminal justice system. So far we don't feel that there is enough of an emphasis on treatment involved in the methadone programme' (Interview with the Police Board, Tallinn).

According to the chief specialist on HIV/AIDS:

> in the police detention houses there is no provision of methadone. I have had many meetings with the Ministry of the Interior and they argue that due to overcrowding it is not

> possible to give methadone to one prisoner as then all of them will want it. The cost of providing methadone is also a problem. What is needed is possibly a methadone pilot programme to see what the actual implementation problems are. The resistance to methadone provision is strongest at the detention house level. The Ministry of Justice are ready to provide methadone in prison to continue what has been started in the community but when prisoners eventually get to the prison there is in fact nothing to continue! (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn).

The head of Tallinn arrest house did not believe in methadone as he felt it would not stop people from committing crimes. In addition:

> felchers are not allowed to provide methadone. At the moment there are no guidelines about how to provide methadone in practice in the arrest houses, the effects on the person and so on. It seems to me that methadone is exchanging one addiction for another. The police administration doesn't have the appropriate guidelines or laws so we can't provide methadone. Previously some arrestees did receive methadone but this caused problems as suddenly all prisoners started to claim to be drug addicted. Tallinn arrest house has never allowed methadone (Interview with the Head of the Arrest House, Tallinn).

This opposition to providing methadone was echoed by the Training Department of the Police Board:

> methadone is not possible to be started in the arrest houses due to the infrastructure! If you have six people in a cell it is not possible to give methadone to one of them! Regarding the distribution of methadone in arrest houses it is not possible we can't provide the basic services currently and if we give methadone to drug, users those who don't use drugs, in effect, get nothing (Interviews with the Police Board, Tallinn; Interview with Training Department of the Police Board, Tallinn).

Interviews with service providers in the community and with former detainees demonstrated the need for help with withdrawal and continuation of methadone programmes started in the community.

At the arrest house as far as problematic drug users withdrawing then:

> time heals the problem. Drug users are given some pills for withdrawal to reduce the pain provided by the felchers. If there are major problems we send the detainee more quickly to the prison (Interview with the Head of the Arrest House, Tallinn).

According to the head of probation in Tallinn:

> it is the first 48 hours at the arrest house that is the most problematic especially when mothers are arrested and their children need picking up from school and the police don't care about this and this brings out aggression and the lack of methadone escalates this. You need to take into account the length of time that a person will be in the arrest house and so it is difficult to start programmes and the police don't have the resources (Interview with the Head of Probation, Tallinn).

Interviews were carried out with four pre-sentenced prisoners at Tartu prison about the treatment they received for their problematic drug use. All four had been on a methadone programme prior to their arrest. All of the interviewees found withdrawal in police detention difficult:

> I was in police detention for four weeks and had been using drugs for the previous six months. I received no treatment when arrested, not even painkillers. I couldn't sleep and this was a very hard time for me. There was a felcher available but no medicines for withdrawal; some painkillers only but these didn't help (Interview 1, Pre-sentenced prisoner, Tartu Prison).

> I was initially in police detention for four days. Some people stay for five to six months. I was using drugs and then on the methadone programme for the last two years and when I was arrested I got nothing [for withdrawal] nor could my family bring in my methadone. I did get some painkillers but they didn't really help (Interview 2, Pre-sentenced prisoner, Tartu Prison).

Previously in some police houses it was possible for the family to bring in methadone for the person arrested if they were receiving methadone in the community but this is not possible now.

Arrestees do not stay in police houses all the time but can go to prison and then back to the arrest house to go to court:

> I was arrested and then taken to prison and then back to the arrest house and the treatment I was having in the prison stopped when I went back to the arrest house. I was on methadone prior to arrest and this treatment in the prison was to help me to come of drugs and I was able to talk with a psychologist to help me. The arrest houses needs to improve medical treatment to the standards of the modern age including continuing methadone treatment (Interview 2, Pre-sentenced prisoner, Tartu Prison).

Interruption of methadone programmes can lead to a return to drug use as one interviewee said:

> I am no longer sure whether I will go back on the methadone programme after release as I did want to stop using drugs but not to experience withdrawal from the methadone again (Interview 2, Pre-sentenced prisoner, Tartu Prison).

All the prisoners interviewed considered the drug treatment provided by the prison as being better than that received while in the police arrest houses:

> I got no detoxification at the arrest house but I got a reducing dose of methadone here in prison for about 3 weeks and now I get some pills. The treatment here is better than nothing (Interview 4, Pre-sentenced prisoner, Tartu Prison).

Although the Prison department is ready to provide methadone treatment in the prison not all prison staff considered this to be necessary:

> …there were very few if any drugs in the prison. If they started methadone in the prison this would be an extra burden on health care staff (Interview with the Health Care Staff, Tartu Prison).

The psychiatrist at Tartu prison felt that:

> The key problem for me is that I have too much work and I only work part time. The prison has a 12 in-patient unit that I am in charge of as well as the rest of the prison population. Patients in the in-patient unit come from the arrest house with alcoholism and others with psychosis. From my perspective the arrest houses appear bad as they don't have medical personnel and they don't provide medication. Prisoners in the prison when they go to court can be out of the prison for one month and during this time the treatment stops (Interview with the Psychiatrist, Tartu Prison).

If the arrestee is an alcoholic they are taken to the psychiatric hospital or if delirium starts the police take them to Tartu prison while they go through cold turkey. This co-operation with the police works. There have been a lot of alcoholic cases recently. In Tartu prisons there are two or three cases of alcoholics per month and one or two cases of wounds requiring attention per month from the arrest house (not police inflicted)(Interview with the Head Nurse at Tartu Prison).

The psychiatrist at Tartu prison said that when she was working in the community with drug addicts on some occasions she would start withdrawal with those who knew when they were going to prison. She keeps links with some community drug services in Tallinn where there is a specialist psychiatric clinic and she is in contact with them. She felt that the provision of drug treatment was a problem both inside and out of the prison (Interview with the Psychiatrist, Tartu Prison).

5.3.4 Germany[101]

Substitution treatment in Germany (with some regional differences) is available in police detention if the detainee provides their own supply in which case the methadone can be administered by healthcare staff. If the detainee's supply of methadone is not enough to cover the time spent in detention, officers will revert to other medication to alleviate the symptoms of withdrawal.

One person in the focus group had been in police detention approximately 20 times. In the discussion about his experiences in police detention he talked about there being no access to substitution treatment (methadone) and no access to health care like tending to his wounds. Sometimes his substitution treatment was interrupted for 1–2 days. Although in some cases the police (criminal investigation department: in German, Kriminalpolizei) would let him take methadone (sometimes they allowed him to get methadone tablets from his home) (Focus Group, In-patient Drug Rehabilitation Centre, Northern Germany 2005).

Several members of the focus group said in many cases they urgently needed a doctor but no medical care was provided. The reason given for not supplying medical care (including the provision of methadone) by police officers was that they would have a medical examination when they got to the remand prison. The focus group made a key point that when they were arrested at the weekends even if they were taken to the remand prison quickly the doctor in the community was not available to confirm that they were receiving substitution treatment. In this situation the detainee may not have their methadone for sometimes up to 3 days. And if finally methadone (or any other substitution medication like buprenorphine) was prescribed by the prison medical staff either it wasn't the correct dose or it was only available for a few days, before detoxification was started (Focus Group, In-patient Drug Rehabilitation Centre, Northern Germany 2005). Another member of the focus group said that as there is no supply of methadone in police arrest, generally detoxification in the remand prison was 'cold turkey'.

Discussion with former detainees about withdrawal suggested that after some delay detainees do get help with withdrawal:

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101 The research in Germany took place in three cities for the following reasons: Bremen was chosen, because it is the location of the Institute for Drug Research where the German partner worked and where the structure of the authorities, drug programmes and so on was already known to the researchers. Stuttgart was chosen, because the central sobering up unit there is seen as an exceptional model; Hamburg was chosen, because they have partly abolished a similar model, but are still different from the usual standard of German cities, where sobering up – like it is the case in Bremen – happens in detention cells at police stations. The three cities thus have been chosen due to differences with respect to sobering up as one of the two core themes of the study.

> I told them how bad I felt, that I had soiled myself, because of withdrawal. When the doctor saw me in prison he immediately realised my situation and he gave, I think, 6 millilitres of methadone to me. Then it was okay. I asked whether I could get something for sleeping as well, but the doctor said I should be glad to have received methadone for now. He made a methadone-supported withdrawal with me, reducing from 6 to 0 millilitres. When this was over I got Diazepam for calming me down and something to help me sleep.
>
> I really think it is a human right's violation that no doctor takes care of us after being arrested. One could die in a police cell. You can do nothing, you are locked in the cell. They told me to drink a cup of warm tea. I told them that tea doesn't help against symptoms of withdrawal. The doctor in prison then asked me why I did not come to see him earlier. I told him that I had no keys for the cell, and that he should ask his colleagues from police detention. I know these are self-made sufferings because of using drugs, but I think they should help us anyway. And don't we pay our health insurance for that? As soon as we go to prison they do not care anymore, they think we are trash.

The lack of understanding that police have about drug use was raised by the focus group in the women's prison in Bremen:

> I know they have doctors there [in police detention] that they can call. They are not present around the clock in police detention, and they do not call them if someone suffers from slight withdrawal symptoms. But if withdrawal gets really bad, they will call a doctor. They can see it, if someone is dizzy or feels really bad. Some police officers are educated to realise the difference but there are also policemen, who have no idea about these things. They do not know how someone, who is withdrawing, looks.

The situation for detainees who are not on a registered methadone programme can be problematic as explained by a doctor from ZAE (a police detention unit for sobering up) in Stuttgart:

> …really difficult are situations with, for example, the two women who arrived at ZAE this evening. Neither of them was in a methadone programme officially, but they are both addicted to heroin and to methadone as well. They will not be accepted in the methadone programme, because they have co-consumption of heroin. One woman was very quiet, she was neither shivering nor sweating. She still had enough [drugs], she was taken to the cell, and will be observed there. But in the morning when these two women wake up they will be withdrawing. They will get Diazepam to bridge the time a

> little, this is what they said they wanted until they will be released in the morning.

A further question was asked whether the help given to those not on methadone programmes while in police detention when they start to withdraw could be started even earlier before they start suffering from withdrawal symptoms. The reply was as follows:

> then they would have to have a doctor there or a system, where a paramedic controls what happens after a prescription from a doctor. They also would need a certain amount of medicine in stock. This does not only apply to drug users, but also to high blood pressure, diabetes and so on. These are things that have to be treated quickly. This obviously does work somehow, and it could work in a similar way with respect to withdrawal. Therefore, they would also have to have some methadone with them. But this is obviously not the case, and this is why they use codeine.

A key finding in Germany was the practice of detention for sobering up with respect to users of alcohol. An interviewee in Bremen was very negative about his treatment in police detention where he was taken to sober up. Another interviewee in Stuttgart thought that being in hospital was better as opposed to police detention. Many of the other people interviewed with problematic alcohol use said the same; from their perspective hospital in principle is associated with care, help and cleanliness. Police detention usually is not perceived in such a way.

In Stuttgart, former detainees of ZAE also said that they realised there were class differences regarding the question of where sobering up takes place. One interviewee, living in a transitional home for the homeless in Stuttgart, for example said:

> a short time after my release from police detention for sobering up I realised that some people who were drunk were taken to hospital. While I was sent away from the hospital despite having some injuries, others were allowed to stay at Katharinen hospital, where the conditions are much better. It was probably because they had more money, although my health insurance would have paid for the treatment. It was unfair that they sent me to police detention instead.

In most German cities police detention is the usual place for sobering up. A doctor from the ‘Doctoral service for preservation of evidence’ in Bremen was interviewed. This service is called to police detention if the arrestee does not have special psychological problems. He explained his work as follows:

> cases in connection with alcohol happen more often at police stations [than in the detention centre], where they are typically brought for sobering up in a cell. With respect to this, there are two kinds of situations, in which I would be called: one is that

> they are so totally drunk and the police are worried if the state they are in could be life threatening – then one has to really do a medical check. If the detainee is unresponsive then according to my opinion a police cell is the wrong place for him to stay. He could suffer from alcoholic poisoning that sometimes ends in death. I would transfer him to hospital immediately. Another situation would be that someone in the cell who is under the influence of alcohol, but the blood alcohol is reduced, and because of this he starts to behave oddly. In this case, the question arises how long this person has to stay in the cell. It would be possible to release him before delirium starts so that he can organise some alcohol for himself.

Interviews with those with problematic alcohol use who had been in police detention in Bremen felt that the police had neglected their duties to take care of their health, many of them also said that they had been intentionally and actively ill-treated by the police.

The two special sobering up centres in Germany, ZAE in Stuttgart and ZAB in Hamburg were included in the research. ZAE is part of the general police detention centre, and the central place for cases of sobering up for the whole city. This means that, there are no other places for sobering up at police stations in the city in addition to ZAE. According to a doctor working at ZAE the:

> people who come to ZAE are under the strong influence of alcohol, they do not come voluntarily, and all of them have problems with alcohol. I check whether someone is responsive and whether they are cooperative. It is often the case that they co-operate, sometimes they are unapproachable or even aggressive. Then it becomes difficult without them telling us about their situation. Then we have to do a physical examination, check vital functions, we have to check their orientation, time and person, whether their pupils react and so on. If they unresponsive we must send them to hospital for surveillance of their vital functions.

From the interviews that were conducted with former detainees of ZAE a few typical themes are discussed; the first group of former detainees while accepting being in detention for sobering up but who were critical of some aspects of the conditions:

> I was in detention when I was drunk after drinking one bottle of spirits and being aggressive in public, being crazy, chatting up people. Then the police took me to ZAE. In the cell I felt a little alone, at the time I didn't known about the CCTV system. This time I was in a single cell, but I also know the cell for more people, I have been there at other times. I remember going crazy, using my fists and knees to bang against the door of the cell all the time. I remember shouting "you fucking little

> green men [meaning creatures from a different planet in German, at the same time hinting at the green uniforms of the police], you should all be sent to the moon". I apologized for that in the morning when I was sober.
>
> I remember that I wanted to get out of the cell but, nevertheless, it was right to keep me there at that time. People who are drunk and don't know what they do should be incarcerated until they are sober again.

This interviewee also described how passers-by called the police, which is a typical way to get taken to ZAE; on this occasion he suffered from the consequences of using heroine, not alcohol, when detained:

> on that day I had bought some drugs, heroine and cocaine, I went to a field where I gave myself a bang [heroine]. Afterwards I didn't know what day it was. I couldn't walk anymore, I knew the police would come. They treated me like a criminal, and they had fun with it. They have to be hard to stand their job. There are exceptions, some of them can be nice, but some of them are gloating, perceiving you as someone of minor value, they talk big and have their malicious pleasure. On the other hand, I somehow understand them, because they are spat at and things like that all the time by one of the detainees.
>
> I can not tell you anything positive about ZAE, I was in a cell for four men. One of them I almost thought was dead. Out of the other two, one was a junkie, the other one suffered from cirrhosis of the liver. They banged against the door all night. I couldn't sleep at all. And for this I should pay 168 Euro. This, of course, I won't do.

Hamburg is the second biggest city in Germany after Berlin with around 1,700,000 registered inhabitants. More than 30 years ago they had introduced an institution with a concept similar to this of today's ZAE in Stuttgart. The "Zentralambulanz für Betrunkene" (ZAB) now only opens in the evening and does not have a resident doctor but makes use of paramedics.

The existence of the ZAE and ZAB sobering up centres, according to service providers in the two cities, has not dramatically changed the attitudes of the police to a more health-orientated perspective towards those detained.

Concerns have been raised about the use of emetics (medication to induce vomiting) in some German police forces. This strategy is targeted at those detainees suspected of transporting drugs inside their body in order to enable officers to proceed with their investigation by getting the drugs out. In other countries, police officers monitor such cases to look for signs of drugs escaping into the body and simply wait for detainees to expel the drug through natural means. The use of, and the concerns about, emetics raises serious issues around

human rights and has led to several fatalities as a result this practice has now stopped in most of the German 'Länder'.

5.3.5 Hungary

The maximum time in detention in Hungary is 72 hours but can be 30 days with a court order (see section 3.5.2 for more details). There are no doctors or healthcare staff based in police stations, they are called out as needed and will administer pain killers or tranquillisers as necessary for detainees with problematic drug users. The police do not see this as an important part of detaining offenders, therefore do not offer other services such as condoms, as this is for healthcare workers, and for serious problems, detainees are taken to hospital, or to the Forensic Psychiatric Hospital (Staff, Drug Prevention Foundation, Harm Reduction Services, Budapest).

One of the key problems for detainees is that they do not get medication to help with withdrawal symptoms, or not a high enough dosage. Also detainees have reported problems with the attitude of police officers, ranging from being ignored, verbally abuse and humiliated and even physical abused.

The length of time in police detention was considered to be too short for health intervention or prevention programmes:

> also the circumstances and physical environment of police stations makes it difficult to offer support and treatment, it is just not the right place. However, it would be better for drug users to have a maximum of 72 hours, so they have the chance to seek help, or they should be in prison where treatment is available (Chief Officer, Police detention centre, Budapest).

During the three days in custody, the forensic medical expert will refer serious withdrawal cases to the Forensic Psychiatric hospital, in accordance with the national strategy (2000), which presented guidelines from the medical profession for the police, when dealing with those detainees with problematic drug use (Forensic medical expert, Police detention centre, Budapest).

The chief officer at Miskolc Police Department thought that:

> for those detainees undergoing treatment, it is important to identify this quickly, such as methadone programmes so this can be continued – but outside the police station, escorted by police officers. However, these cases are very rare, maybe one or two a month. It could be helpful if service providers came to the station, but currently this is not happening. There is a security risk with this, but if it is more cost effective, methadone in police stations should be considered (Chief Officer, Miskolc Police Department, Budapest).

Other police officers interviewed were not so positive as they considered that it was not possible to give methadone in detention. This was contested by a doctor from the methadone clinic who argued that the time in police arrest was long enough to address problems as, in some cases people were kept up to 30 days in police detention, and there is no reason why they can't continue methadone during police detention. Currently, there is no official strategy for prisons or police regarding continuation of methadone there are some exceptional cases where detainees have been transported by the police to get their methadone prescription (Doctor, Methadone Clinic, Budapest).

Approximately 20% of arrestees on the methadone programme have their treatment disrupted when they are arrested. Some detainees are released on time to get their methadone prescription but some are kept in detention too long and end up missing appointments and their methadone dose. It would be helpful if the police informed the methadone clinic that one of their patients had been arrested but often they do not (Doctor, Methadone Clinic, Budapest). Currently, there is nothing official in place for dealing with the police-only guidelines on providing medical data for prosecution case and sentencing (under the Drug Prevention Act) (Doctor, Methadone Clinic, Budapest).

The detainee perspective on medication provided for those with problematic drug use and for those on the methadone programme was generally negative:

> I was on the methadone programme prior to being arrested. In the detention centre I was given tranquillisers, but they do not alleviate the symptoms of pain and trembling. I was unable to sleep at night and the guards don't allow you to sleep during the day. I was given no medication from Friday when I was arrested until the following Monday (Detainee, Budapest Police Detention Centre).

> I need to get back out to get my methadone. I run my own business and was rebuilding my life when I was arrested and the police have not informed the doctor at the methadone clinic, so I am worried about being released and missing out on my prescription. I am really concerned as I know that I could be kept here for 30 days and, if this happens, I will loose business as well as the methadone programme (Detainee, Budapest Police Detention Centre).

> pain killers and tranquilisers are provided for those with problematic drug use but for heavy users, who are often the ones committing crime to fund use, this is not enough. There is no methadone or other opiate substitution treatment. The painkillers are not enough to cope with a headache or toothache let alone withdrawal (Detainees in NEP centre, Budapest).

> showers are only available once a week, in pre-trial arrest house; three times if you have a medical reason. So your own

> hygiene is bad and withdrawal gives you the sweats (Detainees in Needle Exchange Project, Budapest).

The serious cases are transferred to the Forensic Psychiatric Hospital, where drug users get more drugs. On the whole, those detained in the Forensic Psychiatric Hospital felt the treatment and support they received was much better than that in police detention but the conditions in the hospital were poor and, because of this, staff turnover was high, there was a lack of activities and a need for hot water in the rooms (Detainees, Forensic Psychiatric Hospital, Budapest). Staff at the Forensic Psychiatric Hospital agreed with the detainees comments but they have limited funds and the building is in a poor state and the hospital really needs to be relocated (Staff, Forensic Psychiatric Hospital, Budapest).

Younger drug users are not allowed to go on the methadone programme, even though there is a need for this especially among the 16–17 year olds. They can only be offered detoxification or rehabilitation (Doctor, Methadone Clinic, Budapest).

Among drug users, about 50% also have problematic alcohol use, many use it occasionally. Therefore, treatment services need to address this and will often cease treatment if a client turns up drunk (Doctor, Methadone Clinic, Budapest).

The police also identified difficulties with managing withdrawal symptoms of alcohol users, which may need referral to hospital. Alcohol users tend to be the ones with psychiatric problems as well (Chief Officer, Miskolc Police Department, Budapest). The National Institute for Neurology and Psychiatry has the expertise to deal with co-morbidity as there are psychologists on the staff and they have both a methadone programmes and more specialist care (Doctor, Methadone Clinic, Budapest).

Problematic alcohol use was identified as a major problem:

> Hungary's population is 10 million and 1 million have alcohol dependency, so this is a bigger problem than drug use, but there are 700,000 drug users, and yet alcohol is not considered an important issue by the government (Director, Forensic Psychiatric Hospital, Budapest).

Problematic alcohol use, on a national level is higher than drug use, which brings problems for the police as it leads to aggressive behaviour (Chief Officer, Miskolc Police Department, Budapest). There are no special guidelines for dealing with alcohol withdrawal 'only my training as a doctor and experience determine how to deal with this, for example what medication to use for the shakes, fluid to prevent de-hydration and so on' (Forensic medical expert, Police detention centre, Budapest).

5.3.6 Italy

If a detained person has a drug problem requiring treatment an ambulance will be called. The decision to call an ambulance is made by the head of the police station where the person is detained. It was felt that there was now a more sympathetic attitude towards those with problematic drug or alcohol use with the police seeing it as an illness (Officials from the police health department, Ministry of the Interior, Rome).

On the whole, the people interviewed with problematic drug use on the whole considered there to be no help with withdrawal while in police detention:

> I stayed very quiet because I was afraid that they could leave me in police detention for a long time. I know that if you go to prison they give you some therapy, but they do not give you anything while you are in police detention (Interview 2: Female prisoner, San Vittore Prison Milano).
>
> in police detention you don't have any treatment if you are a drug addict. They don't care. I've seen people vomiting and having pain from abstinence, but nobody did anything (Interview 1: Female prisoner, San Vittore Prison Milano).
>
> the conditions in police detention are very bad. I was withdrawing but nobody cared. I vomited, and I didn't know how to clean it up as there was nothing so the smell was terrible. I just stayed on the bed, my legs were hurting me. I was glad to go to prison, because I knew I'd have some therapy and there are always other prisoners that can help you if you feel sick. In police detention nobody can help, because nobody has anything (Interview 4: Female prisoner, San Vittore Prison Milano).
>
> as a drug user you are not offered medical care as they want you to be withdrawing prior to being interviewed and they say things like 'give us a name and all will change' [i.e. they will be given something for their withdrawal or released] (Focus group at therapeutic community, Padova).
>
> I had taken heroin and a police car stopped me, handcuffed and searched me and they found my knife. They kept me for a bit in the car as usual. Then they took me to a police station where I was alone in the cell. I had no problems at first until withdrawal started and then they started to interview me at 9.00pm and released me at midday. No help was given by the police with withdrawal as it is easier for them to question you in this state (Focus group at therapeutic community, Padova).

The focus group held at Villa Maraini were more positive about the treatment by the police:

> on the whole the police are more sympathetic to drug users now whereas before they would take advantage of problematic drug users' drug cravings to get a confession. How the police treat you depends on how you behave, the police will also take you to SERT for treatment (Focus group at Villa Maraini, Rome).

This group of drug users may be more positive about their experience in police detention due to the work that is done by Villa Maraini in police stations in Rome. Villa Maraini is the only NGO in Italy which isable to prescribe methadone. They work in all Rome police stations although this is not underpinned by any protocol or agreement; the police are not obliged to allow them into the police stations. However, they do as it works to their advantage because, after receiving therapy, the drug users are easier to manage (Interview with staff at Villa Maraini, Rome). Staff from Villa Maraini wear the Red Cross uniform and this increases their acceptability to the police. Staff from Villa Maraini were asked about their relationship with the police, which they described as good and they also said that officers would bring problematic drug users to them, especially those from outside the EU. This is also the case for users who have overdosed and are found in the street. The police inspectors interviewed had heard about Villa Maraini but they had little knowledge of its services and, therefore, felt that it would be useful to receive leaflets from them, detailing what they did and services that could be offered. This also seemed to be the case among ministerial and healthcare representatives, who were aware of this organisation and their links with Rome police stations.

Those interviewees who were in contact with SERT felt that it would be helpful if workers from SERT visited them while they were in the police cells in the same way that SERT worked with those in prison (Focus group at therapeutic community, Padova). Some of the focus group thought that being in police detention was an opportunity for SERT to suggest treatment that was available in the community such as therapeutic communities or methadone programmes. Two members of the focus group were on a methadone programme provided by SERT. Although both of these members of the focus group considered that the SERT sometimes gives too much methadone:

> I am given 120 mgs of methadone and this is a very high level and doses are easy to get. For me 70 mgs is enough so I could sell the rest as I didn't need it (Focus group at therapeutic community, Padova).

> in Padova it is easy to get high doses and sell it and then use heroin, but these high levels of methadone have reduced overdoses from 20 per year to 1 per year (Focus group at therapeutic community, Padova).

> I was on methadone for 13 years before coming here [to the community]. Many people take methadone for all their lives. I am taking 5mgs of methadone and buprenorphine for short periods (Focus group at therapeutic community, Padova).

These three people provide good examples of how treatment can help people to control their drug use and remove them from having to commit crime to sustain their use and protect people from overdose.

Two police officers who were interviewed thought that it was difficult to do anything for drug users in police detention during the times when SERT were closed. Drug use was identified as a problem in the local area (Interviews with 2 police officers, Rome).

The SERT in Milan that is based at the court offers an alternative to prison for problematic drug users and has initiated good cooperation with the police and the courts. The police bring the arrestee to the SERT based in the court after the initial 24–48 hours in police custody and after the police have charged the drug user but before they see the judge. The arrested person comes to the SERT and an assessment is made about a suitable drug-treatment programme and the judge can decide to use this option without the arrested person having to go to prison first (depending on the crime and danger assessment of the arrestee). This option is only available to those who have committed small crimes with a maximum sentence of 10 years. In one year, 1,400 people have come through the SERT and about 400 per year have had a programme to go to a closed community and about 90% finished the programme. This is much higher than those who voluntarily go to such a programme as many do not keep to the treatment (Interview with the SERT based in the Court, Milan).

The SERT based in the Milan Court works with 80 judges and 'some of them don't know about our existence so there is a constant process of educating the judges. We have had to go to look for the problematic drug users in court but now often the police bring prisoners straight to the SERT as they know us well' (Interview with the SERT based in the Court, Milan). Arrestees do not have to have been in contact with the SERT previously to use the service. If migrants are known to the SERT then they can benefit from the service provided. There are so many migrants and they are often small drug dealers, because of this, and having no documents, the SERT can often do nothing for them. SERT have very good relations with the defence as they provide written reports for the court. They also work with alcoholics and those with psychiatric problems, that is, dual diagnosis:

> after the interview with the detainee there is a lot of work to follow the judicial outcomes with lawyers and to deal with the formal paperwork. Some therapeutic communities accept those with alcohol problems as alcohol and cocaine often go together. We have made good relationships with communities in order to make quick referrals (Interview with the SERT based in the Court, Milan).

In Italy, SERT provide continuity of drug treatment from the community to prison but the treatment is broken at the time of arrest as detainees (apart from the Villa Maraini initiative in Rome) are not able to continue with their methadone programme (MacDonald 2005).

5.3.7 Lithuania

In Lithuania, police officers argued that they were not expected to provide treatment (for example, pain relief or substitution treatment) to detainees. Officers primarily viewed their role as one of law enforcement and felt the healthcare needs of detainees were met by doctors or nurses called to the station, or through community or prison services that users would access on release.

This view was echoed by an interviewee at the Ministry of Interior:

> generally the police station is a stressful place where it is difficult to be concerned about anything but security and control and basic health of detainees, i.e. referring them to help. This may work if the detainee wants helps and wants to cease drug use; but even then in such a short time the police can only point them in the right direction. Also, for those needing psychological support, this should be referred to the relevant hospital and not done in detention, this is not the right place and they [the police] have limited time (Deputy Chief, Ministry of Interior – Health Department, Vilnius).

In addition, this interviewee made the point that:

> criminal justice agencies and the health service cannot work alone to address problems of drug use and crime, we need 'active communities' to help with social and health issues. If these structures are not in place in the community, then the police cannot refer detainees to services. This also affects funding and working together, and sometime there are problems in establishing who is responsible. For example primary healthcare is managed by the local municipality but funded centrally. Therefore we can only 'symbolically' initiate programmes if the funding is not available (Deputy Chief (Dr), Ministry of Interior, Health Department, Vilnius).

There were no protocols to make referrals to treatment services for detainees and any such service would be dependent on the officers' discretion and knowledge of local services. Police detention was seen as a time when there is a gap in treatment services and thus it is considered to be important to have healthcare professionals in place to care for detainees (Ministry of Interior, Public Health Division, Vilnius). The Chief Officer at the Police Commissariat in Vilnius considered it to be:

> important that social services and educators also take on their responsibility, the police have too many other function, to address all problems in society. These needs [of detainees] have to be considered and discussed at the strategy level to determine which Ministry is responsible. For example, under the 'Safer Cities' initiative police officers were given extra

> resources and pay to work with social services, especially child care centres, to develop prevention programmes.

Former detainees thought that the police could do more to help some drug users:

> the police should get more involved in drug services, it might make them more understanding, many have been doing their job so long they have lost all sensitivity, they treat us like mud (Former Detainees Focus Group, AIDS Centre, Vilnius).

> drug users already know more about where to get help than the police, only new users could benefit from the police helping them in this way. If they intervened early on, this could help some people (Former Detainee, Drug Dependency Clinic, Vilnius).

The major cities in Lithuania have methadone maintenance programmes and centres and day-care facilities to help dependent users and many projects carried out by NGOs have received government support. Methadone is not available to those in police detention and there tends to be a negative attitude towards methadone treatment amongst professionals and some drug users:

> many see choosing methadone as not being a serious attempt by drug users to change their lifestyle and, in fact, as a way to get free drugs. In addition, among young people on methadone, there is evidence that they still offend and use other drugs and the programmes are not always well regulated; that is, do not have regular drug testing (Probation staff, Vilnius).

Former detainees were ambiguous about methadone programmes:

> It is difficult to access methadone programmes if you are not registered in a certain town, or if you are not considered a high risk. It has helped me previously but then it stopped after 3 months: that was the end of the programme (Former Detainees, Demetra Care Centre, Vilnius).

Staff from the Drug Dependency clinic argued that methadone is seen as the last resort for many people with problematic drug use and they will only use methadone if they cannot get heroin. This is partly due to withdrawal being worse from methadone and because the dose provided in the methadone programme is too low, but ‘we do see that it [methadone] reduces crime and health problems for some users’. According to a former detainee interviewed:

> methadone is not always the best way to stop using drugs, but it maintains users’ health as it reduces the number of injections and you are less likely to use impure heroin or amphetamine. The problem is the withdrawal symptoms are worse so you need to make sure you have enough to keep you going, and the police [at arrest] can disrupt this so when you are released you are more desperate, if the clinic is closed, you will take

> anything (Focus Group, Former Detainees, Residential Clinic, Vilnius).

Links with NGOs are limited and it is the forensic doctors and nurses who are mostly responsible for detainees, they mostly administer primary care. However:

> they could participate more in treatment programmes for users, but at the moment most are focused on prevention and abstinence, but they could be more active in relation to harm reduction and rehabilitation. The network of NGOs needs to be expanded to care for drug users' needs – health and social assistance, and to work with the police (Staff, Drug Control Department, Vilnius).

According to interviewees at the Ministry of the Interior:

> making the links with NGOs is in development and money is being put in place to do this, but it is important to make sure the NGOs have the right expertise. At the moment, the police work with the Drug Control Department in Vilnius to refer users but there is no national strategy for this. The responsibility should be with the Ministry of Justice, not NGOs (Chief Officer, Police Commissariat, Ministry of Interior).

A major problem highlighted by the probation service is that most of the NGOs work with young people who use drugs, but they have problems as they are not state funded, so good projects end (Probation staff, Vilnius). Although there are services available for drug users, many are provided through NGOS, and there is a lack of control and some places are very expensive and not an option for many users.

The Demetra Care Centre was highlighted by former detainees as being a place where practical help, medicine, gynaecological checks and being able to see a psychologist was possible as without the centre they would have to pay for state healthcare (Detainees, Demetra Care Centre, Vilnius). As one former detainee said:

> if you are not registered [for health insurance] you need places like Demetra, most of us do not have insurance, so you cannot get onto treatment programmes (Former Detainees, Demetra Care Centre, Vilnius).

Former detainees also praised the services offered by the AIDS Centre and Linus, a NGO residential treatment Centre in Vilnius:

> this place is the only one offering practical help and you feel secure when you come here (Detainees, AIDS Centre, Vilnius).

Staff from the AIDS Centre added:

> users feel safe here, so they treat us well. Human rights violations are seen as normal by them, they don't understand

> they should not be treated like this. Here we create an atmosphere of trust; users come for help and just to talk, to be away from hostility. They get healthcare, many are very good at understanding their needs, and problems that come up (Staff, AIDS Centre, Vilnius).

Former detainees interviewed at Linus Residential Treatment Centre said:

> that the problem is that there are so few community places [for drug treatment] and most are short term for only 3 months, which is not enough time. Here at the centre the programme is for 12–14 months, and it is fulltime residential, you cannot go home unless you have earned the right. You need to understand what you have done is wrong and that you must avoid the circle of friends that got you into using drugs (Focus Group – Detainees, Residential Treatment Clinic, Vilnius).

Alcohol seems to be a bigger problem and a lot of the police work is focused on dealing with drink driving. It is also not clear as to which ministry is responsible for funding the alcohol strategy: the health system or the police. This depends on whether problematic alcohol use is seen as illegal activity or as a public health problem (Ministry of Interior, Public Health Division, Vilnius).

Alcohol users are seen as more problematic for health professionals, as many are older, career criminals, and the withdrawal time can be dangerous for them. They can be aggressive, and because of age, not open to change. If symptoms are not recognised they can suffer brain damage, if medical help is not called for (Deputy Chief, Ministry of Interior, Health Department, Vilnius).

Alcoholism is very widespread, compared to drug use, and there is no mandatory treatment for alcohol use, which makes it difficult to address this problem unless the user wants to stop drinking (Chief Officer, Police Commissariat, Vilnius).

At the time of the research there were no standardised treatment protocols for alcoholism but the Public Health Department has legislation planned to develop standards of care for treating problematic alcohol users including psychiatric help, which will also apply to drug use. A case management principle is considered as the most appropriate way to deal with all the problems, such as drug use in addition to alcohol use, health problems and social problems (Ministry of Health, Person's Health, Vilnius).

5.3.8 Romania

At the time of the research substitution treatment (methadone) was not available in prisons or police detention and only limited availability in the community.

According to the chief of the medical service for the police there is no methadone in police detention as the police provide primary care and not long-term care. They provide no continuing treatment of any kind for detainees. When a drug user is arrested the police immediately notify the psychiatrist of the problem who then decides the treatment required. The police have their own psychiatrists (Chief of the Medical Service for the Police, Bucharest).

When a detainee requires detoxification the police medical staff:

> make the decision to send prisoners to Rahova prison hospital. They send us about 6-8 drug users per month depending on the number of drug users in police detention. I [one of the doctors] suspect that it is those who have the most serious problems of drug addiction that are sent to the prison hospital by the police. After detoxification the prisoner is returned to police detention or back to prison. The time that they stay here at the hospital for detoxification is 14–21 days (Prison Healthcare staff, Rahova Prison Hospital, Bucharest).

For those detainees with problematic drug use the experience of withdrawal was difficult:

> I got nothing in police detention when I was arrested and I was a heavy drug user. I have been on detoxification a few times. I was supposed to receive care but all I was given was some pills in the evening. For the first 3 days I was knocked out and not examined by a doctor or a nurse – they told others [drug users] in there to put them under the shower! This was 3 years ago but it is still the same now (Focus group, ColibaŞi Prison Hospital).

> in police detention they give you [drug users] sedatives only and one man was taken to hospital and was told he was just pretending. His family had to pay for him to get treatment and to get the prescription. The conditions are inhuman and disastrous one person was withdrawing and they threw water over them. In Bucharest drug users are sent to withdraw under ground in one particular remand house with only diazepam. County police detention was ok, better than Bucharest. There is no psychological help (Focus group, Giurgiu Prison).

Many detainees stay from one week to 6 months in police detention. In police detention detainees have to go through withdrawal from drugs (heroin/cocaine/pills) and if the detainee was on the methadone programme in the community this will stop in police detention. In order to provide continuity of drug therapy in particular methadone substitution ‘there needs to be a clear short time in police detention and then either the person is free or goes to a remand prison’ (Spanish Accession Counsellor, Bucharest Prison).

In future, according to ANA (Anti Drugs Agency) there will be no gaps between community, police detention and prison as methadone programmes

will operate in all detention sites. All people with problematic drug use who are on a methadone programme will be recorded by ANA and if they are arrested then the ANA centre will manage their methadone substitution. Those on methadone programmes will have a card enabling them to continue their methadone programme. Those arrestees with problematic drug use will have detoxification provided by the Ministry of Health (ANA, Director, Bucharest).

Romanian prisons are considered now to be ready to implement methadone programmes:

> in 2000-1 the prison administration started to think about the drug problems. Things have improved, there is now a legal framework about drugs in prison and there will be methadone provision. It is important for all prison doctors to be able to prescribe methadone for the future. Prisons now have a better social support system. The prison service now has the understanding and awareness of the problems and the need for methadone (Spanish Accession Counsellor, Bucharest Prison).

Prison staff interviewed were also very positive about the future availability of methadone in prisons:

> we are determined to implement methadone but we are waiting for the legal framework and money from the Ministry of Health or for a change of legislation to allow the Ministry of Justice to provide methadone. We are ready to start the training for all medical staff. At first the general doctors may be a bit apprehensive about providing the methadone but this depends on the quality of the training that they receive (Head of health Care, Rahova Prison, Bucharest).

Health care staff at Colibash Prison Hospital were less enthusiastic about the implementation of methadone maintenance treatment but at the time of the interview they had not received training about this:

> the law is imposing methadone maintenance on us and we have received the lab kit but not yet had the methadone training. It will happen but we are not sure exactly when. The Ministry of Health does not relate or co-operate with the Ministry of Justice and this may be a problem in providing methadone maintenance (Health Care Staff, Colibash Hospital).

The future seamless provision of methadone maintenance will be under the direction of ANA. The assessment to include a prisoner on the programme will include a worker from ANA as ANA has centres in all regions. Methadone provision in the community will be via these centres. The continuity of a drug users' methadone treatment will depend on the ANA assessment centres where:

> the police should notify ANA and they will provide a 'case manager' for the detainee and once referred to prison they will be monitored by the same case manger if they stay in the

> county or if they go to prison in a different county the prison will have to notify the local ANA when they are transferred. If there is good cooperation with ANA we will be able to provide a continuous system of treatment. At the moment probation is not involved but they are only starting and are understaffed and not working across all the Romanian counties (Head of Health Care Rahova Prison, Bucharest).

The NGO ARAS pointed out that there are, as discussed above, existing action plans and strategies for the provision of methadone but that implementation is not happening. Another interviewee said:

> we are not able to implement the methadone programme due to the current situation about the control of methadone in Romania: no liquid methadone is available in Romania. I don't know the reason why although there have been negotiations at the highest governmental level (Doctor, Hospital No. 9, Bucharest).

A representative from ANA thought that the lack of cooperation from the Ministry of Health in implementing the methadone programme may be due to their loss of power where in future they will be responsible for detoxification while the drug agency ANA will control the methadone programme.

5.3.9 Summary

Doctors from the emergency service in some participating countries (Bulgaria, Italy, Lithuania, Hungary) are used in the assessment of both drug addiction and alcoholism and for providing help with withdrawal. The doctors from the emergency service will administer pain killers or tranquillisers as necessary for detainees with problematic drug use. The Forensic Medical Service (England and Wales, Germany) will provide assistance with withdrawal for detainees. In Estonia felchers give drug users some pills for withdrawal to reduce the pain. In Romania the police use the prison hospital in Bucharest to provide help with withdrawal for some detainees. However, detainees from most of the participating countries complained that often they received no help with withdrawal while in police custody.

Methadone was available to some degree in the community in all of the participating countries. Only in England and Wales and Germany (if the detainee provides their own supply) was methadone available in police custody (but not in all police stations). Detainees who are on the methadone programme in the community with ID cards can have their methadone brought to the police station by their families in Bulgaria and this also used to be possible in Estonia. In Italy in Rome an NGO visits detainees with problematic drug use and will provide methadone. The general experience of those detainees who are on a methadone programme in the community, in the majority of the participating countries, is disruption of their methadone when they are arrested due to the

lack of liaison between community, police and prisons exacerbated by prisons and the police usually being under different Ministries.

Detainees with problematic alcohol use was identified as a key problem as there were a lack of services for alcoholism both in police detention and in the community. A key finding in Germany was the practice of using police detention for sobering up with respect to users of alcohol. Alcohol users were also identified to be the ones with psychiatric problems as well in most of the participating countries

5.4 Access to healthcare in police detention

Access to health care was on the whole less available in police detention than in the prison systems of the sample countries. The availability of health care was different in those countries where the police had arrest houses (detention centres) under the control of the Ministry of the Interior than those where detainees went directly to pre-sentenced prisons under the control of the Ministry of Justice.

5.4.1 Bulgaria

When arrested, the detainee writes a request to say that he/she needs medical treatment, then the police will call the emergency services. In the police station they have a book where they write that the detainee is a drug user. If the doctor is called they will write in this book that, for example, the drug user is undergoing withdrawal (Interview with Head of Police Station No. IV, Varna, March 2006).

If the detainee is considered to be under the influence of drugs and thus not responsible for their actions the inspectors wait until they ‘come down’ or take them to hospital where they are examined. According to the regional prosecutor all drug users under the influence of drugs are taken to hospital. In his experience pre-sentenced prisoners received medical help and they continue to use drugs while waiting for the sentence or trial (Interview, Regional Prosecutor, Varna March 2006).

During the first 24 hours in police detention the detainee can make a written request to see a doctor, their lawyer or parents. According to one interviewee, police officers often ignore these requests. ‘The police don’t always phone our relatives as they want to get you to the remand centres as soon as possible’ (Focus Group with experience of Police detention, Varna, March 2006).

The police make use of the emergency health service that is availability Monday to Thursday 24 hours per day and on Friday and Saturday night. Prisoners have a right to see a doctor. The police officer on shift decides whether to call for a doctor or not,

> as the police don't have the necessary training they call all the time for the emergency service (Interview with a doctor working with emergency service, Varna March 2005).

One doctor from the emergency service who was interviewed considered that he had a good relationship with the police in three of the five police stations in Varna. He felt that it would be better if there were specialised doctors with one doctor for two police stations. It is always a doctor from the emergency service who goes to the police cells, never a nurse. He considered the relationship between the police and the arrested was acceptable: if they need medical attention the police call the emergency service (Interview with a doctor working with emergency service, Varna March 2005). Another interviewed doctor said that:

> the conditions in the police cells are not good, and they only call the emergency services sometimes. Police have a bad impression about those with problematic drug use. I tell the arrestees that I meet about treatment and I give them contact numbers and I think this is a good way to meet hard-to-reach problematic drug users (Interview with Doctor working with police to provide Drug Assessments, Varna March 2005).

An Inspector interviewed said that conditions in remand houses were not good as:

> there is no possibility for exercise outside and the detainees are locked up for the majority of the day. In addition some Bulgarians want to be kept separately from Roma prisoners and it can be difficult to do this. For those detainees in the remand centre that I am dealing with I buy cigarettes and soap as hygiene equipment is not available (Interview, Inspector, Varna March 2006).

Health care in the remand houses is provided by a felcher who are similar to paramedics and are able to prescribe some medicines. According to one member of the focus group in essence, there was no medical care in the remand houses:

> there is a felcher in the remand houses but no real medical care as they don't pay attention to what you say. You are treated like animals and if your mother or family takes things for you to the remand centre you don't get them (Focus Group with experience of Police detention, Varna, March 2006).

When a doctor is called to see a detainee:

> there is always a guard in the room during the consultation. I hope to improve this situation when there is more money to provide a medical consultation room. If the doctor writes something in the book after he has seen the detainee then, yes, all discussions with the doctor are made known. We do this as

> prevention to protect the staff if, for example, the detainee is HIV-positive. External people can't read this book and we only give the book to the prosecutor if they demand it (Interview with the Head of Police Station, Varna, March 2006).

A doctor from the emergency service agreed that this practice breaks confidentiality in a way as, in the book, the detainee's treatment is written and all the officers in the police station can read it (Interview with a doctor working with emergency service, Varna March 2005). This interviewee went on to say that many of the police officers are not educated and many of them treat HIV-positive detainees in a different way (Interview with Head of Police Station, Varna, March 2006).

It is important that the police are informed about HIV and hepatitis as, in Bulgaria, 70–80% of IDUS are hepatitis C positive and there is a programme to treat hepatitis C provided in the hospital in Varna. If the IDUs show that they have been drug free for six months then they can access treatment for hepatitis. In Sofia those on the methadone programme can have hepatitis C treatment (Doctor working with PDUs and provide Drug Assessments, Varna March 2005). In Varna bout 60–70% of the clients on the methadone programme are hepatitis C positive. They cannot access treatment for hepatitis C through the health insurance system until they have been drug free for six months and there is also a long waiting list so sometimes it is impossible for them to access treatment. Due to this the Director of he Methadone programme would like to be able to include hepatitis C treatment in the methadone programme in the future (Director of the Methadone Programme, Varna March 2005).

5.4.2 England and Wales

There are various models of health care provision for detainees in police custody with about half of the police forces who have outsourced their forensic services while the other half use GPs. The cost of the service to the police varies according to the provider but on average it is more expensive than the old system but all administration is included in the cost [NB as the number of detainees increases the cost drops per visit]. The police pay an annual fee to the provider. According to one interviewee:

> prior to the outsourcing of forensic medical services the standards of health care in police stations were archaic, where, up until recently for example, drugs were kept at police stations and expiry dates etc. were not clear as the GPs were not responsible for the 'stock control' of the drugs (Forensic Medical Services Manager, Essex, UK).

At the time of the research the providers of forensic services to the police were not regulated by the NHS or the Health Care Commission but this is expected to change.

Also in England, custody nurses are based in a few police stations to assess and treat the healthcare needs of detainees: this is a relatively new initiative being piloted in the UK. Custody nurses were considered to be a useful initiative both for the detainee and the police:

> custody nurses are a very good idea. We need medical assistance for a high percentage of detainees as many are drug users and they help the police investigation and ensure that all procedures are carried out correctly if the health of detainees is assured. Custody officers can at best make an educated guess about the health requirements of detainees, but we are not medically trained (Custody Sergeant, Inner City Police Station, UK).

The custody nurses interviewed argued that they provided a wider coverage of health care as they provide 24-hour cover every day of the year. The custody nurse manager interviewed made the following additional point:

> probably one benefit of custody nurses that never really gets measured, is the support the service gives to custody staff, because previously they were responsible for the health and welfare of every detainee in custody and often the sergeants' were in that role with very little health care training. So they were essentially looking after the most vulnerable group of people you could find under one roof so you had essentially the main person looking after this group on their own and the fact that somebody else came along and said well I'll do that bit for you, certainly helped morale and support (Custody Nurse Manager, UK).

The medical notes written by the visiting doctor are confidential and are kept securely in the custody suites. The records are only released on written consent from the detainee. However, some information from the notes will be released as detainees are told that their notes are not totally confidential and they are asked to sign a form provided by the Association of Forensic medicine showing that they are aware of this. According to a forensic Medical Services Manager:

> if a detainee was HIV- or Hepatitis-positive, in theory, the police would not know this but in practice the detention officers sit in on the doctor patient consultation and this is seen as normal practice in some forces. I think this is wrong. I will provide the police with any information if it is forensically relevant or if it is related to the case or if it is necessary for the care of the individual, i.e. diabetes. There is no reason to tell the police if the detainee is HIV-positive. The police should be trained about how to deal with body fluid spillages. If the HIV-positive individual requires medication, with the consent of the individual, he may divulge this information. The police officers are not on the whole well trained about HIV and the risks and

> are on the whole ignorant and have little knowledge of HIV or hepatitis (Forensic Medical Services Manager, Essex, UK).

Detainee confidentiality can be compromised due to a lack of facilities:

> the facilities for the medical examination vary; the room is usually too small and can often have the staff toilet in it so staff are coming in and out [impacts on confidentiality] or the computer and be the base for the arrest referral drug workers. In newer buildings conditions are usually better (Forensic Medical Services Manager).

A custody nurse manager felt that knowledge and understanding of HIV was limited not just amongst the police but more widely:

> police staff say what's the risk if you have a needle stick injury and every officer in this force will tell you that their biggest fear is HIV when its not at all, it's Hepatitis C and they are more likely to get it, it's easier to catch. The amount of people that have ever contracted HIV from a needle is absolutely miniscule. But I think you know that within this police organisation we do have to try and educate officers but I do also think it's a national problem, even across health I don't know why Hepatitis C has never managed to push HIV off the beacon sight that it seems to have got itself on (Custody nurse manager).

5.4.3 Estonia

The provision of health care for detainees in police custody relies heavily on the emergency services and the prison service health care. Felchers are used in the police detention houses and initial medical screening is done by the felchers (Interview with the Head of the Arrest House, Tallinn). The police board provides no training for the felchers, rather it is up to the police prefectures to provide this training if they see it as appropriate (Interview with Training Department of the Police Board, Tallinn). Another potential problem is that while the:

> arrest houses should have felchers, the medical schools are no longer training felchers so when the current felchers retire then there will be a greater lack of health care provided in arrest houses (Interview with the Head Nurse at Tartu Prison).

The law stipulates that the police must organise for new prisoners to have a TB X-ray within 10 days after arrest but according to professionals interviewed they do not do this and it is in fact done by the prisons. The reason why the police don't provide the X-ray is because of the cost. It is also common for prisoners to complain about the health care they received while in police

detention (Interview Head of Prison Health Care, Tallinn; Head Nurse, Tartu Prison).

Treatment is not generally offered in the arrest houses; if it is needed an ambulance is called for or the arrestee is sent to the psychiatric hospital:

> we have some painkillers and sleeping pills available here. If necessary we will inject the pain killers and sleeping drugs (diazepam). There is no methadone available but we will consult with the psychiatric clinic about their patients (Interview Felcher, Tallinn Arrest House).

The reason given for the lack of health care available in the arrest houses was due to a limited budget:

> we have some budget for medicines but if we have a health problem like epilepsy or diabetes we send the arrestee to the prison as soon as possible. We have good co-operation with the prison and they will give prisoners one months supply of their medication if they think they need it when they return to the arrest house and if this runs out then we go to the community hospital to get the required medication. The problem is that the prisons and the police are in different ministries with different budgets! If we have to send someone to hospital it is a problem to provide the necessary escorts and it is also expensive to do this. It used to be better before they closed the prison hospital (Interview with the Head of the Arrest House, Tallinn).

It is not just the lack of medication that is problematic but in some instances the health of prisoners with chronic diseases such as epilepsy worsen during police detention:

> the arrest houses lack medical personnel and only offer first aid and they will call the emergency services if there is an emergency. If prisoners have chronic disease such as diabetes then the relatives can bring in their medication. What the arrest houses need are some medically educated staff, for example, nurses to manage basic mental health problems and to provide some medication (Head Nurse, Tartu Prison).

A big problem for the prison health care is that police detention is under another ministry. This is especially a problem in the case of the provision of ARV treatment:

> when a prisoner goes from the prison back to the police houses we send two week's ARV treatment with them. There have been some cases when HIV treatment has stopped in the arrest houses. However, it is not possible to do this [send medication] with other treatments as it is impossible to monitor where the prisoners are (Interview with the Head Nurse at Tartu Prison;

> Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn).

There is no connection with the police and the prison department on a strategic level about these issues of continuation of treatment. This lack of co-operation also results in other situations such as the following:

> if a prisoner in the arrest house needs an operation they [the police] try to send them to the prison first so that we have to pay for the operation out of our budget (Interview with the Head Nurse at Tartu Prison).

It is important that HIV treatment continues at the point of arrest, in police detention, in prison and when the detainee returns again to police detention. ARV treatment is available to all Estonians regardless of having health insurance as HIV treatment is not linked to health insurance cover (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn). The prevelance of HIV was high in 2001 and has been going down every year since but the rate is the same as 2005 this year and the virus is becoming more sexually transmitted with more than 50% of new cases being sexually transmitted to partners of IDUs (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn).

Providing HIV treatment is not considered a problem in the prison system. At Tartu prison 12 prisoners were receiving this treatment as of 13/12/2006. In the prison there is a total of 140 HIV-positive prisoners. The prison has this number because they have an HIV specialist working in the prison (Head Nurse, Tartu Prison). In addition those prisoners who are HIV-positive are tested for hepatitis A, B and C. Prisoners who are at the prison for one year or more receive the hepatitis B vaccination. At the moment there is no treatment for hepatitis C available but next year there will be a programme funded by Roche for hepatitis C treatment (Head Nurse at Tartu Prison).

Providing treatment is more problematic in police arrest houses but providing HIV treatment is easier according to one felcher:

> when detainees say that they are HIV-positive we can get medicines for this from the community hospital or the family can bring it in. This is quite new – providing HIV treatment (Interview with the Felcher, Tallinn Arrest House).

One prisoner interviewed said that he was receiving HIV treatment while in prison but when he went to court and stayed in the arrest house at Narva they didn't give him any treatment and his immune system went down while he was there. The prison gives some medicine to take with him but they don't know how long he will be in the arrest house. He told the felcher in the arrest house and 'she could have called the prison and they would have sent more medicine but they just don't do it' (Interview 3: Pre-sentenced prisoner, Tartu Prison).

The Head of Tallinn arrest house said that the staff were trained to take precautions assuming that all arrestees may be HIV-positive. Ongoing training

is provided for the staff and some courses are available on hepatitis, HIV and tuberculosis. Staff can attend these courses voluntarily or be required to attend. However, there are some problems due to staff shortages to release staff to go on the training (Interview with the Head of the Arrest House, Tallinn).

5.4.4 Germany

The medical or health service for people in police detention in Bremen (not the unit for deportees) is carried out by the "medical proof securing service" (in the German: ärztlicher Beweissicherungsdienst), which provides a 24-hour service. In each of the cities included in the study, hospital is one possible place for sobering up as an alternative to being taken to police detention. If an ambulance comes to the scene, drunken people are quite often transported to hospital for sobering up in German cities. The criterion for accepting alcoholics at the hospital is that their life functions are endangered. It was not possibly to learn much more about the way in which the decision was made to take drunken people to hospital rather than to police detention. Interviews with the ambulance service suggested that if the person who was drunk became violent then they would more likely be taken to police detention.

A shift commander of a police detention unit in Stuttgart was asked about hospital as an alternative to remaining in police detention if someone is without health insurance and does not receive social welfare benefits:

> the hospital will always accept him, although I don't know who will pay for it. But luckily we do not yet have a situation like in the United States where someone who is not able to pay will be sent away.

Being sent to the hospital to sober up was perceived by all of the former detainees interviewed as a much better than remaining in police detention:

> I have been [in the hospital] several times [to sober up] because of seizures, but I always run away after two or three days. Although the nurses were so very nice and helpful to me. They did everything they could, but as soon as I got money I got drunk.

The same interviewee was very negative about the way he was treated by the police (in Bremen). Other detainees interviewed also said their treatment in police detention was poor and that provided by the hospital being much better.

The police have an internal electronic 'information system' where information about detainees are kept. Also detainees' HIV/AIDS or Hepatitis status is noted on this system. Interviews with former detainees gave rise to a range of negative experiences regarding accessing health care while in detention:

> I asked for a doctor. In this case all they said was that I would go to prison soon, and could see a doctor there. It is different

> how long this takes. If you arrive in the evening after 6 or 7 pm you usually have to wait until the next day to see the doctor. If you make noise and complain they [the police] threaten you, saying they could also use the isolation cell.
>
> if I told the Criminal Investigation Police I felt bad, that I took this and that, that I was not able to be processed as they wanted, they threatened me with violence. Not that they stood there using a bludgeon or something, but they communicate it in a way you can understand, like telling you they will call a colleague for help. It is more important to them to measure your height and to get finger prints than to call a doctor.
>
> it often takes a very long time until they come [the police] after we rang the bell. Anything could have happened to us; but they probably think we just want another coke and let us wait.
>
> They don't care. All they say is that we have to wait until prison. In prison then you get the first chance for conversation about health problems. They ask about HIV, drug addiction etc. All of this didn't apply to me at the time. No heroin, no methadone, I had had a detoxification, I have been clean for four weeks from then, but the problem is that I started drinking afterwards. Therefore, I told them that I needed pills to help me with symptoms of withdrawal, e.g. Diazepam. They said they would not give Diazepam to me, because I had been addicted to drugs.

The doctor from the forensic service was asked whether he saw himself as working for the authorities or the doctor for the detainee as his patient:

> first of all I still see the detainee as my patient. I know that I also do a favour for the police officers as well, because otherwise the detainee will use the call button every five minutes, because he needs something.

Most detainees had access to a doctor while in police custody and where needed detainees were transferred to a hospital within a reasonable timeframe. The CPT report recommended that designated qualified health care staff should be identified in police detention establishments. The report highlighted some concerns regarding detainee confidentiality, for example medical examinations were carried out in the presence of a police officer and in another example:

> that for a number of detained persons, a note had been added to the custody register indicating that the person concerned was infected with Hepatitis C, HIV or tuberculosis. It appeared that this data was accessible to all police establishments, which were connected with the Criminal Data Service (KDD) of the Federal Criminal Agency (BKA) in Wiesbaden. This state of affairs is also not acceptable in terms of medical confidentiality (CPT, December 2000, Section II A, Sub section 3, point 46).

This lack of confidentiality is of concern as many problematic drug users may be HCV or HIV positive and identification of their health status could lead to discrimination. The CPT also raised the management of drug-related issues in prison in their report. It was noted that in one establishment that was visited the scale of drug abuse had significantly increased in recent years, which indicates that many drug users are being arrested and will experience police detention as the first point of contact with the criminal justice system, prior to being sent to prison, and who will require a range of drug services at this time.

It is obviously the police, who will be the first to decide about involvement of a doctor if someone is in police detention. If police officers realise a need for medical care or advice about the (in) ability to undergo detention in a certain case they, typically, have two options. The head of the detention centre in Bremen described this as follows (but it in principle it also applies to detention at police stations):

> we will always call the doctor service for preserving evidence (ärztlicher Beweissicherungsdienst) from the Bremen Institute of Forensic Medicine if we see any health problems with a detainee. If a problem is of a psychological kind we would call the psychiatric crisis intervention service (at night, Krisendienst) or local social psychiatric service (Sozialpsychiatrischer Dienst) during the daytime. We will then decide together with them whether a forced institutionalisation to a psychiatric clinic is required. This happens very rarely. We wouldn't call them in connection with drugs.

One former detainee in Germany felt that the police were not well informed about communicable diseases:

> the first thing the police asked me when they knew I was addicted to drugs was, whether I had any infectious diseases like HIV/AIDS. I said yes, I am HIV-positive. It was clear to me that they did not ask this because they wanted to help me in any way but because they were afraid of me scratching them or something like that. I was kept in a separate room, it was a room like a shower room. They told me these were rooms for isolation that can be disinfected after I leave. And this is complete nonsense. I could not infect someone by just being in a cell; if this was true I should not even be allowed to walk on the streets. It is just discrimination, nothing else. A professional approach towards preventing transmissible diseases to spread would be different.

5.4.5 Hungary

There is a problem with recruitment of all healthcare staff in detention centres as the money and conditions are not as good as in the community and 'you are dealing with very vulnerable people. The ratio is 1 psychologist to 100 inmates, so they have very short consultations in addition many nurses are moving to other EU countries, like Sweden' (Staff, Forensic Psychiatric Hospital, Budapest).

The level of health care provided is different in each district of Budapest as there are no national standards in place. Problems in providing health care can be more acute in rural areas where 24-hour health care is not usually available (Chief Officer, Police detention centre, Budapest). In Budapest there is a 24-hour medical service for detainees and 'those with problematic drug use are observed carefully for signs of illness, withdrawal etc. The doctor will be called out as necessary, if the detainee is still having withdrawal symptoms after three days they will be referred to the Forensic Psychiatric Hospital' (Chief Officer, Police detention centre, Budapest). Guidelines for the police regarding problematic drug users were formulated by medical staff in accordance with the National Drug strategy in 2000 (Forensic medical expert, Police detention centre, Budapest).

Medical records are accessed by healthcare staff only, police officers only have access to general information such as gender, or if the detainee has used drugs. There is no screening for HIV or Hepatitis, so this is only disclosed by the detainee, or their symptoms may become apparent, which must be treated (Head of Medical Department, Miskolc Police Department, Budapest).

Any details recorded by healthcare staff are kept by them and transferred with detainees to prisons or into the community: police officers are only informed if they have to administer medicine (Chief Officer, Police detention centre, Budapest). It was not explored with interviewees whether, in reality, detainee confidentiality was breached.

In Hungary, HIV testing is free, but Hepatitis B or C requires a referral, which the Needle Exchange Clinic can provide for drug users by taking them to hospital to get tested. There is concern about Hepatitis B and C being a bigger problem than HIV among drug users in Hungary. Staff interviewed also felt that there are many injecting users with hepatitis and some HIV, but also TB and syphilis, who are severely affected by the time they spend in police detention (Staff, Needle Exchange Clinic, Budapest).

5.4.6 Italy

In Italy, as detainees spend a short time at the police station there is not a developed health care service for detainees. There are doctors and nurses employed by the Ministry of the Interior but their role is to work with the staff

(to monitor whether staff are ill and so on) and very rarely would they visit an arrestee (Interview with State Police, Padova; Officials form the police health department, Ministry of the Interior, Rome).

Members of the focus group felt that the availability of health care in police detention was very limited:

> you don't get medical care while in the police station. There isn't a doctor there. A man who had diabetes shared my cell for a few hours and they didn't give him anything, and when he felt sick, they had to take him to the hospital (Interviewee 2, Female Prisoner, San Vittore Prison Milano).

> while you are in police detention you don't have any care. I have psychiatric problems, I regularly see a psychiatrist, and I felt very bad when they took me to police station, but nobody cared (Interviewee 3, Female prisoner, San Vittore Prison Milano).

> I was in police detention for about one day, from morning to evening. I was not arrested for drug crimes. I'm HIV-positive, but I'm not a drug addict. The place is very bad, small and I was there alone. I was sick, I'm on therapy with anticoagulant agents, and I have skin lesions on my feet, but nobody cared about it. They didn't give me anything, no water, no food, no therapy. I asked many times for a doctor. In the end they took me to the hospital, where I had blood tests and medicine, and from there I was sent to prison. It was a very bad experience and I wouldn't like to do it again. I think you need to change everything in police detention (Interview 5: Female prisoner, San Vittore Prison Milano).

The discussion about confidentiality was not fruitful for the research, as the view of the interviewees was, for example, that those with problematic drug use would want to tell them that they were HIV-positive as they then would receive benefits from the judge. In theory, only the lawyer and the judge would know but this is not the case in reality (Officials from the police health department, Ministry of the Interior, Rome). When a detainee is moved to prison the police do not provide medical information but:

> sometimes a medical file will come with the detainee if a medical doctor visited the person in police detention but this is often lost. The health and drug history of the detainee is diagnosed during the first medical when they see the doctor at entry to the prison. The detainee only stays for 48 to 72 hours with the police. More co-operation would be useful between the prison and the police but the police need medical doctors themselves as they don't have a dedicated medical service. There are medical doctors who for legal reasons visit crime scenes but they do not visit arrestees. The police decide

> whether a person is able to be interviewed or not (SERT Doctor working in prison, Italy).

Arestees do not receive any medication for HIV while in the police station, and they are usually only there less than 24 hours. According to one doctor at San Vittore prison, as soon as a detainee gets to prison he would take the word of the prisoner. If prisoners say that they are receiving HIV treatment then the doctor would give it to them (Interview with Doctor of Central Clinic, San Vittore Prison).

5.4.7 Lithuania

The Ministry of Health is responsible for providing healthcare services in the 46 detention centres, through 24 medical points. There are guidelines for the standards of care and hygiene and services provided. Only major police stations have direct services, as this is not possible in smaller stations, due to economic constraints, as a result there is an agreement with public health to provide services to police stations (Deputy Chief, Ministry of Interior, Health Department, Vilnius).

The Person's Health Department (Ministry of Health) deals with the medical care of detainees within the police and corrections houses, particularly in line with human rights legislation. Working with this group includes those with mental health problems, drug addiction and other diseases, who need medical help and psychiatric support. The interviewee argued that the budget allocated by insurance payments for this group is too low, especially now that there are more clients young people.

Those interviewed with experience of police detention were negative about the health care that they had received:

> in detention you face many problems but you cannot get help; in fact the police cause the problems, or they don't believe you. If you ask for help they beat you, most detainees are too fearful to ask for medical help (Detainee interviewee with experience of detention, Drug Dependency Clinic, Vilnius).

> the police will wait until symptoms are bad, until they recognise them before they call the Doctor. The police only act correctly if they have a visitor coming, especially when the visitor is from another country (Detainees, AIDS Centre, Vilnius).

Staff from the AIDS Centre argued that what was needed was a 'wider healthcare service not just for those who pay insurance, especially for our clients who have multiple needs and the problems are increasing. We cannot just erase this issue, it will get worse if we do not help them' (Staff, AIDS Centre, Vilnius). A Social worker from the Drug Dependency Clinic stressed that:

> many medical staff in the community do not know how to work with HIV-positive people, for example, they leave medication outside the door! This is even more difficult among the police (Social worker, Drug Dependency Clinic, Vilnius).
>
> I had an epileptic fit while in the cell, but there was no call for the ambulance or the doctor and the police officers said I was pretending to be ill (Detainees, Demetra Care Centre, Vilnius).

All information about a patient should be confidential under Ministry of Health legislation, which lists who can access this and in what circumstances, and all of this applies to the police. Medical records in police detention are managed by healthcare staff according to patients' rights under Ministry of Health guidelines. For referrals, police staff may access medical records to ensure they are transferred properly to ensure the continuing process of care; but the records must remain sealed. Also police officers in the detention block are informed by medical staff if they need to observe detainees diagnosed with mental health problems or who are at risk of suicide. Patients/detainees can give permission for their medical records to be accessed and they can also approach the Ministry if their rights are breached (Ministry of Health, Person's Health Department, Vilnius). When confidentiality is breached this:

> …highlights a training issue as the legislation is there but often in practice, the police do not follow this and this maybe due to ignorance, not abuse of power. Codes ensuring confidentiality should be initiated by the police, they need to be better aware of medical ethics (Ministry of Health, Person's Health Department, Vilnius).

5.4.8 Romania

There are 26 precincts in Bucharest and out of the 26, 12 have detention houses. There are 296 cells across the 12 precincts. Outside Bucharest, the detention centres are located in the local regional/county police headquarters. In theory there is 24-hour healthcare and nurses available to meet the needs of those detained.

The rules governing police detention are largely the same as prisons. Prior to 1981 they had the same rules but in 1991 the prisons were handed over to the Ministry of Justice. The rules taken from Ministry of Interior say that it is mandatory that detainees have a medical within 24 hours including blood samples and x-rays. At arrest, detainees are visited by the doctor within 24 hours. During the 24 hours the detainee is assessed whether they are drug users or alcoholics. If they are drug users and the police see needle marks the detainee is handed over to the treatment centre or national institute for psychiatry for detoxification. In Bucharest there is one doctor and three nurses for the care of detainees. The chief of the police medical service said that:

> the police doctors decide what treatment is required and this is not a problem as 24-hour medical service is provided.

It appears to be a very heavy workload for this one doctor and three nurses to see all new detainees within 24 hours in Bucharest. However, the police also use the emergency health services when required. For the counties it is proposed that there should be three nurses in the detention houses (Chief of the Medical Service for the Police, Bucharest).

In the police houses there is a special place for medical examinations. The detainee may be alone with the doctor or sometimes not and 'we try to do this but sometimes security comes first' (Chief of the Medical Service for the Police, Bucharest). Detainees' medical records are kept confidential as only the doctor or other health care specialists will see them. The detainees' notes go to the prison with him or her and only the prison doctors would have access to them (Chief of the Medical Service for the Police, Bucharest).

5.4.9 Summary

There were various models of health care provision for detainees in police custody such as a dedicated forensic service (England and Wales, Germany); provision by the Ministry of Health (Lithuania and Hungary); reliance on emergency service at police stations (Italy, Estonia, Bulgaria) and provision by the Ministry of Interior (Romania). In the police remand houses health care is provided by felchers (Bulgaria and Estonia) and normally treatment is not offered. A lack of consistent provision in all police stations and in remand houses was raised in the participating countries, in particular the difference in health care provision in urban and rural settings.

Lack of detainee confidentiality was raised as an issue in some of the participating countries due to a guard being present during the consultation between the detainee and the doctor, confidentiality compromised due to a lack of facilities and a lack of training resulting in police officers feeling they needed to know a detainee's HIV or Hepatitis status.

5.5 Harm reduction and police detention

Generally, police officers in most of the participating countries did not see the provision of harm reduction measures as an important part of their role. It was something users could access in the community or in prisons. Harm reduction was much more likely to occur in relation to occupational safety for officers.

The initiatives developed to address the need of problematic drug and alcohol users in police detention demonstrated the partnership between the police and community healthcare or NGOs providing treatment services. The majority of more innovative approaches to address the needs of problematic drug and

alcohol users in police detention came from NGOs working in partnership with the police (for example, Villa Maraini in Italy) or providing services in the community and promoting harm reduction (for example, the 'I Can Live' organisation and Open Society Fund in Lithuania).

5.5.1 Bulgaria

All the professionals interviewed from the Bulgarian Criminal Justice System felt that there was a need for further training, in particular about harm reduction and drug use:

> every one in this system [CJS] needs training about drugs: the inspectors,[102] police, prosecutors and especially the judges as they make the decision to keep the person in custody. There is a serious lack of training especially for police detention officers as they are the ones who have the first contact with the problematic drug users. They treat drug users like other criminals and ignore the physical condition of the drug user (i.e. withdrawal, etc.). In the last two or three years they [the police] are learning how to treat drug users despite not having had training on drugs or dealing with mental health issues. In reality they have to learn on the job! In the same way inspectors are not provided with guidelines for dealing with drug use – they have to search the Internet themselves for information (Interview, Inspector, Varna March 2006).

From the 1st April, 2007 a new law was enacted, that means the investigation of cases will be done by the police and not inspectors. The inspector interviewed felt that the police are not trained enough to do the work of inspectors and that this will give rise to quite a few misunderstandings. She argued that inspectors have learned from colleagues about dealing with drugs and those with problematical drug use as there is no school to teach them whereas currently the police are just not well trained or experienced in drugs and drug use (Interview, Inspector, Varna March 2006). This inspector also stressed that the conditions in police cells and the remand houses are getting better and the real need now is for training:

> most of my colleagues are younger and they would benefit from this training especially as the job has been restructured: the more education that they have the better it is for their career. I think that most of the inspectors would want to provide harm reduction information to help the problematic drug users. This is very important as most detainees are hepatitis C-positive and they don't tell the staff but then most

102 Inspectors have a legal background and direct the police investigation. They are not part of the police structure.

> of them have not been tested so they may not know. Harm reduction training would be good for police officers and for those detainees who are sex workers and for the Roma community. The inspectors are well placed to be in a position to give this information [harm reduction] (Interview, Inspector, Varna March 2006).

The regional prosecutor in Varna who was interviewed also stressed the importance of national training about drugs and problematic drug use to prevent unnecessary arrests for minor drug use:

> yes, there is a need for training in the areas of drug use and harm reduction for all personnel. The police department don't have the necessary experience about drug users and they only want to resolve the crime and don't think about all the circumstances. In some other cities some stupid cases would be accepted for possession of five cigarettes containing marijuana but this would not happen here in Varna where there is a better understanding about drugs (Interview, Regional Prosecutor, Varna March 2006).

Training has been provided for a limited number of police in Varna and this was considered to be crucial because:

> the police have little information about how to search drug users, for example, they do not use protective gloves and are unaware of the risk caused by infected needles. They [the police] don't know how to deal with people exhibiting aggressive behaviour due to stimulant use or where to get the information about how to deal with this. They don't know how to deal with overdose or the appropriate medical services required. Felchers in the remand houses have some medical knowledge but it is unlikely that they understand drugs (Interview, Doctor from Centre for Drug Prevention, Varna, March 2006).

This lack of knowledge about protecting themselves during searches is exacerbated by the police not being issued with safety gloves but they 'buy them sometimes with their own money' (Interview with Head of Police Station No. IV, Varna, March 2006).

A problem identified by the head of one police station was that the police do not have the training to be able to recognise if a detainee is a drug user or not:

> sometimes the police are scared that those with problematic drug use pretend to be sick so that the emergency services will be called and drug users can manipulate this situation (Interview with Head of Police Station No. IV, Varna, March 2006).

During the six-months basic residential training at the police academy there is some training about drugs provided by the specialised drug unit. There is no other training about drugs or harm reduction provided (Interview with Head of Police Station No. IV, Varna, March 2006).

As discussed previously the police remand houses have now come under the control of the Prison Administration and training to change the attitude of staff working in the remand centres is considered to be crucial:

> the attitude of inspectors [in the investigation] before the change [from Ministry of Interior to Ministry of Justice] was to weaken prisoners and make them more susceptible to the investigation. Whereas now the idea is that those detained should receive some kind of treatment as they are not yet sentenced and shouldn't be treated worse than any other prisoners (Interview Official at the Prison Department, Varna).

Since the changeover many changes have started to be implemented and the need for training has been highlighted:

> it is crucial to carefully select and train staff about how to treat the prisoners in the remand centres. Each year between 40–60 staff from remand centres receive training. A lot of staff were sacked for bad behaviour who were previously working in the remand houses. In the remand house in Sofia almost 80% of the staff are new. It is a major problem to deal with these remand centres. Integrating them into the prison system is still a problem and the problems are increasing because we also want to integrate probation with the police but probation want to be separate from the police. Regionally, the remand centres are administered by the Ministry of the Interior. The regional administrations will build some new remand houses. The worst remand centres have been closed, some have been refurbished and some have been rebuilt (Interview Official at the Prison Department, Varna).

5.5.2 England and Wales

Some police forces provide harm reduction training provided by a range of different organisations. Interviewees from the police were on the whole very positive about harm reduction both for their own practice and in provision for detainees.

Generally knowledge about harm reduction was good amongst police officers who were interviewed:

> I have had harm reduction training and we have gloves and all searches must be carried out using them, we have clear instructions to use thicker mitts in case of needles; personally I

> am aware of the risk of communicable diseases and younger police officers are now more aware of the need for harm reduction. In the 1990s, officers were more naïve and very scared about blood spills (Police custody officer, Inner City Police Station).

Some police officers had a wider understanding about the importance of harm reduction:

> harm reduction is important as policing is about the safety of the community, to reduce harms to them and as police officers serving the community so our job is not just about preventing and detecting crime. I am well briefed about how to deal with health and safety issues and as a risk assessor, I am aware of the risks within custody suites; officers are very careful in custody suites as they are more aware of the dangers. However, when working on the streets may not have the time to be as careful but officers do wear gloves and have medi-packs (Police custody officer, Inner City Police Station).

One officer suggested that there is more focus on drug users as being a high risk:

> you do need to be vigilant but for most drug users it is unlikely that they would have needles on them and we do ask them to empty their pockets. Warnings come up on ISIS records about violence, communicable diseases, self-harm risk and medical conditions; this is important information as arrestees don't always inform officers about their health. We are not allowed to ask directly if someone is HIV-positive, but rather do they have any medical issues that I should be made aware of, as I am responsible for their welfare and also to ensure that they are fit to be interviewed (Police custody officer, Inner City Police Station).

However, not all police officers are open to the idea of harm reduction:

> I think it's fair to say that, on balance, many officers have been absorbed into police culture, which is about enforcement as the only way to tackle the drugs menace and to reduce and restrict demand and supply and that this is the only way forward and that this does need a culture shift in order for the ideas of harm reduction to be accepted (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

The need for a more holistic approach to the drug problem was stressed:

> training in harm reduction is something that we want to do and I think the time has come for police officers to be trained about the holistic approach of tackling the drug menace because they are very enforcement-focused and understand very little about

> treatment and education issues and the part they play in that. An example of this is police officers recently stopped and searched someone and seized their clean needles, their actual packaged needles and they didn't understand that these people are given clean needles to reduce blood born viruses and disease and by taking these, increases the risk of sharing of needles (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

Probationary police officers are given training about drugs that:

> starts with what you need to think about before conducting a search, what sort of things would make you think about your personal safety and others around you and what things might make you think about risks to the individual if we arrest them, for example, are they going to survive? (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

Different agencies provide the training for the police but this is not always formalised, for example in North Yorkshire this was provided by the Drug Action Team (Forensic Psychologist North Yorkshire Drug Action Team).

One Forensic Medical Services Manager said that harm reduction information was not currently provided by the police or the forensic service he operated but he thought that this is something that they should be building up especially as the police are not currently sufficiently educated in harm reduction to do it (Forensic Medical Services Manager, England).

The provision of harm reduction tools was less evident and perceived as more problematic by some police officers. Arrest referral workers were generally accepted and the process of referring those arrested to drug agencies was perceived as useful:

> there is a need for clear protocols as police culture does not lend itself to individuals taking decisions. However, it is easy to decide to use the arrest referral worker. It is difficult for the police as they don't get positive feedback regarding the outcomes of their referrals (Police Inspector, Forensic Psychologist North Yorkshire Drug Action Team).

Arrest referral workers were also seen as those who would provide harm reduction information:

> harm reduction measures are accessed through arrest referral workers, and it is often just health advice, not needles or substitution treatment-information on who does provide this is given out. Police referral often carries more weight, compared to a GP, as being arrested means they are classed as a 'problematic' user in that their use is affecting others (Police Sergeant, Custody Manager, West Midlands).

It was pointed out by some former detainees that their clean needles were taken from them when they were arrested (reflecting comments above from another force):

> the police take them [clean needles] off you, even clean sealed needles, which defeats the object of being given them, if you are going to be released and they take your clean works [drug injecting equipment] off you, where are you going to get anymore from if it is late at night when you are released? They [the police] should have some clean needles there to replace those they threw away. If you are starting to withdraw when you are released and you have no works then you are at a higher risk of sharing needles (Former Detainee Focus Group, West Midlands).

> it would help to have clean needles when you leave the police station, as they throw those you have away when you are arrested, and if everything is closed when you get released – I don't know what I would do (Former Detainee Focus Group, West Midlands).

The arrest referral workers interviewed said that the concern that some police have about giving clean needles to detainees at the point of release is that they could go out and take drugs and overdose, and it is considered better that they go to needle exchange sites (Arrest Referral Workers, West Midlands Police). However, if the detainee is released later in the evening or at weekends the needle exchange sites will not be open. Some officers are not in favour of needle exchange or replacement:

> needle exchange is a diabolical waste of money, as officers have to remove them and bin them as detainees cannot have any sharp implements in custody; we can't put them in the detainees' property so we have to destroy them. Personally, I have no sympathy for people who use needles for drugs, when you see the state they get into, breaching ASBOs and having to be taken to hospital. I have seen pregnant women taking drugs and in one case the mother was pinching the baby's methadone as it was born an addict. For some, the only medical treatment they get is when arrested, which is a huge drain on resources; you can only offer so much help (Police custody officer, Inner City Police Station, West Midlands Police).

However, some police forces do provide needle replacement schemes:

> in custody suites there are needle replacement schemes but this is not available for those detainees under 18 years. The replacement scheme is available in York and one other area and they want to roll this service out to all the other areas (Police Inspector, Forensic Psychologist North Yorkshire Drug Action Team).

Needle replacement is also available in the Kent Police Force who work closely with KCA Forensic Services. An interviewee suggested the reason this is not available in all forces:

> I think its fair to say that implementation of needle replacement schemes is down to personality and opinion. This is very similar to the debate in prisons about whether clean needles should be provided or not and the same discussion whether it should or shouldn't exist within the police service (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

Arrest referral workers in the West Midlands said that they give detainees with problematic drug use painkillers, but not methadone, when they are released in the evening, they will buy heroin, sometimes they just need money to get home, or to buy food (Arrest Referral Workers, West Midlands Police). One police sergeant thought that:

> providing substitution treatment in police detention for users to administer is problematic due to the risk of double dosing. It is useful to have custody nurses in police stations to properly monitor detainees given substitution treatment. Most are in detention for a relatively short period and painkillers are often sufficient until the detainee is released or sent to prison, where they can access further help as required (Police Sergeant, Custody Manager, West Midlands).

5.5.3 Estonia

The Police Board has been providing harm reduction training in arrest houses over the last five years and there have been 26 training courses with 700 police officers having attended (Interview with Training Department of the Police Board, Tallinn).

In addition to the training provided by the police board the police prefectures also have their own training budget and this training links, to some extent, with that offered by the Police Board (Interview with Training Department of the Police Board, Tallinn).

The Police Board provide training in health and safety for officers that includes information about communicable diseases and work place safety about using gloves for blood spills. There are protective gloves in the arrest houses (Interview with Training Department of the Police Board, Tallinn). There is also a book provided by the police that has a section on drugs and related communicable diseases:

> we have a handbook and, in this book, harm reduction and drugs are covered and each police unit has a copy and it is also available on the intranet. I don't think that all police officers

> are aware about the risk of communicable diseases. We also have a video that comes with the handbook that was made by doctors in Finland, funded by the WHO. The prefectures have their own health specialists and can arrange other trainings regarding occupational safety (Interview with the Police Board, Tallinn).

People with problematic drug use were considered to be a severe problem for the arrest houses:

> in 2003, there were a lot of HIV-positive arrestees and they were kept separate but now nobody knows who is HIV-positive and staff take precautions assuming that all arrestees may be HIV-positive (Interview with the Head of the Arrest House, Tallinn).

The training related to police detention and HIV is provided by the Ministry of Interior. The Police Board is issuing guidelines regarding occupational safety and HIV in the prefectures. The prefectures are also providing gloves but, according to the chief specialist on HIV/AIDS, the gloves are too thin to offer protection against HIV (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn). Some resources have become available as a result of joining the EU for training police officers about HIV (Interview with Training Department of the Police Board, Tallinn).

The Police Board does not provide training for the felchers; it is up to the four prefectures to provide this training if they see it as appropriate (Interview with Training Department of the Police Board, Tallinn).

According to the Chief Specialist on HIV/AIDS, Estonia has received funding, as part of a project for the three Baltic countries, from UNODC for providing harm reduction in prison and in the community. This is a four-year project and a key aim of the project is to put together an action plan for Estonia where consensus is reached amongst service providers about substitution programmes and 'this will involve a major psychological jump for many!' (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn).

It is important that the police arrest houses are involved in the discussions about the provision of methadone as :

> the movement of prisoners from pre-trial prisons to the arrest houses is a result of state policy regarding regional centres and the distance from the courts and pre-trial centres. If there were facilities nearer then the prisoners could go directly from the pre-trial prisons and not be 'stored in the arrest houses' (Interview with the Head of Probation, Tallinn).

This movement between prison and arrest house necessitates cooperation between the two to ensure that substitution programmes and in fact any treatment started in prison can continue in the police arrest houses.

The prisons while not providing methadone programmes do provide other harm reduction tools, for example, condoms are available from the nurses and the guards on the sections. The nurses go to the sections for about three hours each day and they deal with simple problems then. Bleach is not available in the living areas on the sections as the prison staff are afraid that some prisoners would drink it. But one of the prisoners on the section has access to bleach and also the guards have bleach (Head of Prison Health Care).

Information leaflets are available:

> they were first of all put in the waiting room in the health care department but 500 leaflets went in one day (assume to be used for other purposes) and the prison can't afford this so now the leaflets are put on the sections (Interview with the Head Nurse at Tartu Prison).

The head nurse in the prison provides training for all new guards and health issues (including HIV, Hepatitis and TB) takes up one day of the week-long programme (Interview with the Head Nurse at Tartu Prison).

5.5.4 Germany

The attitude of German police to a harm reduction approach is not consistent across all states but in some large cities the police have been actively involved in the development of harm reduction policies and practices. In Hamburg and Frankfurt:

> the police have also developed an approach somewhat similar to the Netherlands in that they do not arrest those found in possession of small quantities of drugs for personal use. However the police sometime put drug users from out of town on buses or trains bound for their hometowns. Of course, the police do arrest those suspected of trafficking in drugs. Weber and Schmidt (1998) state that weekly meetings and good information exchange among all municipal policy-makers, including police, state attorneys, health department, drug policy division, drug user groups, drug user help providers, the business community, and political bodies, contributed to the success of the Frankfurt approach (Public Health Agency of Canada 2003).

However, police practice with problematic drug users at the point of arrest and detention is not clear. The research with both the police and those with problematic drug use suggests that currently few, if any, services are available to them.

The findings from the research indicated that harm reduction was not seen as part of the role of the police for people with either problematic drug or alcohol

use. As the head of one police detention centre described the process when users of illicit drugs are detained:

> there are a few problematic drug users, though not many of those arriving in this police detention centre are addicted to illicit drugs. We know this already when they arrive, because it is in the computer system. If somebody suffers from withdrawal symptoms the rule is that he will tell us. He would say what kind of substance he needs. We rely very much on communication. Of course there are also cases in which we realise ourselves that someone is withdrawing. If one or the other is the case we will call the forensic medical service (ärztlicher Beweissicherungsdienst), who will come and examine the detainee. We will give the medicine to the detainee in accordance with what the doctor has prescribed. The detainee will get what he needs to survive police detention. The only kind of medicine they can get without involvement of a doctor is paracetamol for a headache.

Later in the interview the same interviewee said that he was not aware of what kind of medicine the doctors give to the detainees:

> I would expect that someone who is on a methadone programme would get methadone. But I have no idea, what else they get. You have to keep in mind that they stay here only for a very short time. Depending on the time of arrest it can take 10 or 12 hours, but at latest after 10 or 12 hours they will be released again. If no judge is involved, because we only have to check the identity of someone, he will be released after 1 or 2 hours.

In principle, this head of the detention centre was not against the idea of harm reduction but did not see this as part of his remit. However, the lack of knowledge amongst the police about harm reduction could be problematic and it is them who make the decision as to whether to call the doctor or not. As one doctor commented:

> we only work with detainees if the police request our presence. It is thus them who decides whether a doctor is necessary. I don't know the exact text of the official instruction at the moment, but they are supposed to call a doctor if a detainee is sick. But this rule is interpreted differently in practise. In some cases I get the feeling that some detainees feel so well that I am more or less superfluous, others are in a recognisable state of withdrawal, where it makes sense that we have come.

5.5.5 Hungary

The term 'harm reduction' is not well known in Hungary, or it is perceived as a 'necessary evil', where the ultimate goal must be to stop drug use. A politician described harm reduction as like an 'umbrella after the rain', in that it is not an effective way to address problematic drug use (Staff, Needle Exchange Clinic, Budapest).

According to one chief officer:

> police officers go through theoretical and practical training, with regards to users, such as being aware of the symptoms of use and the effect on detainees' behaviour. Also health and safety information such as when searching detainees the importance to use gloves. This health-related information is integrated in the general training (Chief Officer, Miskolc Police Department, Budapest).

In relation to safety for the officers, searching kits for officers, including gloves, etc. will be available in 2008 (Chief Officer, Police detention centre, Budapest).

The current level of harm reduction training is not seen as enough by some professionals interviewed and more is needed for healthcare staff, particularly in prisons and for those who work with the police, 'as harm reduction for detained persons is both important and possible and Methadone is cheaper than tranquillisers, so the cost cannot be used as an argument' (Doctor, Methadone Clinic, Budapest). According to one doctor:

> The police are aware of harm reduction measures and generally open to the idea – as long as you can convince the management, then it is carried out, as there is still a militaristic culture in the police force and prison system, so front line staff will 'follow orders' (Doctor, Methadone Clinic, Budapest).

The police interviewed did not think that it was possible to give methadone in the 72-hour period of detention, and that:

> detainees must be released to get their methadone, as is done for some prisoners. The time is too short and the conditions in police custody are not right (Chief Officer, Police detention centre, Budapest).

The doctor at the methadone clinic in Budapest thought that it was relatively easy to convince prison medical staff of the need to provide methadone but, as it is not solely their decision, these initiatives can often come to a halt. This is especially the case if the management see detoxification measures as effective; even though they are expensive and, often, users relapse. (Doctor, Methadone Clinic, Budapest).

The methadone clinic in Budapest provides their clients with ID cards saying that they are part of the programme:

> if you have the right ID card, the police will not take the needles, unless they arrest you and detain you, then you cannot have them during detention. Others turn a blind eye, but not because they are tolerant, but because they are lazy. They don't want the paperwork! Some are afraid you will be sick in their car [if you go into withdrawal]! (Detainees in NEP centre, Budapest).

As already mentioned in the discussion about practice in England and Wales, the police in Hungary also do not return the clean needles confiscated at the time of arrest.

Interviews at the Ministry of Interior with the head of the medical department were positive in that if methadone maintenance is approved by healthcare professionals with proper protocols then the police will have to accept this and work with healthcare staff to provide it (Head of Medical Department, Miskolc Police Department, Budapest).

One key problem identified is that methadone is becoming less popular as it is administered in small doses and users need to top it up with other drugs, so many professionals see this and think that methadone programmes are not working (Director, Forensic Psychiatric Hospital, Budapest).

5.5.6 Italy

Harm reduction information forms part of the police training as part of workplace safety (Law 626) and takes up about 50 hours of basic training and also includes first aid. The training takes place in small groups (approximately 15–20) and is interactive in nature. The training informs the officers about changes in drug use to keep them updated. According to officials from the Police Health Department who were interviewed, the police were considered to be well informed about HIV and safety with all police having gloves in their cars and at the station. They are aware of how to act in violent situations and how to deal with blood spills (Officials form the Police Health Department, Ministry of the Interior, Rome).

Interviews with police officers indicated that they did know what to do during a violent incident if they received a needle stick injury but although they knew to use latex gloves they had no idea where in the station they were kept. One of the officers remarked:

> I have not received training about harm reduction regarding HIV or Hepatitis. In reality I feel that I have received more information about HIV from the media than from training. I think that there is a need for much more training in the area of drugs and communicable diseases. There are some internal

> documents about such issues but people don't read them. In order to get people to read information about drugs/communicable diseases the information should be put in the form of a well-written leaflet rather than just in official communications (as these tend to be looked at quickly and then ignored). There is no professional update training available you have to ask to attend training and in theory we have six days per year allocated to this but in reality we are very rarely able to use these training days due to a lack of staff available to provide cover (Interviews Police Officer, Rome).

Other members of the criminal justice system such as lawyers and prosecutors do not have any training in drugs and addiction only experience from working in the field. Now, in the last five years they do have to go for two years to 'school' where a small part of the curriculum can be about alternatives regarding addiction (Interview with a Prosecutor, Padova).

A former detainee demonstrated the need for the provision of harm reduction information at the point of arrest:

> you don't get anything while you are in police detention, nothing at all: nobody thinks about giving you harm reduction material! It was horrible in police custody. It was tragic (Interview 1: Female prisoner, San Vittore Prison Milano).

The SERT based in prisons has no role with detainees with problematic drug use in police detention. Sometimes the police may ask the community-based SERT about the doses of methadone that detainees are on. According to one interviewee:

> the time of police detention could be a useful time from a professional point of view [providing drug services/harm reduction] and from a healthcare point of view, but at this time of arrest [when a detainee may be withdrawing] the aims of the police are different; and if the detainee is stressed and in withdrawal they will say anything! (Head of SERT in Prisons, Padova 2006).

It was thought by one interviewee that it would be useful if SERT visited police stations because:

> many migrants are not known to SERT and the period in police detention would be useful time to be in contact with the migrant detainees as it would put SERT in contact with them both to provide treatment, harm reduction and health checks, i.e., blood tests (same as is done with people who come from streets) (Doctor from SERT working in Prison, February 2006).

This was reiterated by one of the focus groups who thought that:

> if SERT visited us while in police cells it would be very useful for problematic drug users. The police do not give us any

> information about harm reduction in fact the police are more interested to watch the SERT office to see who goes there for treatment (Focus Group, Therapeutic Community, Padova).

It is possible for SERT drug workers to visit police custody suites but they need to negotiate this with the police and where it happens it is based on local agreements (Doctor from SERT working in Prison, February 2006). One such local agreement is the services provided by an NGO based in Rome, called Villa Maraini, who are able to provide methadone maintenance to arrestees in police stations only in Rome (see section 5.3.1 for more details).

Generally interviewees felt that the police on the whole were more interested in crime control than harm reduction and an example of this was in the past there used to be two needle exchange boxes but the police watched them to identify people with problematic drug use (Doctor from SERT working in Prison, February 2006).

Alcohol was also identified as a major problem in the Veneto region of Italy and again SERT has no contact with the police for detainees with alcohol-related problems (Doctor from SERT working in Prison, February 2006).

Methadone treatment is not available in police detention because the police are under the Ministry of Interior not the Ministry of Justice. The police can ask for SERT to visit a detainee or call the emergency services (Doctor from SERT working in Prison, February 2006).

The SERT based in prisons in the Veneto region has a regional role in prisons regarding harm reduction. However, there is no written harm reduction strategy:

> but at staff meetings in the prison we [SERT] did write a strategy but it is up to the prison doctors to implement it. SERT cannot control what the prison medical staff do. Thus, currently there is no programme of harm reduction but we have set the seeds for thought. Nothing has happened as no practical leaflets have been produced, no needle-exchange projects, no condoms, no bleach but information is given to addicts if it is considered to be necessary. SERT has provided individual information to their clients and some information leaflets (Head of SERT Prisons, Padova 2006).

The harm reduction projects that do exist in prisons are not consistently available in all prisons and they tend to be short term. However, it is in fact possible to obtain methadone maintenance therapy in prison, but this is only available for those who were already in treatment in the community. Methadone maintenance is not available in police detention and those arrestees who are on a community methadone programme will have a break in their treatment due to the lack of liaison between prisons and the police exacerbated by the prisons and the police being under different Ministries.

5.5.7 Lithuania

Harm reduction was considered to be something that should be organised between the Ministry of Health and NGOs:

> but they need more support to implement this. At the moment we have separate supply and demand reduction strategies, and it is difficult to see how harm reduction fits into this – the focus [for the police] is on preventing drug use (Deputy Chief, Public Health Division, Ministry of Interior, Vilnius).

Police officers it was argued do understand the concept of harm reduction, as it is part of their training, for example the use of methadone:

> however, in police detention, users cannot just start on methadone, it can be administered if they are already on a programme as long as someone can bring it to the police station. Methadone programmes in the community are very strictly regulated, and this must also be the case in police detention (Deputy Chief, Public Health Division, Ministry of Interior, Vilnius).

Discussions with the chief officer of the Police Commissariat raised a key point:

> although many police officers do understand harm reduction, they do not see it as part of their role, as it is in conflict with crime control and keeping detainees sober or drug free. Also the police are limited in what they can do if users do not declare that they do use drugs (Chief Officer, Police Commissariat, Vilnius).

Interviews with staff at the Drug Control Department pointed out that harm reduction programmes are not well developed in the community and what is provided is not very accessible, and depends on the attitude of individual municipalities. The harm reduction services in the community are provided through the 'Open Society Fund', using the 'Blue Bus Scheme'. This is a bus which travels around Vilnius and surrounding areas that provides clean needles and advice for users. It is particularly important as it accesses hard-to-reach groups, for example, those who cannot access state healthcare or treatment services based in the city centre. Currently, methadone programmes are limited to Vilnius and Klaipedia (port town). They felt that it was difficult to reassure authorities including the police that harm reduction is legal due to the current debates about the use and provision of methadone (Staff, Drug Control Department, Vilnius).

However, the police are informed about the use of harm reduction services like the methadone programme, and detainees on methadone programmes have ID cards, which should prevent them being arrested as drug users (Staff, Drug Control Department, Vilnius).

Former detainees stressed the importance and benefits of being on a methadone programme and the availability of needle exchanges:

> it is difficult to access methadone programmes if you are not registered in a certain town, or if you are not considered to be a high risk. It helped me when I was previously on the methadone programme but then it stopped after 3 months – that was the end of the programme (Detainee, Demetra Care Centre, Vilnius).

> needle exchanges are very good, it stops people sharing and also stops people throwing them away in the street. But the police distrust us, so it is difficult to explain why you have them, but we are not harming anyone else, so why? This is why we cannot ask them for help in the police station, they will not help or they will cause more problems for you (Detainees, Demetra Care Centre, Vilnius).

One reason suggested by a representative from a Human Rights NGO for the lack of harm reduction provision both in the community and police detention was due to the exclusion of harm reduction strategies in legal codes, in that they were seen as part of the remit of healthcare agencies or NGOs.

An interviewee from the Ministry of Health felt that the police could assist with implementing needle exchange programmes and methadone, with a revision of the law regarding substitution treatment, although he felt that this would work better in prisons (Ministry of Health, Person's Health, Vilnius). He also thought that police officers should take detainees to the clinics for their methadone so that their healthcare continued. However, this may be difficult as although there are nurses and doctors in police custody units, the care provided is limited (Ministry of Health – Person's Health, Vilnius).

In Lithuania the police receive a training course of 60 hours on general healthcare of detainees [not specifically about harm reduction], including dealing with detainees with problematic drug and alcohol use (Deputy Chief, Health Department, Ministry of Interior, Vilnius). In addition:

> the National Drug and Alcohol Prevention programme includes co-operation between the police and the Health Service, and with the AIDS Centre, to involve police officers in prevention work, especially with young people. This is so the police can recognise symptoms of drug and alcohol use and know how to deal with infectious diseases, i.e. so it is clear when they need to call for medical help (Deputy Chief, Health Department, Ministry of Interior, Vilnius).

Police officers are expected to learn how to deal with the effects of problematic drug use, alcohol, domestic violence and noisy parties through seminars and training programmes and 'after just one year of experience as an officer they get to know who are the drug users' (chief officer, police commissariat,

Vilnius). Professionals from the Drug Control Department in Vilnius argue that:

> although the police have this information [knowledge about drug users], have had training and are aware of the problems faced by users, they see the short time in detention as a reason not to engage with healthcare, and this is not seen as their priority. Medical care in police detention is seen as an emergency measure (Staff, Drug Control Department, Vilnius).

This group of staff also argued that the police should be concerned about crime control and healthcare and that:

> they need to make more use of the Drug Dependency Clinic to refer detainees with problematic drug use. There is also a need to expand police training to include harm reduction, not just prevention and crime control (Staff, Drug Control Department, Vilnius).

5.5.8 Romania

The chief of the medical Service for the Police believed that eventually harm reduction will play an important role for those in detention and the response to those with problematic drug and or alcohol use will be co-ordinated by the National Anti Drug Agency (ANA) who will provide case managers for those detainees with problematic drug use. He thought that this system will work and under the new legislation detainees can also ask for their own GP but the administration forms take a long time to process. He said that, in 1992, all nurses and doctors received training and understand harm reduction well. This was not the view held by many other professionals who said that the police were not sufficiently trained in harm reduction or addiction:

> the police doctors participated in training with police officers. A first aid book has been written. The front line police should be able to recognise drug addiction. The curriculum for police agents is a chapter in the first aid book. Police are using gloves at all times to search and they are aware of the risks of communicable diseases. After arrest the police call the [police] medical team at all times of the day or night. They also use the emergency system (Chief of the Medical Service for the Police).

There is no methadone in police detention as the police provide primary care, not long-term care. There is no continuing treatment of any kind provided. The police immediately notify the psychiatrist about any problems who will then decide the treatment required (Chief of the Medical Service for the Police).

In the future, there will be no gap in detainees' methadone treatment because drug users will be on record at ANA and if arrested the ANA centre will take

over the management of the detainees' methadone and drug users will also have a card showing that they are part of the methadone programmes (Staff, Anti-Drug Agency). A key problem that was identified in the provision of methadone treatment was that:

> [in Romania] we need to lose the idea that detoxification needs to be done in psychiatric units. Step one is for the NGOs to identify locations for methadone centres; this requires money, premises, staff and organisation and a whole anti-drug network. Bucharest needs at least six treatment centres. The framework through which methadone can be administered needs to be enlarged, i.e., by using GPs and other experts. In Bucharest only 400–500 drug users are getting treated out of an estimated, 25,000 users. There is nothing in the countryside for drug treatment this is only currently available in Bucharest (Professional, Romania Public Health Directorate, Bucharest).

At the time of the research, methadone provision in prisons was under development and will be available later in 2007.

5.5.9 Summary

Harm reduction training was provided for the police in a few of the participating countries. In most of the countries police officers were aware of how to search a detainee safely and to use protective gloves. However, protective gloves were not always available to police officers in all of the participating countries. The need for more training for police officers on harm reduction was highlighted in all of the participating countries.

Interviewees from the police in most of the countries were on the whole positive about harm reduction both for their own practice and in provision for detainees but some police did not see harm reduction as part of their role. A key point made by a representative from a Human Rights NGO as an explanation for the lack of harm reduction provision both in the community and police detention was due to the exclusion of harm reduction strategies in legal codes, in that they were seen as part of the remit of healthcare agencies or NGOs.

Provision of information or referral to drug or alcohol treatment services generally were accepted but not necessarily seen as the role of the police. A key finding was that internal documents for the police about harm reduction should be put in the form of a well-written leaflet rather than just in official communications (as these tend to be looked at quickly and then ignored). Initiatives like needle replacement and substitution treatment were generally not accepted by police officers who were interviewed. Methadone maintenance is not available in police detention in most of the countries and those arrestees who are on a community methadone programme often have a break in their

treatment due to the lack of liaison between community, police and prisons, exacerbated by prisons and the police usually being under different Ministries.

Other members of the criminal justice system such as lawyers, prosecutors and magistrates were unlikely to have had any training about harm reduction.

5.6 Lack of joined up approach across the criminal justice system

During the course of the research a variety of service providers and service users were interviewed. A key theme that emerged was that there was often a lack of co-ordination and/or co-operation between different criminal justice agencies, government organisations and non-government organisations. This lack of a joined up approach often reduced the potential impact that services could make on the lives of those with problematic drug or alcohol use.

5.6.1 Bulgaria

According to one professional interviewed the problems and needs due to problematic drug use will not be met as:

> in Bulgaria there is a need to change the attitude and approach currently towards the drug problem, we are still talking academically and not about solutions for real situations. NGOs won't change things on their own, at first people need to accept the problem and then open their eyes and start to deal with it. Society needs to think about those drug users who are imprisoned and provide changes to help those arrested. This will need agencies to work together and share good practice (Interview with Doctor and Head of Department for Prevention, Varna, March 2006).

One NGO who offered a residential drug rehabilitation project said that they sometimes work with probation and the police. They would like to develop their contact with the probation service as currently the head of probation has reservations about their project and they hope that this will change (Interview with two Fathers of the Orthodox Church residential drug treatment programme, Varna).

It was argued by the interviewee from the Varna Drug Department that a key problem was not just a lack of co-operation between services but:

> the lack of social services is a key problem for those who have had drug treatment. We need centres for social services and probation. Probation has made the first steps starting with a pilot project and now it is a formal service but they still don't

> have premises and all the necessary services and staff (Interview with Doctor and Head of Department for Prevention, Varna, March 2006).

5.6.2 England and Wales

As part of the current drug strategy the police work in partnership with a range of agencies. Arrest referral workers are based in police stations and they work with a range of people:

> we work with treatment agencies and the relationship is excellent. With prolific offenders we work with probation, who are very good, and there are very good links and regular meetings with them and the communication link was there straight away. We can have problems with custody sergeants not co-operating: they say they are worried about safety, but sometimes it seems to be about they don't want to give you the time, and you are not their priority. This is not always the case and now I have a good relationship with the custody team, and the arrest referral workers are the ones that know how to make the link with other services, to promote services to users and to help the different organisation work together. It is important to remember arrest referral workers are invited guests, my predecessor was not helpful as she would use their phone, bark orders and get in the way (Arrest referral workers, Inner City Police Station, Birmingham).

A police custody officer interviewed also valued partnership work:

> we are all one big family, another cog in a big wheel as part of preventing offending, so it is important to work together. A partnership approach means we do interact with outside agencies; important that we do work together as this is in everyone's interest to come aboard as if someone has a drug problem they may also has a housing problem, if one link is not available then the whole system collapses; nothing is perfect: problems that arise could be due to an individual or an organisation. Partnership is the best approach as all agencies involved with drugs now have a better understanding of everyone's role and more inter agency-liaison and sharing of information (Police custody officer, Inner City Police Station).

Interestingly, some police who were interviewed felt that often they took the lead in partnership working and that other agencies are slowly catching up to the idea that working with drug users in custody is their responsibility and does effect them (Police custody officer, Inner City Police Station). As one officer said:

> well, what we do is partnership working. It's being recognised in the police that quite often our movement is quicker than other agencies. I went to a meeting yesterday about neighbourhood policing and one of the things discussed was that when you are in partnership work the expectations should be that you would stay in the group for a number of years, because its all about developing relationships. Certainly, if you look at what these forces are doing around restructuring what they are looking to do is have nine areas that revert to six, each of those will be headed up by a Chief superintendent who will be there for a minimum commitment of three years and will have a Superintendent below him or her who will then step into those shoes to give a consistency in partnership working, so I think with what we've said we are starting to realise that we need is more consistency and longevity (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

Partnership working was not always seen as successful:

> The *Crime and Disorder Act* (1998) promoted partnership working but this is not straightforward as there is non co-operation between agencies, and the police often lead with the other services dragging behind. There is sometimes a lack of co-operation or a clash of cultures it is not clear why partnership is not working (Custody sergeant, Birmingham).

Another interviewee reinforced this and also pointed out that provision is not consistent:

> there are other forces that are within spitting distance of us where they don't see partnership as a high priority and therefore although treatment services may actually be there, as the council provides it, and all the rest of it, there may not be the link into the CJS and so therefore, the offenders with substance misuse are falling out of the net. So the actual community services actually can, in some areas, be really, really good, absolutely brilliant but there are certainly other ones up and down the country where there doesn't seem to be a link between criminal justice and the community (Custody nurse manager, Kent Police).

An officer involved in the Crime Reduction Partnership argued that drug policy was being implemented inconsistently:

> the message coming back to me is that there is inconsistency in approach to drug testing and treatment orders. I feel that the whole criminal justice system and the court systems are decades behind everybody else, they're old and stuffy, not the people themselves but the actual systems that they work in.

> The courts are the most inefficient service within the criminal justice system in my view. What we're finding is that there's an inconsistency in the sorts of people who are actually given the orders and there's inconsistency around those who are breached who don't comply with their orders (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

One officer felt that the opportunity to work in partnership enhanced his job:

> Yes, I suppose people move to different roles, and the whole point of policing is the variety of the career and if you were going to join up and be a beat officer for 30 years, then no thanks very much, it would be even harder to recruit people to the police. The fact that every couple of years you can do something completely different is great. There are people like me who have basically done 10 years in different partnership roles (Police officer, Department of Partnerships and Crime Reduction, Kent Police).

5.6.3 Estonia

At the time of the research in Estonia the Head of Probation considered there to be good working relations between prosecutors and the probation service. They have a monthly meeting where they discuss problems and changes in the legislation (Interview with the Head of Probation, Tallinn). The relationship between probation and the courts is more distant as they meet only three times per year to inform the courts about what they are doing. There are two people from the probation service working in the court system who monitor that the probation plans are implemented but, in reality, partnership working is minimal (Interview with the Head of Probation, Tallinn).

According to the Head of Probation the co-operation between the prosecutors and the police is quite good and the prosecutor is the co-ordinator of the criminal proceedings. This co-operation is more about discussing cases and solving issues together about collecting evidence etc. rather than about solving social issues (Interview with the Head of Probation, Tallinn).

The police interviewed also considered that:

> the system with prosecutors works OK depending on the individual. The system has changed from some years ago since the new law in 2004 that changed the role of the prosecutor to the leader of the investigation. I think it is good that they are located in the Ministry of Justice and the new system means that the prosecutor takes the responsibility for the case. This does depend on the seriousness of the case if a minor crime then the police will go directly to the court (Interview with the Police Board, Tallinn).

This does provide an example of where two criminal justice agencies located in two different ministries do find a way to work well together.

The courts have their own training centre in Tartu but this training is more legally-based rather than about social issues and there is no joint training with probation anymore on social aspects (Interview with the Head of Probation, Tallinn).

According to the Head of Probation the criminal justice system is not working together:

> especially as the police are not in favour of methadone and the different agencies do not have a common vision about methadone provision. The police see methadone as having no use (Interview with the Head of Probation, Tallinn).

Interviewees at the Training Department of the Police Board identified that there is a joint working group with the prisons about training but there was not considered to be an easy working practice (Interview with Training Department of the Police Board, Tallinn).

A good demonstration about the difficulty of multi-agency co-operation was provided in Estonia. The Ministry of Social Affairs has received funding as part of a four-year project for the three Baltic countries from UNODC for providing *substitution programmes* in prison and in the community. In order for this to be successful it is important that the police are also involved and agree to the provision of substitution treatment for those in police detention:

> this project has a key aim to put together an action plan for Estonia where consensus is reached amongst service providers about substitution programmes and this will involve a major psychological jump for many! (Chief Specialist on HIV/AIDS, Ministry of Social Affairs, Tallinn).

The police have a different attitude towards those with problematic drug use and were not enthusiastic about providing substitution treatment:

> We see those with problematic drug use as criminals. The provision of methadone is under discussion with the Ministries of Social Affairs and Justice but so far no conclusion has been reached. So far we don't feel that there is enough of an emphasis on treatment involved in the methadone programmes (Interview with the Police Board, Tallinn).

An official from the Ministry of Social Affairs said that it was not easy to reach aggreement about substitution treatment or to create an easy working relationship with the different criminal justice agencies.

5.6.4 Germany

As opposed to other countries in the study, there are very few NGOs directly involved with police detention. Thus it was not possible to talk to professionals from NGOs about detainees with problematic drug use.

5.6.5 Hungary

Staff at the Drug Prevention Foundation thought that it was important to have established links with the police:

> co-operation with the police is a complex issue, as any co-operation with the police is or suggestions to how they should do things is slow and bureaucratic. But it is important to have [co-operation] as users often experience problems in accessing services at the foundation, as they would be questioned and even arrested by the police for using drugs [methadone], or even if they were just found with injecting equipment on them. This has become less of a problem, once the police understood the reason for having such services for users, but there are still some officers who are ignorant about users' needs; in 2003, there was an agreement made with the police to give users a card to show why they had needles/equipment on them, as they were registered users of this service, to prevent(from) them being arrested. There are still some problems, mainly among prosecutors, where providing clean needles/equipment is seen as assisting drug use (Staff, Drug Prevention Foundation – Harm Reduction Services, Budapest).

Further problems are caused due to a lack of co-operation with the police in the treatment for those with problematic drug use as:

> being arrested disrupts treatment for about 20% of cases of those on methadone; the rest are released in time to get their methadone prescription. Some arrestees are kept in police custody too long and miss their appointments and methadone dose (Doctor, Methadone Clinic, Budapest).

The Director of the Forensic Psychiatric Hospital in Budapest said that they were just starting to build contact with outside groups, especially for those detained on forced drug treatment as part of their sentence, as NGOs have better expertise to provide help regarding drugs.

The police interviewed in Miskolc and in Budapest said that although links have been established with human rights groups to provide legal advice, no links had been established with NGOs providing drug treatment (Chief Officer, Miskolc Police Department, Miskolc; Chief Officer and Forensic medical expert, Police detention centre, Budapest).

5.6.6 Italy

In some parts of Italy the community drug service (SERT) provides a link between a range of criminal justice agencies; it works in prisons, is based in the courts to divert drug users from prison and has limited contact with the police.

SERT is now integrated into prisons and on the whole this works well:

> SERT is fundamental to the prison as they can deal with drug addicts professionally. It is not easy to deal with drug addicts in prison. In prison drug addicts are patients of SERT and prisoners of the guards and it is not easily to integrate these two cultures. I don't have overall management of the SERT but this is not a problem as the relationship has worked well over the years, I would be less comfortable with having SERT in the prison if it was not also a public service (Director San Vittore Prison, Milan).

In another prison in Milan, the director felt that they had reasonably good links with the police but 'they don't give any information about the person if they are problematic drug users for example, only how they were arrested and their crime and nothing about their health' (only if the detainee was sent to hospital this would be recorded and the reason why they were sent) (Interview Director of Padova Circondiarle Prison, Padova). This director also said that the police want to transfer problematic drug users to prison very quickly and with 'some excuse transfer them to prison even when they have a direct trial, the police ask the magistrates to please transfer them to prison. The police don't want to deal with drug users-overdose etc. (Interview Director of Padova Circondiarle Prison).

In Padova the prison SERT has no role with problematic drug users in police detention as previously mentioned. This same interviewee thought that as many migrant drug users are not known to SERT the period in police detention would be a useful time to make contact with the migrants and enable SERT to provide treatment and health checks, i.e. blood tests (the same as is done with people who come from the streets) (Interview Head of SERT for prisons, Padova).

At the time of the interviews there were no links between the prison health care service and the police provision of health care (Medical Chief of Police, Ministry of the Interior, Rome). However, there was a close link between Villa Maraini and the police in Rome. As discussed previously the police notify staff at the Villa Maraini, who go to the police station to attend to the needs of those prisoners with problematic drug use (Interview with Villa Maraini, Rome).

An interesting example of a multi-agency project is La Prima (DAP-Prima) which involves SERT, the court and the Providitore. There are four pilot projects for diversion from court for arrestees with problematic drug use in Padova, Rome, Catonia and Regio Calabre. The project arose from the view that prison is not a useful response to those with problematic drug use who

have committed low-level crimes; rather they should be treated outside of prison. Italian law allows prisoners to ask for alternatives to prison. The current law means that arrestees have to go first to prison and then request an alternative to prison. This project enables the arrestee to go directly to an alternative from the court.

All the projects started at the end of 2006 except for Rome as the SERT has a management problem and poor links with the court in Rome. At the preparatory meeting of the project team it was hard to convince the court to provide an office for SERT to meet detainees prior to attending their trial (immediate after arrest) so that they can go immediately to treatment or to a therapeutic community with a suspended sentence. The SERT team in the court then has a few hours to write a drug-treatment programme and then if the judge agrees the detainee will go to the programme without having to go to prison first. If the programme is not working then the detainee will go to prison. The project at the court in Milan is the most developed:

> the SERT office (Area Penal SERT) based at the court has the prisoner coming there after the initial 24–48 hours in police custody after the police have charged the drug user and before they see the judge. The arrested person comes to the SERT and we can make an assessment about the programme for treatment for them and the judge can decide to use this option without the arrested person having to go to prison first (depending on crime and danger assessment of the arrestee). In one year, 1400 people have come through SERT office and about 400 per year have had a programme to go to a closed community and about 90% have finish the programme. This is much higher than those who voluntarily go to such a programme as many of those don't keep to the treatment (Officer from the SERT based in the Court in Milan, Milan).

The results of the programme so far show that the key to the success of the programme is having good links with the court and the community and a constant process of educating the judges in the court:

> the SERT work with 80 judges in the Milan court and some of them don't know about our existence. We have had to go to look for the problematic drug users in court but now often the police bring prisoners straight to the SERT office as they know us well (Officer from the SERT based in the Court in Milan, Milan).

5.6.7 Lithuania

The deputy Chief of the Health Department at the Ministry of the Interior was in favour of multi-agency co-operation:

> criminal justice agencies and the health service cannot work alone to address problems of drug use and crime, we need 'active communities' to help with social and health issues. If these structures are not in place in the community, then the police cannot refer detainees to services. This also affects funding and working together, and sometime there are problems in establishing who is responsible. For example primary healthcare is managed by the local municipality but funded centrally. Therefore, we can only 'symbolically' initiate programmes if the funding is not available (Deputy Chief Health Department, Ministry of Interior, Vilnius).

This interviewee went on to say that making links with NGOs is in development and money is being put in place to do this, but that it was important to make sure the NGOs have the right expertise. Currently,

> the police work with the Drug Control Department in Vilnius to refer drug users to but there is no national strategy for this. The responsibility should be with the Ministry of Justice, not the NGOs (Deputy Chief Health Department, Ministry of Interior, Vilnius).

The majority of professionals interviewed were in favour of partnership working and to some extent were doing this with at least one other agency:

> we have good working relationships, especially with the probation service as they are a young innovative organisation. But we need more social workers and programmes - if there is a need, there is a way (Social worker at Vilnius Correction House 2, Vilnius).

In addition to the motivation to work in partnership it is also necessary to have the legislation in place to allow this:

> we work with local police officers and the community to talk about our work and how they can help those with problems with addiction. The criminal code needs revising to provide alternatives for minor offences linked to drug use, currently the police and courts are limited by the law (Director, 'Linus' NGO Residential Treatment Centre, Vilnius).

At the community level, the police and other groups work together on prevention projects with young people, for example the Ministry of Health have 214 programmes on prevention for school pupils, training for teachers, with co-operation from the Drug Control Department in line with the National Drug Prevention Programme (Ministry of Health, Person's Health Department, Vilnius). The official from the Ministry of Health who was interviewed remarked that 'generally working together is good, but there are some problems, mostly discussions and some disagreements' (Ministry of Health, Vilnius).

5.6.8 Romania

At the time of the research changes were underway to provide a more organised management of drug services and those with problematic drug use under the Anti-Drug Agency (ANA). The new system will adopt a case-management approach so that a person who is on a methadone programme in the community will have the same case manager while they are in police custody and while in prison. Those interviewed at the medical service for police thought that this system would improve the situation for drug users in police detention:

> we believe that harm reduction and drug services for detainees are important and this is why we are co-operating in this project with ANA. ANA will provide the case managers for drug users. This system will work and under the new legislation detainees can also ask for their own GP but the administration forms take a long time (Chief of the Medical Service for the Police, Bucharest).

In Bucharest, there is a degree of co-operation between the police and the prison hospital in the provision of detoxification:

> the medical staff from the police make the decision to send prisoners with problematic drug use to Rahova prison for detoxification, usually about 6–8 per month, it depends on the numbers of drug users in police detention. I suspect those who have the most serious problems of drug addiction are the ones sent to the prison hospital by the police. After detoxification the prisoner is returned to police detention or goes back to prison. They usually stay 14–21 days for detoxification (Doctor, Rahova Prison Hospital, Bucharest).

According to the director of Rahova prison the prison has good co-operation with the probation service and he wants to continue to strengthen this relationship. The prison also has a series of protocols with the inspectorate of police, ANA, the prosecution and the courts. Also some religious organisations have good relations with some prisons and not with others (Director, Rahova Prison, Bucharest).

The implementation of prison methadone programme provides a good example of the need for inter agency co-operation:

> we are determined to implement methadone in prison but we are waiting for the legal framework and money from the Ministry of Health or changes of legislation to allow the Ministry of Justice to provide the methadone. We are ready to start the training for all medical staff. At first the general doctors may be a bit apprehensive about providing methadone but this depends on the quality of the training. The assessment to include a prisoner on the programme will include a worker

> from ANA. ANA has centres in all regions of the country and this is needed to ensure continuity of treatment. The continuity of a drug users' methadone treatment will depend on the ANA assessment centres. The police should notify ANA and they will provide a 'case manager' for the detainee and once referred to prison they will be monitored by the same case manger if they stay in the county or if he/she goes to prison in a different county then the prison will have to notify ANA when they are transferred. If there is good co-operation with ANA we will be able to provide a continuous system of treatment. At the moment probation is not involved but they are only starting and are understaffed and not working across all the Romanian counties (Head of Health Care, Rahova Prison, Bucharest).

Not all those who were interviewed were as enthusiastic about the ability of ANA to provide this network of drug centres:

> what I am most unhappy about is that there is no policy or strategy to bring the disparate groups together: people want to protect their own field/area of drug-addiction expertise. ANA wants to be the boss. The county centres are turning into methadone centres and they are not suitable for this (Interview Doctor, Hospital Number 9, Bucharest).

5.6.9 Summary

The participating countries were at different stages of partnership working with a range of agencies to meet the needs of detainees with problematic drug or alcohol use. On the whole those interviewed thought that working in partnership and sharing best practice was the only way to respond to problematic drug and alcohol use. Partnership where it did exist was not always easy to manage and problems were identified by responds both amongst police officers and service providers. In order for partnerships to be successful there needs to be well developed social services and NGOs in the community. The research has highlighted some good examples of partnership; arrest referral workers in England, Villa Maraini in Italy and the case-management approach of problematic drug users in Romania.

5.7 Good practice and gaps in provision

In the participating countries a range of good practice was identified in the provision of services and treatment for those with problematic drug and alcohol use. Some examples of good practice are: the practice in the methadone treatment programme to provide withdrawal for clients before they go to prison (Bulgaria); arrest referral workers who provide information to detainees on

treatment for problematic drug use and custody nurses (England and Wales); provision of HIV medication to prisoners when they are transferred back to police arrest houses from prison for court appearances (Estonia); the development of detention facilities specifically for those with problematic alcohol use in some German cities; in Hungary detainees' medical records are accessed by healthcare staff only, police officers only have access to general information such as gender, or if the detainee has used drugs; Villa Maraini, the only NGO in Italy, that is able to prescribe methadone and that works in all Rome police stations although this is not underpinned by any protocol or agreement; the major cities in Lithuania have methadone maintenance programmes and centres and day-care facilities to help dependent users and many projects carried out by NGOs have received government support; In future in the Romania, according to ANA (Anti Drugs Agency) there will be no gaps between community, police detention and prison as methadone programmes will operate in all detention sites. All people with problematic drug use who are on a methadone programme will be recorded by ANA and if they are arrested then the ANA centre will manage their methadone substitution during their detention.

The gaps in provision for problematic drug and alcohol users in the participating countries bore some similarities. A lack of support for detainees during withdrawal was raised in most of the countries; poor condition of police cells and arrest houses; a poor understanding of harm reduction amongst police officers and a lack of harm reduction information or services provided for detainees and a lack of training for police officers on drugs, basic health care and harm reduction was identified; methadone maintenance not generally being available in police detention nor needle replacement schemes to replace injecting equipment removed from detainees during arrest; a lack of partnership with community drug agencies (governmental and non governmental) and other criminal justice agencies (prisons, probation); other members of the criminal justice system such as lawyers, prosecutors and magistrates were unlikely to have had any training about harm reduction; a lack of alternatives to custodial sentences for those with problematic drug and alcohol use; the emphasis on strategies and policies regarding problematic drug use was identified as problematic as they tended to deflected attention away from other vulnerable groups such as those with mental health problems, those with problematic alcohol use, foreign nationals, Roma and young (under 18 years) problematic drug users; a lack of confidentiality regarding detainees' medical records while in police custody. In some of the participating countries there were not well developed social services and NGOs in the community for the police to refer those with problematic drug or alcohol use to.

Chapter 6: Conclusion

Introduction

This research has highlighted the needs of those with problematic drug and alcohol use in police detention and identified examples of best practice and gaps in provision of services for those with problematic drug or alcohol use.

The criminal justice system contributes much to the everyday lives of those with problematic drug and or alcohol use living at or beyond the margins of legality: from police practices on the streets, the operation of the courts and the conditions of police cells and arrest houses and prisons. This research focused mainly on the experiences of detainees at the point of arrest and during detention in police houses. There is a need for greater attention on police practice in their response to problematic drug users in the provision of drug services, harm reduction and health care. It is argued that the police and their practices are an important link between the initiatives in place for drug users and public health in the community and to some degree in prisons. The police also have a role in reducing the spread of communicable disease and harm reduction among IDUs and for referring drug users to treatment interventions.

Drug policy

The existing drug strategies in the participating countries were considered to have positive and negative elements. Some of the positive elements were a focus on harm minimisation aiming to improve the basic health of those with problematic drug use and attracting them into treatment. However, engaging drug users with harm reduction is still very much seen as a route into treatment and abstinence from drug use (Hungary, England and Wales). In addition, in some of the participating countries the drug strategy was positive in encouraging a multidisciplinary, multifactor, integrated and comprehensive approach to drug users that aimed to improve the quality of the programmes (Romania) and to provide more services for those with problematic drug use in the community (Estonia).

The problems with the drug policy in the participating countries was discussed by interviewees who raised issues such as the lack of distinction between drug users and drug dealers (Bulgaria and Italy), the focus on prevention at the expense of harm reduction, that the law did not distinguish between the type of drug used (Italy, Romania, Bulgaria) that impacted on the provision of services for those with problematic drug or alcohol use.

Even when harm reduction is stressed as an important element and emphasised in the drug strategy, it is still difficult to implement, often due to a lack of

resources and negative attitudes towards those with problematic drug and or alcohol use.

In some countries, the theory behind the drug strategy was considered to be very good, but its implementation was problematic as many of the goals and targets were not being met (Hungary) or the focus on drugs led to gaps in provision for those with problematic alcohol use (England and Wales). The national drug policy may not be implemented in the same way in the individual states (e.g. Germany) within a country where the departments responsible for drug strategy create their own programmes and policies for drug users. The policies in each state can be very different from each other and are not always in complete harmony and, in addition, not all city-level initiatives have state-level support.

General comparison with prison

A lot of work has been and is currently being done in the prison systems of Europe to provide drug services and harm reduction for those with problematic drug use. The police are lagging behind: many detainees interviewed stated that they were glad to leave police detention and get to prison where they were offered better facilities and services for problematic drug use.

Issues like throughcare are being tackled by many prison services. Seamless care for those with problematic drug use requires cooperation between community drug agencies, prisons and the police. Currently, the gap in the provision of drug services is during arrest and in police arrest houses. Many prisons, for example offer substitution treatment or are considering the implementation of substitution treatment in the near future.

Providing continuing care requires multi-agency partnerships and a commitment to do it and as the research has shown there is often a major difference between the attitudes towards harm reduction initiatives, such as needle exchange provision and methadone treatment, in the community than from the police (and to a lesser degree prison administrations). In the participating countries it was rare to find a police service that considered the provision of drug services and treatment for those with problematic drug or alcohol use as being a key part of their job.

Culture change and training

There is a need for a culture change amongst some police officers to one where treatment and healthcare are also seen as part of the role of police and to reduce negative attitudes towards detainees with problematic drug or alcohol use. This can only be achieved by education and training. To some extent training that involves professionals from different agencies, both government and non-

governmental can impact positively on negative organisational cultures and effective a shift in attitudes. The appropriate training:

> can make great advances for harm reduction - when talking to the police it is important to educate them about HIV, about drug use, about their own professional safety, and showing them the human face of drug use. Many police simply regard a drug user as a criminal. We should ask the police for help, but we should also show them that it is an equal exchange and that we can provide them with valuable knowledge in return (IHRD 2004, 22).

Many detainees reported that there were occasions when they would be detained for more than the standard 24–48 hours. This may be due to being kept in detention over the weekend when courts were closed, or for a variety of reasons of which they were not always informed. Particular problems were highlighted in Lithuania, where detainees were often kept in detention for up to ten days without charge. In England, instances of being kept in detention for five days or more were reported as a result of prisons using police cells to cope with overcrowding.

In all of the participating countries, examples of exploitation of detainees by police officers were reported. They claimed that police officers recognised when problematic drug and alcohol users were most vulnerable during withdrawal and would use this time to coerce them to confess or pass on information about dealers.

The conditions of police detention were described by many detainees as unhygienic, with lack of space and with no provisions for maintaining their personal hygiene. In England, one detainee stated:

> It's horrible, there was no mattress, I couldn't have a shower not even before court…something needs to be done about that.

Although detention in police custody can be for a relatively short period in police stations it can last for much longer in those countries where there are arrest houses usually under the Ministry of the Interior. The conditions in police detention can have a negative impact on detainees' health, drug treatment or harm reduction initiatives started in the community and breach human rights.

In England, particular problems were highlighted when detainees were transferred to court detention cells, often for a whole day, with up to six people sharing a small cell with benches, whilst waiting for their case.

Detainees who were interviewed in all of the participating countries emphasised the need for improvements to both the condition of detention and in relation to how they were treated by the police. Specifically, they stated that the most important measures that would improve their situation would be medical care when you need it, i.e., pain relief, or methadone, clean clothes, better food, a private toilet and showers, and an exercise yard. Many also felt

the attitudes of officers towards detainees' with problematic drug and or alcohol use were generally more negative than towards other detainees.

Vulnerable detainees and human rights

In all the participating countries, certain groups among problematic drug and alcohol users were identified as presenting particular problems, for example, those with mental-health problems and foreign nationals or 'non-citizens' who are not eligible for state healthcare. In England, problems arose when mental healthcare providers refused clients who used drugs or alcohol, and drug-treatment agencies were often ill-equipped to deal with users who also have mental-health problems. Young people (i.e., under 18), although they had different (and usually better) conditions at the point of arrest in the majority of participating countries, were also often excluded from referral services, as community treatment services for young people were limited (England and Wales). Initiatives such as arrest referral workers in England were considered to overcome concerns about certain groups being excluded as detainees do not have to test positive for drugs or alcohol, nor do they have to commit a specific offences to take up this service. However, both police officers and arrest referral workers felt there was still a general lack of resources in the community to address the needs of problematic drug and alcohol users from diverse groups.

The research has shown that detainees' human rights are often overlooked in matters relating to problematic drug and alcohol use. The Universal Declaration of Human Rights provides for the right of everyone to have the highest attainable standard of physical and mental health. These conventions also provide the legal basis for 'states to respect, protect and fulfil, equitably and in a non-discriminatory manner, all injecting drug users' human rights.' This includes comprehensive harm reduction programmes along with providing treatment, care and support, including anti-retroviral therapy for HIV-positive drug users as necessary (International Federation of Red Cross and Red Crescent Societies 2004, 24).

The police need to be aware that their need to progress the investigation of an offence must be balanced against the need to respect the detainees' human rights and not cause harm and distress to them. By causing harm and distress, police officers may find their methods are counter-productive and could lead to complaints (Kothari et al. 2002). Many detainees in this study reported examples of exploitation by officers whose primary goal was to proceed with the investigation of their case, and would take advantage of users' vulnerable state during withdrawal.

The use of emetics (medication to induce vomiting) in Germany, for example, presents clear breaches of human rights, as identified by Amnesty International and the World Socialist Website (Sokoll 2005). At the time of the research concerns were raised about the use of emetics in some German police forces.

This strategy is targeted at those detainees suspected of transporting drugs inside their body, in order to enable officers to proceed with their investigation by getting the drugs out. In other countries, police officers monitor such cases to look for signs of drugs escaping into the body, and simply wait for detainees to expel the drug through natural means. The use of, and the concerns about, emetics raises serious issues around human rights and has led to several fatalities as a result this practice has now stopped in most of the German 'Länder'.

Access to drug and alcohol treatment

Access to drug and alcohol services and treatment for police detainees was on the whole limited. A key need for detainees with problematic drug and alcohol use was help during withdrawal and to continue with their methadone programme. The help available to most detainees during withdrawal in the participating countries was limited to tranquilizers and pain killers with methadone being available only to detainees in Germany and England and Wales. Detainees who are on the methadone programme in the community with ID cards (to identify their participation in the programme) can have their methadone brought to the police station by their families in Bulgaria and this also used to be possible in Estonia. One project run by the Red Cross in Rome demonstrated that it was possible to provide professional help to problematic drug users in police custody (methadone treatment) that was beneficial to both the detainees and to the police. A common reason given by police in the participating countries for not providing drug services was a lack of resources and in some cases, particularly in the arrest houses, a lack of medical staff or reliance on the emergency health service or lack of relationship with community drug service providers. The reality for most of the detainees interviewed who were on a methadone programme in the community was that during their time in police custody their programme was disrupted.

Detainees with problematic alcohol use were identified as a key problem as there was a lack of services for problematic alcohol use both in police detention and in the community. A key finding in Germany was the practice of using police detention for sobering up with respect to users of alcohol. Alcohol users were often identified to be the ones who were homeless and with psychiatric problems as well. Key issues that were raised in Germany were that the criteria for releasing or transferring those with problematic alcohol use were not clear and that there was not well-defined approaches about dealing with those who had both problematic drug and alcohol use. The emphasis on strategies and policies regarding problematic drug use was identified as problematic as they tended to deflected attention away from other vulnerable groups such as those with mental health problems, those with problematic alcohol use, foreign nationals, Roma and young drug users (under 18 years). In addition, a lack of treatment facilities for problematic alcohol users in the

community, despite the numerous and widespread harms caused by alcohol, meant that detainees were released from custody with nowhere to go for support. This is particularly important as often drug users will use alcohol as a substitute, and will need additional support because of this.

In England and Wales there was an emphasis on addressing the needs of problematic drug users at the point of arrest:

> generally, among police officers in England, the point of arrest was seen as a prime opportunity to address the needs of problematic drug and alcohol users. It was viewed as part of the 'journey' of treatment, a starting point where users can begin to address their problems. The remit of the police was described by one officer as being to address the cause of the offending and look beyond investigative and legal procedures and follow up enforcement with treatment, or to make the episode of arrest a much richer event.

This was not a view that was shared by police officers interviewed in the other participating countries. Many police officers did not expect to provide treatment, (for example, pain relief or substitution treatment). Ministerial representatives in Italy emphasised that the main role of the police is the enforcement of the law and not referral to treatment or treatment provision. Officers primarily viewed their role as one of law enforcement, and felt the healthcare needs of detainees were met by doctors or nurses called to the station, or through community or prison provision, which users would access on release or transfer from police custody. There were no protocols to implement referrals to treatment services for detainees and any such service would be dependent on the officers' discretion and knowledge of local services. Clear protocols for service provision with other agencies is important as these take the personality out of the decision making and help to overcome the loss of expertise and experience when personnel change and prolong organisational memory of good practice. In addition, these protocols need to be embedded in the structure of the police, laying out the agreements and with clear directives.

A key point that was raised by police officers and magistracy staff in England and Wales was a major difficulty associated with the treatment of problematic drug and alcohol users as being delays in court appearances, leading to delays in treatment provisions via criminal justice sentences. Concerns were raised by other criminal justice and healthcare participants in England about the feasibility of treatment through the criminal justice system. Users engaged in treatment through court orders can suffer more serious consequences (i.e., more severe sentences) if they experience a relapse compared to others accessing treatment through health services alone. In addition, the use of Anti-Social Behaviour Orders (ASBOs) in England, often leads to users being banned from city centres, which impacts on their access to treatment services.

Police officers in some of the participating countries held negative attitudes towards detainees with problematic drug or alcohol use, such as, a perception

that drug users do not want to be treated (which is not true as a large proportion do); that drug users do not need treatment; and that when given treatment it is not effective. Views such as these need to be challenged in order to engage the police in playing a wider role in referral to treatment or in providing drug services for detainees with problematic drug or alcohol use especially in a situation where locking up those with drug or alcohol problems is not an effective response.

Health care

Detainees interviewed in the participating countries felt there was a lack of healthcare provision in police detention, in that often their requests were ignored and the medical staff would take a long time to get to them.

Medical care in police detention is regularly perceived as a subject of low importance with police detention often being seen as a period of transition that requires emergency care. For more general healthcare needs, police officers and other staff working in police stations in all the participating countries reported that detainees were able to access healthcare when they needed it. Some problems were identified by police officers when they had to detain prisoners when community healthcare, such as SERT (in Italy) was unavailable, for example over the weekend.

Who provides health care for police detainees is variable both within a country and between the participating countries. The medical care provided in police arrest houses was generally limited and not comparable to either that in the community or in prisons. The standard of health care available in police cells is inconsistent with inadequate training in relation to drugs, alcohol and mental health amongst police officers who have the responsibility for the care of detainees. There is a clear need for training about health care for police officers as without it they are less likely to be able to access whether a detainee is intoxicated or to identify illness that may be masked by alcohol. The provision of medical care in police cells may be constrained by a lack of suitable consultation rooms, equipment and resources.

Healthcare in custody should be equal to that in the community and this needs to be rigorously enforced during the period of detention both in police cells and arrest houses. Some minimal level of qualified medical care should be accessible in police custody to enable the assessment of the risk that detainees pose to themselves, to identify those who need to be transferred to hospital and to provide regular medical care such as that provided by custody nurses in some police forces in England and Wales. Such initiatives like custody nurses were rare in the participating countries. More frequently there was a reliance on the emergency services or a doctor would be called for from the forensic medical service. A priority should be to provide officers with training in basic first-aid, in dealing with drug and alcohol addiction and mental health matters

so that they are in a good position to know when they need to call for medical services. Training should not be a one-off event but be regularly updated.

The condition of police cells and police arrest houses and the available facilities raises the question whether they are suitable places to detain those with acute healthcare needs, mental-health problems and addiction. In Germany, there are special police detention facilities for those with alcohol problems where detainees could be more closely monitored. However, detainees interviewed who had experienced these centres were critical of the care they had received whilst there, which compared less favourable to the treatment they had received in the community hospital. The PCA report in England and Wales concluded that:

> the police service is simply not equipped to deal with the complexity of extreme alcohol intoxication, and does not have the systems in place to offer adequate care to this population. Unless there are vast improvements in custody staff training, detainee risk assessment, the extent and quality of medical support and organisations' commitments to effective detainee management, there is no alternative but to conclude that drunken detainees should not be taken to police stations in other than the most extreme circumstances (Joint Committee On Human Rights 2005).

These conclusions from the England and Wales report are also relevant to the situation found in police detention in the participating countries.

Improving health care in police detention is important in itself and usually necessary to meet basic human rights requirements of detainees. Reforming the provision of health care can be a useful way of introducing wider reforms. Living conditions in police detention may be an abuse of human rights in themselves due to the shortage of space, air, light, ability to exercise and nutritious food. The conditions in police detention may be harmful to health so that change can be justified on health grounds even when the human rights argument might be less politically acceptable.

A key component in improving healthcare for detainees is education and staff training on health risks and infections. Some of the police officers interviewed were ignorant about transmission of infections and especially about the transmission of HIV. Although some officers in some of the countries had some training about occupational health they did not always have access to such things as protective gloves to use during searching.

Confidentiality of detainees' health status

The lack of training that police officers had about infectious diseases led in some cases to a breach of detainees' confidentiality where officers felt that they had a right to know of detainees' HIV status, or record books where such

details were kept were accessible to a wide number of people. A balance is required where detainees are asked to declare any health problems in order for their welfare needs to be met while at the same time their right to confidentiality is respected. Police officers saw disclosure of health problems as necessary to ensure the health and safety of anyone coming into contact with detainees, so they would make sure colleagues were aware of the need for caution, without necessarily declaring the specific nature of the detainees' illness. However, among other staff who come into contact with detainees (magistrates, arrest referral workers) this was not considered necessary as all detainees should be treated with caution, thus police officers did not need to know specific details about detainees' health to protect themselves.

The lack of healthcare and treatment for detainees raises concerns about public health, in much the same way as the need for such provisions in prison (MacDonald 2005). Those with problematic drug and alcohol use who do not receive treatment or referral to treatment and are released in the community, are vulnerable. Without harm reduction measures, they are at risk of overdosing and contracting and spreading infectious diseases, and without substitution treatment or detoxification, they are likely to re-offend in order to continue using drugs and/or alcohol. There are clear implications for health services when considering injecting drug users, as they are more likely to be responsible for the spread of infectious diseases (HIV/AIDS, hepatitis, tuberculosis) and numerous studies have highlighted the growing problem of this spread among incarcerated populations (MacDonald 2001, 2005; Hammett et al 1999). The detainees interviewed in this study reported specific problems with time in police detention disrupting their treatment or access to harm reduction services, putting themselves and others at greater risk.

Harm reduction

The use of harm reduction measures in police detention is variable, both within and across all the participating countries, and yet, where it is available, there has been a willingness to adopt such measures and a recognition of their effectiveness. The roles of the police and health professionals based in police detention centres are key in implementing such strategies. However, for many countries, the need for a shift from more punitive and coercive strategies is paramount in order to enable such policies to develop and be implemented effectively. Examples of best practice came primarily from community providers and NGOs, which are more experienced and open to using harm reduction techniques to minimise the health risks and other harms associated with problematic drug and alcohol use. However, such services are limited and in some cases non-existent, in some of the participating countries, especially in rural areas.

Generally, among police officers in all the participating countries, providing harm reduction measures was not seen as an important part of their role, and

was something they considered that detainees with problematic drug use could access in the community, or in prisons. A key point made by a representative from a Human Rights NGO as an explanation for the lack of harm reduction provision both in the community and in police detention was due to the exclusion of harm reduction strategies in legal codes, in that they were seen as part of the remit of healthcare agencies or NGOs.

Many police officers interviewed did not understand the importance of harm reduction measures and this highlighted the need for further training. The lack of understanding about such measures was emphasised by detainees who confirmed that officers in England would often remove clean injecting equipment from detainees and destroy it. For some detainees, when they were released back into the community, this resulted in sharing needles with others, if they could not access needle-exchange services in the community.

Police officers interviewed reported that harm reduction measures were seen as useful, as far as giving out leaflets and advice were concerned, but more practical measures such as providing condoms and clean needles were seen as unnecessary and potentially risky, within the confines of police custody. Many felt that users knew more about availability of clean needle provision or needle exchange programmes in the community than police officers and were well informed as to where to go. However, this was contradicted by one officer who felt that embracing the treatment agenda necessitated a more open mind to using innovative methods such as needle exchange programmes, particularly for more rural areas where such provisions are not readily accessible in the community.

Some magistracy staff, prosecutors, arrest referral and NGO staff thought that practical harm reduction measures should be available in police detention.

Securing committed and enduring support from important stakeholders, both in the community and in police detention, is crucial for harm reduction programmes that want to become established and sustainable. Police, politicians, public-health officials, doctors, lawyers and journalists play key roles in either hindering or promoting harm reduction programmes. A key task for harm reduction projects is to educate various stakeholder groups about the importance of harm reduction. In many countries harm reduction is still a new and controversial philosophy and a range of methods need to be used to convince stakeholders about the necessity and effectiveness of harm reduction measures. One such method that has been found to be effective in gaining stakeholder support is study tours, as abstract discussions and lectures have been found to be unlikely to convince stakeholders that harm reduction is an effective way to reduce HIV infection rates and improve occupational safety.

Lack of joined-up approach across the criminal justice system

Many criminal justice policy directives encourage organisations to work in partnership rather than in competition, which has led to a plethora of partnership groups dealing with a wide variety of issues particularly in England and Wales. In the participating countries where the police were working in partnership with other agencies this was considered to be a good thing. As mentioned previously the provision of health care in police detention can be very limited. The provision of health care is an area where partnership working with either the National Health Service or the prison health service would be beneficial. There tended to be very few links between prison health care and police detention health care. The reason given for this was that the police and prisons are usually under different ministries and subject to different budgetary constraints.

The lack of a joined-up approach across criminal justice agencies can have a detrimental effect on the healthcare or treatment programmes of those with problematic drug and alcohol use. Detainees who are on a methadone programme in the community are unlikely to be able to continue their methadone at the point of arrest but they may be able to continue their methadone in prison. However, by the time they have reached prison they may well have experienced a break in their programme. A lack of co-operation between the police and community drug agencies may result in detainees being released at times when they are unable to access clean needles or methadone. This can lead to detainees who find themselves in this situation sharing needles.

Working in partnership was not considered to be easy but respondents felt that when it worked it was of mutual benefit to the police and the community agency or prison. The process of establishing partnerships needs time to develop good relationships to be ready to deal with some of the more difficult issues that inevitably come up, for example, does everyone have an equal voice round the multi-agency table. Concerns were raised about the lack of training for organisations in engaging in multi-agency working, and, among police officers, it was felt other agencies in one country expected the police to take the lead with initiatives and addressing local problems. A police officer in England and Wales said that:

> there are tensions sometimes in custody suites with multi-agency working and this can cause some frustration. There is very limited multi agency working training and also there is the problem of who is going to deliver it and pay for it. It is not only resource issues that impede training but taking drugs workers off line to attend training when in a situation that is already under-resourced is not easy. Normally police work to

performance indicators but in this area there are none but introduction of them would help.

Even when partnerships are in place problems dealing with those with problematic drug and alcohol use can arise in the evenings and at weekends when for example arrest referral workers in England and Wales are not working. However, in England and Wales and in Italy the police said that they appreciated the drug agencies who worked with them as they managed to calm the drug users down and made their life easier.

There were inconsistent responses among police officers interviewed in the participating countries, in relation to the point of arrest being a realistic opportunity to address problematic drug and alcohol users' needs. A key issue was the lack of understanding that some demonstrated about harm reduction techniques and treatment provisions, and others, who felt that such strategies were not part of their role. This was reflected very much in the experience of detainees, many of whom reported on the lack of basic healthcare and services for those with problematic drug and alcohol use, and also identified negative attitudes and exploitation from police officers. The lack of facilities and treatment provision can be attributed to inadequate resources, but there were also cases where such resources do exist and where detainees reported receiving little or no assistance on request. Different views were expressed by other criminal justice staff and NGO representatives who emphasised the need for the police to engage with harm reduction measures, as they are a key contact point for many problematic drug and alcohol users and to establish stronger links with NGOs and other government agencies.

It is necessary to establish what works in what situations, to look beyond national policy at implementation of strategies and to bring together examples of best practice and identify where problems still exist. The study indicates both similarities and differences in the police response to problematic drug and alcohol users across the participating countries. Differences in national approaches to the problem may be dependent on the extent of the problem, the resources available, cultural attitudes among the police and public and also historical and political changes occurring throughout the EU.

Chapter 7: Recommendations and International Standards

International standards for the care of police detainees

There are a range of standards for the care of detainees in existence both specific to police detention and to the prison setting. Individual countries have their own guidelines, for example the British Medical Association (BMA, 2004) guidelines for health care in detention that could easily be made appropriate to other countries. The recommendations that have come out of this research will follow the short discussion of existing standards.

The World Health Organisation has established guidelines through consultation with international NGOs and governments to help control the spread of HIV/AIDS in prisons, which include public health standards for prison authorities (Møller et al. 2007; WHO Regional Office for Europe 2001). As Lines (2007,61) argues:

> In many countries, the groups most vulnerable to or affected by HIV and AIDS are also the group at increased risk for criminalization and incarceration, as many of the same social and economic conditions that increase vulnerability to HIV and AIDS also increase vulnerability to imprisonment.

A report by the CPT (2006) presents international standards of care specifically for police detainees (See Appendix C). These include preventing police officers abusing their powers of arrest and detention to intimidate or physically abuse suspects and to ensure that the aim of the interrogation process:

> must be to obtain accurate and reliable information in order to discover the truth on issues on which an investigation is being done, not to obtain a confession from the suspect who might be guilty (CPT 2006).

Interrogation by the police (CPT 2006) should be done in accordance to the following, where the prisoner is informed of:

1. the identity (name and/or number) of interrogational people present;
2. the possible length of an interrogation; the periods of rest between the talks and the pauses during an interrogation;
3. the places where interrogations can be carried out;
4. whether they will be asked to stand while interrogated
5. the modalities methods of interrogating of people who are under the effects of drugs, alcohol, etc;
6. the beginning and the end of the interrogation (which should also be recorded).

The three key rights of suspects in police detention, to act as safeguards to the ill-treatment of suspects, according to the CPT are:

1. the right of notification of detainment to a third party (member of the family, friend);
2. the right of to have a lawyer;
3. the right to demand a medical visit by a doctor chosen by the suspect (in addition to a medical visit by a doctor called by the police authorities).

All detainees must be informed of their rights, in particular, the right to have a lawyer and a medical visit chosen by the detainee, which should be guaranteed in a short time through a list of available professionals. Medical visits for detainees must be carried out in private, away from police officers, and the results of these visits should be registered and made available to the detainee and their lawyer. For more serious health conditions, it should be guaranteed that the detainee will be taken immediately to hospital.

Generally, the time in police detention is relatively short, which, as noted above, often means the general conditions are not as favourable as in other detention settings, such as prisons or remand centres that detain suspects for much longer periods. Despite this, the CPT recommends that police cells must be of adequate size with proper lighting (to allow detainees to read, and also to be turned off at night); good ventilation, seating and or proper beds and clean mattress and blankets for overnight stays. During detention, suspects must be provided with clean bathroom facilities and receive food at appropriate times, with at least one balanced meal every day (CPT 2006).

The CPT emphasises that the first few hours of detention present the highest risk to detainees with regards to intimidation and physical abuse by officers, therefore, it is important they have immediate access to a lawyer. When there is suspicion that the police have abused a suspect, a judge must take appropriate action, that is, to record the written declaration and order a medical visit immediately.

As mentioned above, standards of care for police detainees have also been developed by the British Medical Association (BMA 2004), which presents guidelines for police officers in ensuring the welfare of detainees and also to observe their rights. A key element of these standards is the principle of equivalence of care: that treatment should equal that which is available in the community. They also emphasise the need for forensic medical examiners to be aware of detainees' human rights and to be 'sensitive to the ways in which those rights can be compromised' and to speak out when 'services are inadequate or pose a potential threat to health' (BMA 2004, 2).

Recommendations

This research has identified a range of good practice in meeting the needs of detainees while in police custody but it has also shown a number of gaps in provision for detainees with problematic drug use. It is hope that the following recommendations will promote discussion and change where appropriate in current practice.

Drug policy

The drug policy in the participating countries was considered to have both strengths and weaknesses and there were some problems with implementation of some initiatives. National drug policy, to be effective, needs to distinguish between the type of drug used and reflect this in the criminal justice response to drug users and to stress the need for harm reduction and the development of programmes for those with problematic drug and alcohol use. It is recommended that:

- legislative and policy reforms be pursued to change criminal law and penalties with the objective of reducing the criminalisation of personal drug use and significantly reducing the use of arrest and imprisonment for drug users who are not involved with violence;
- the police in discussion with drug agencies in the community (NGO and Governmental) develop practice guidelines, for example providing harm reduction information to detainees;
- National Police Authorities should commission the development of guidelines for the management of those with problematic drug or alcohol use in police detention. Guidelines should include supportive care, harm reduction and treatment;
- links be established with prisons by the police to ensure continuity of treatment for those with problematic drug and or alcohol use while in police detention.

Staff and training

There is a need for a culture change amongst some police officers to one where harm reduction, treatment and healthcare are also seen as part of the role of the police and to reduce negative attitudes towards detainees with problematic drug or alcohol use. It is recommended that:

- police officers receive training so that they understand the human rights of problematic drug users and do not use the time of withdrawal to coerce them to confess or pass on information about dealers;
- regular staff training is provided to facilitate culture change amongst some police officers to one where treatment and healthcare are also

seen as part of the role of police and to reduce negative attitudes towards detainees with problematic drug and/or alcohol use;
- police officers, as part of their training, gain sufficient awareness of the symptoms of key conditions, involving addiction (drugs and alcohol) and health conditions, and to be able to conduct risk assessments of detainees in their charge;
- regular update training is provided.

Access to drug and alcohol treatment

The reality for most of the detainees interviewed who were on a methadone programme in the community was that during their time in police custody their programme was disrupted. Detainees were also unlikely to receive harm reduction information or referral to treatment options. Maintenance programmes for opioid dependent prisoners are considered to be successful interventions with a positive impact on the health status of those in the community and during imprisonment. It is recommended that:

- maintenance therapy should be available during police detention to avoid detainees experiencing a gap in their treatment;
- relationship with community drug-service providers be created and developed;
- protocols to implement referrals to treatment services for detainees be established;
- training that challenges the view that drug users do not want to be treated, do not need treatment and that when given treatment it is not effective.

Health care

The principle of equivalence means that health care interventions that are available in the community should be available to those in police detention. Detainees are entitled, without discrimination, to a standard of health care equivalent to that available in the community including prevention measures. However, the principle of equivalence is not being met in police detention, particularly in the areas of general health care and drug services. It is recommended that:

- police forces should guarantee the confidentiality of detainees' medical information and that it should not be shared with others without the detainee's consent except in exceptional circumstances that are clearly defined and explained to the detainee;

- healthcare in custody should be equal to that in the community and this needs to be rigorously enforced during the period of detention both in police cells and arrest houses;
- training in relation to drugs, alcohol and mental health is increased amongst police officers who have the responsibility for the care of detainees.
- training about health care for police officers is provided so they are more likely to be able to access whether a detainee is intoxicated or to identify illness that may be masked by alcohol.

Harm reduction

The use of harm reduction measures in police detention is variable, both within and across all the participating countries, and yet, where it is available, there has been a willingness to adopt such measures and recognition of their effectiveness. It is recommended that:

- harm reduction strategies be included in legal codes;
- consideration be given to implementing needle-replacement schemes in police stations;
- needle-exchange programmes be considered in police arrest houses;
- to promote acceptance of harm reduction methods by police officers joint training events, study tours and site visits, conferences and communications materials and other literature be used.

Promoting a joined-up approach across the criminal justice system

Many criminal justice policy directives encourage organisations to work in partnership rather than in competition and in the participating countries where the police were working in partnership with other agencies this was considered to be a good thing. It is recommended that:

- national and local governments should allocate NGOs with sufficient funding to play an integrated and effective role in provision of drug services for detainees;
- training for organisations in engaging in multi-agency working be provided;
- links between prison health care and police detention health care be explored both at the operational and Ministerial level.

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- Possession of illicit drugs:
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- Decision 54/2004 of the Constitutional Court (amending the Penal Code)
- Referral to alternative treatment by the criminal justice system:
- Ministry of Health and Ministry of Youth, Family, Social Affairs and Equal Opportunities Decree no. 26 of 2003 on diversion of drug users into treatment

Prisons and Police Detention:

- Act XI of 1978 on the Criminal Procedure
- Ministry of Justice Decree no. 6 of 1996 on the Implementation of Imprisonment and Detention
- Ministry of Justice Decree no. 5 of 1998 on Healthcare for Prisoners
- Ministry of Home Affairs Decree no. 19 of 1995 on the Rule of Police Detention Places
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Law no. 143 / 2000, Law no. 218 / 2002 regarding organization and functioning of Romanian Police, Law no. 300 / 2002 regarding the juridical regime of precursors used at illicitly fabricate drugs, Law no. 360 / 2002 regarding the policeman status, Law no. 381 / 2004 regarding some financial measures in the field of control and fight against trafficking and illicit use of drugs, Law no. 522 / 2004 for the modification of Law no. 143 / 2000 regarding control and fight against trafficking and illicit use of drugs.

Government Emergency Order no. 92 / 2000 regarding organization and functioning services of social reintegration of offenders and regarding supervising of not imprisonment punishments, modified by the Law no. 211 /2004.

Romanian Government Decision no. 1489/2002, modified by Romanian Government Decision no. 183 / 2003 regarding the setup of Anti-drug National Agency (ANA).

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Romanian Government Decision no. 73/2005 for the approval of the Anti-drug National Strategy for the period 2005–2012.

Romanian Government Decision no. 860/2005 for the approval of the Regulations for applying the dispositions of the Law no 143/2000 regarding control and fight against trafficking and illicit use of drugs, with ulterior modifications.

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Appendix A

Ethical and procedural guidelines and checklists

Police detention in Europe: A comparative study of the provision of services for problematic drug and alcohol users

Ethical and methodological guidelines

Introduction

The European Commission AGIS Programme has awarded the University of Central England in Birmingham (UCE) a grant to conduct a study on *Police Detention in Europe: A Comparative Study of the Provision of Services for Problematic Drug and Alcohol Users.* The study will use a qualitative methodology that requires interviews and focus groups with police officers and other criminal justice professionals, government officials, healthcare staff, non-government organisations and problematic drug and alcohol users who have experienced police detention. The interpreter (where necessary) who accompanies the researcher should be independent of any of the organisations participating in this study.

The sensitive nature of the research requires clear ethical and confidentiality procedures and guarantees for the participants. UCE has clear ethical guidelines which will be strictly adhered to, in order to ensure the welfare of all participants, in terms of fully understanding their rights, the purpose of the interview and how the data collected will be used.

Ethical statement – summary of UCE guidelines

The University expects that staff will behave professionally and ethically in all its activities. This implies that staff and students who are engaged in research and other activities are aware of the ethical implications of such activities and are committed to discharging their responsibilities to the University, to clients and to research participants in an ethical manner, conforming to the highest professional standards of conduct.

Principles for the consideration of ethical issues

- Staff and students shall be made aware of their responsibilities and obligations to consider ethical issues arising from their research at or on behalf of the University.

- The dignity, rights, safety and well-being of participants must be the primary consideration in any research study.
- Informed consent is at the heart of ethical research.

To ensure adherence to the ethical guidelines and maintain the rights of all participants involved:

- Participants shall be made fully aware of the true nature and purpose of the study.
- Participants will have given their explicit consent to take part in the study.
- Participants will be informed at the outset that they can withdraw themselves and their data from the research activity at any time and they must not subsequently be put under any pressure to continue.
- Processes shall be in place to ensure that the rights of those participants who may be unable to assess the implications of the proposed work are safeguarded.
- Any data collected will be anonymous. It will not be used to identify participants in any way and will be stored in a secure place to maintain confidentiality.
- All those involved in the collection of data and facilitation of access to the participants will be made fully aware of the above guidelines.

Aims and objectives of the study:

Key Aim: To investigate legislation, policy and practice in relation to treatment of problematic drug and alcohol users in police detention in 8 countries in the European Union.

Objectives:

- To explore trends in problematic drug and alcohol use for each country.
- To establish national legislation and strategies in place to address problematic drug and alcohol use in each country.
- To investigate the provision of healthcare and treatment services for problematic drug and alcohol users in police detention and establish who is responsible for this, for each country.
- To consider the impact for those countries recently joining the European Union on strategies and service provision for problematic drug and alcohol users in police detention.
- To consider diversity issues (gender, ethnicity, citizenship) relating to problematic drug and alcohol use within each country.
- To explore the co-operation between the different agencies of the criminal justice system in relation to problematic drug and alcohol users.
- To identify gaps in service provision for problematic drug and alcohol users in police detention for each country.

- To identify and disseminate good practice identified in each country, among all partners involved in the study.

Participants and data collection

The specific details of the participants involved in the study, the fieldwork timetable and key themes to be addressed will be discussed and agreed at the first partner seminar, in the UK (December, 2005).

In order to achieve the aims of the research we intend to interview:

- Ministry of Justice (responsible for police) - 1
- Ministry of Health (responsible for Drugs and Alcohol issues) - 1
- Police (Chiefs & Heads of Drugs and Alcohol control) - 2
- Police (Health workers/Treatment referral workers) - 2
- Prisons (Head of Healthcare) - 1
- Probation staff - 1
- Magistrates - 1
- NGO's (providing services/working with police)- 3
- Problematic drug and alcohol users detained by police – 8

These will be organised through the partner organisation contacts, who will assist in co-ordinating the fieldwork and facilitating access.

A comprehensive literature review will look at policy information, current research and statistical data. This will include previous and current research in this area and regarding the treatment of problematic drug and alcohol users in general, along with official reports for each participating country and details of the trends in drugs/alcohol misuse and healthcare provisions. Statistical data will present current findings on the extent of the problems experienced in each country, in order to put into context the response by the police and other organisations.

The qualitative research will involve one to one interviews with key personnel in each country's criminal justice system, health care and government, along with police detainees who are identified as problematic drug and alcohol users. The interviews will be in-depth and will provide comprehsive data on both policy relating to and the reality of police detention for problematic drug and alcohol users. The research will also explore the liaison and co-operation between the different agencies of the criminal justice system i.e. the police with the prosecutors and courts, transfer to pre-trial prisons, NGOs providing drug services etc.

It is anticipated that the interviews will last approximately 45 minutes, and will take place during the fieldwork visit with all participants over 5 days. For each of the interviews, an appropriate space will be required to ensure confidentiality and to accommodate the participant(s), researcher and interpreter.

Role of the partners

- Identify key participants (individuals or organisations/departments) in their criminal justice system (police, prosecutors, magistrates, probation, prison), government, health, NGOs and any other agencies or organisations that would be useful to interview
- Identify how detainees can be accessed during the fieldwork visits, e.g. through NGOs, treatment centres.
- Identify any key themes to be addressed, which fit with the aims and objectives of the study.
- Identify sources of information accessed as part of the literature review, e.g. national statistics, structure of key organisations (police, health), surveys, evaluations of projects to address problematic drug and alcohol use, academic articles.
- Identify diversity issues in their country, i.e. any groups who are excluded from accessing treatment/healthcare.
- Provide a short description of the organisation of the police and information about length of time arrestees can be kept in police detention.

INTERVIEW SCHEDULES FOR PARTICIPANTS

1. Brief overview of the CJS. I.e. how long can a person remain in police custody (maximum length of time) before release or transfer to prison? Who makes this decision? On what criteria? Describe the process from the point of arrest. What is the role of prosecutors in your system?
2. Is there effective liaison between the different agencies of the CJS i.e. Police with prosecutors and magistrates/judges, Probation etc?
3. Are there any specific issues/problems that you can identify in multi-disciplinary working with different professionals in the CJS?
4. Facilities available for detaining those arrested – sufficient, key problems? (Overcrowded? Number of prisoners per cell? Amount of time out of cell? Usual numbers detained in a custody unit?)
5. What, in your view, are the most common complaints raised by arrestees? Process for registering complaints – prosecutors, lay visitors? Independent?
6. Training for criminal justice personnel i.e. police, judges, magistrates and prosecutors – effective, involve information about PDUs, harm reduction etc? Would this be helpful for the CJS personnel?

7. What do you think are the most effective teaching strategies for ensuring skills and knowledge about drug and alcohol addiction and harm reduction are delivered in criminal justice personnel training programmes?
8. Is the point of arrest too short a time period to address problems re drugs and alcohol – can it be effective in reducing offending? Is it feasible to think that the police would have a role in referring PD&AUs to treatment?
9. As this is also a comparative research project, initially with 4 countries, to be broadened to 8 EU countries, it would be useful to get an overview of your views on how to deal with problematic drug and alcohol users, i.e. treatment in the community or in prison?
10. What are the key debates re alternatives to prison and particularly for PDUs? What is currently available – nationally?
11. What would you identify as the main barriers to implementing alternatives to custody?
12. Do you feel there are any sentencing provisions more appropriate for problematic drug and alcohol users?
13. Would information regarding offenders' use of harm reduction measures (i.e. receiving substitution treatment) be useful in determining sentence?
14. Is the criminal justice system always the best response to problematic drug and/or alcohol users? Are there mechanisms in place to deal with a wide range of circumstances and problems presented by problematic drug and alcohol users? Generally, how do prosecutors and police view PDAUs and their current treatment? Does addictive behaviour influence sentencing?
15. Are there any other measures, initiatives that would help you deal more effectively with PDAUs?
16. Do magistrates/courts/prosecutors have links with NGOs/Voluntary organisations which treat problematic drug and alcohol users?
    - if not, would this help?
17. What are the key problems for the criminal justice system in dealing with PDAUs?

Problematic drug and alcohol users treatment in police detention

18. Do you think that police detention is a good opportunity to refer problematic drug and alcohol users to treatment agencies?
19. What treatment services are provided for problematic drug and alcohol users in police detention?
20. Do the police have links with healthcare professionals for detainees?
21. How are detainees transferred from police detention into prison? Do detainees medical records get transferred? Confidentiality?

22. Do the police have links with NGOs which offer services to problematic drug and alcohol users? Do they have access to detainees in the police station?
23. Do the police have links with other criminal justice agencies when dealing with problematic drug and alcohol users? How well do they work together?
24. What are the national protocols and strategies to deal with problematic drug and alcohol users in police detention?
25. Are problematic drug and alcohol users considered to be a problem?
26. Are the levels of drug use and associated crime rising? What do you think are the main reasons for this?
27. What do think the pubic think of problematic drug and alcohol users? Would they prefer they received treatment or punishment?
28. Do the police deal with foreign nationals who are also problematic drug and alcohol users?
29. Among problematic drug and alcohol users, are there any groups which present more difficulties? How are young people dealt with (i.e. under 18 years)?
30. Do the police make use of strategies to divert offenders from further detention into treatment in the community? Who provides these services?
31. Do you have any specific strategies for problematic alcohol users? Is this a major concern for the police?
32. How are these strategies disseminated to other forces and to front-line police officers?
33. What do you see as the main problems in implementing these strategies?

Harm reduction questions

34. 'Harm reduction' is a phrase increasingly used in police policy documents about drugs and alcohol. How well do you believe this term is understood by police officers?
35. How well do you think the concept is accepted by police officers?
36. What do you foresee as barriers to police implementing drug and alcohol harm reduction strategies in your jurisdiction?
37. Are existing Policing Operational Core Competency Standards applicable to drugs and alcohol?
38. Is there a centrally designed harm reduction strategy for arrestees in police detention? What does it consist of?
39. Who delivers the information for harm reduction?
40. Do community groups have a role in delivery?
41. What are your views about the provision of harm reduction materials, such as, condoms, clean needles, methadone, detoxification?

42. Do you have a strategy to deal with detainees at risk of suicide or self-harm?

Healthcare for problematic drug and alcohol users in police detention

43. Who provides the health care in police detention (e.g. police surgeons/custody nurses in the UK)?
44. Is it equivalent to health care provision and drug treatment in the community?
45. Who makes the decision to call the doctor and based on what training?
46. Is detainees' confidentiality ensured?
47. What do you consider to be the main problem in the delivery of health care in police detention?
48. How are problematic drug and alcohol users requiring substitution treatment managed? What about other needs, such as detoxification, psychiatric care?
49. Are the staff based in detention centres well informed about the needs of problematic drug and alcohol users? Who provides the training?
50. Are there any groups among problematic drug and alcohol users which present additional needs or problems?

Training

51. What training is in place for police officers in dealing with problematic drug and alcohol users? Does this cover issues around harm reduction?
52. What do you think are the best examples of quality drug and alcohol training resources and programs for police in your jurisdiction? Why are they such good examples?
53. Do you think this it is possible to share examples of best practice at a national level?

For new EU members

54. In relation to problematic drug and alcohol users in police detention, what policy changes were made in preparation for joining the EU?
55. Has joining the EU impacted on national policy and resources available to deal with problematic drug and alcohol use?
56. Has joining the EU affected levels of problematic drug and alcohol use and offending, in any way?

57. How has this impacted on training for those involved in the care of problematic drug and alcohol users in police detention?
58. Do you view joining the EU as a positive step?
59. Are you aware of any individuals, groups or organisations who were resistant to joining the EU?
60. Do you have improved co-operation with other countries in preventing and reducing offending?

For accession countries

61. In relation to problematic drug and alcohol users in police detention, what policy changes were made in preparation for applying to join the EU?
62. Has applying to join the EU affected levels of problematic drug and alcohol use and offending, in any way?
63. Has applying to join the EU impacted on national policy and resources available to deal with problematic drug and alcohol use?
64. How has this impacted on training for those involved in the care of problematic drug and alcohol users in police detention?
65. Do you view joining the EU as a positive step?
66. Are you aware of any individuals, groups or organisations who were resistant to joining the EU?
67. Do you think as a member of the EU, you will have improved co-operation with other countries in preventing and reducing offending?

FOCUS GROUP/INTERVIEW WITH DETAINEES

1. How long were you in police detention?
2. Were you arrested due to a drug related crime?
3. What were the conditions like in police detention?
    - space in your cell
    - number of people in your cell
    - availability of hot water etc; toilet facilities
    - availability of basic hygienic equipment (toothpaste/brush; soap, toilet paper)
    - access to showers?

4. Overall how would you describe your experience of police detention and the services that you received for your drug or alcohol problem?
5. What access to medical care did you have? Did you experience problems in getting your health needs met?
6. How long did you wait to see the doctor? Did you need access to specialist care?
7. Was treatment for drug/alcohol use disrupted while in detention?
8. Did you experience any ill-treatment from police officers whilst in detention? E.g. verbal or physical abuse, bribery from officers to access treatment?
9. Are you currently receiving drug treatment programme/therapy in the community? How did you access this?
10. Are you aware of NGOs providing treatment services for drug or alcohol use, substitution treatment, withdrawal etc?
11. Are you aware of harm reduction measures such as clean needles, substitution treatment, giving advice on health risk etc?
12. Were you offered any such measures while in police custody? Would you have found this useful?
13. What two things would you most like to see changed in police detention?

Appendix B

Guidelines to the partners on their role and for the production of the country profiles

- Identify key participants (individuals or organisations/departments).
- Organise the programme for the fieldwork visit.
- Identify how detainees can be accessed during the fieldwork visits, e.g. through NGOs, treatment centres.
- Identify any key themes to be addressed, which fit with the aims and objectives of the study.
- Identify sources of information accessed as part of the literature review.
- Identify diversity issues in their country.
- Provide a short description of the organisation of the police and information about length of time arrestees can be kept in police detention.
- Attend the two partner seminars.
- To participate in the evaluation of the project.

Appendix C

CPT standards for detainees in police custody

The CPT is required to draw up every year a General Report on its activities, which is published.

In a number of its General Reports the CPT has described some of the substantive issues which it pursues when carrying out visits to places of deprivation of liberty. The Committee hopes in this way to give a clear advance indication to national authorities of its views regarding the manner in which persons deprived of their liberty ought to be treated and, more generally, to stimulate discussion on such matters.

The "substantive" sections drawn up to date have been brought together in this document.

Preface

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) was set up under the 1987 Council of Europe Convention of the same name (hereinafter "the Convention"). According to Article 1 of the Convention:

"There shall be established a European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment... The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment."

The work of the CPT is designed to be an integrated part of the Council of Europe system for the protection of human rights, placing a proactive non-judicial mechanism alongside the existing reactive judicial mechanism of the European Court of Human Rights.

The CPT implements its essentially preventive function through two kinds of visits - periodic and ad hoc. Periodic visits are carried out to all Parties to the Convention on a regular basis. Ad hoc visits are organised in these States when they appear to the Committee "to be required in the circumstances".

When carrying out a visit, the CPT enjoys extensive powers under the Convention: access to the territory of the State concerned and the right to travel without restriction; unlimited access to any place where persons are deprived of their liberty, including the right to move inside such places without restriction; access to full information on places where persons deprived of their liberty are being held, as well as to other information available to the State which is necessary for the Committee to carry out its task.

The Committee is also entitled to interview in private persons deprived of their liberty and to communicate freely with anyone whom it believes can supply relevant information.

Visits may be carried out to any place "where persons are deprived of their liberty by a public authority". The CPT's mandate thus extends beyond prisons and police stations to encompass, for example, psychiatric institutions, detention areas at military barracks, holding centres for asylum seekers or other categories of foreigners, and places in which young persons may be deprived of their liberty by judicial or administrative order.

Two fundamental principles govern relations between the CPT and Parties to the Convention - co-operation and confidentiality. In this respect, it should be emphasised that the role of the Committee is not to condemn States, but rather to assist them to prevent the ill-treatment of persons deprived of their liberty.

After each visit, the CPT draws up a report which sets out its findings and includes, if necessary, recommendations and other advice, on the basis of which a dialogue is developed with the State concerned. The Committee's visit report is, in principle, confidential; however, almost all States have chosen to waive the rule of confidentiality and publish the report.

I. Police custody

Extract from the 2nd General Report [CPT/Inf (92) 3]

36. The CPT attaches particular importance to three rights for persons detained by the police: the right of the person concerned to have the fact of his detention notified to a third party of his choice (family member, friend, consulate), the right of access to a lawyer, and the right to request a medical examination by a doctor of his choice (in addition to any medical examination carried out by a doctor called by the police authorities).[103] They are, in the CPT's opinion, three fundamental safeguards against the ill-treatment of detained persons which should apply as from the very outset of deprivation of liberty, regardless of how it may be described under the legal system concerned (apprehension, arrest, etc).

37. Persons taken into police custody should be expressly informed without delay of all their rights, including those referred to in paragraph 36. Further, any possibilities offered to the authorities to delay the exercise of one or other of the latter rights in order to protect the interests of justice should be clearly defined and their application strictly limited in time. As regards more particularly the

103 This right has subsequently been reformulated as follows: the right of access to a doctor, including the right to be examined, if the person detained so wishes, by a doctor of his own choice (in addition to any medical examination carried out by a doctor called by the police authorities).

rights of access to a lawyer and to request a medical examination by a doctor other than one called by the police, systems whereby, exceptionally, lawyers and doctors can be chosen from pre-established lists drawn up in agreement with the relevant professional organisations should remove any need to delay the exercise of these rights.

38. Access to a lawyer for persons in police custody should include the right to contact and to be visited by the lawyer (in both cases under conditions guaranteeing the confidentiality of their discussions) as well as, in principle, the right for the person concerned to have the lawyer present during interrogation.

As regards the medical examination of persons in police custody, all such examinations should be conducted out of the hearing, and preferably out of the sight, of police officers. Further, the results of every examination as well as relevant statements by the detainee and the doctor's conclusions should be formally recorded by the doctor and made available to the detainee and his lawyer.

39. Turning to the interrogation process, the CPT considers that clear rules or guidelines should exist on the way in which police interviews are to be conducted. They should address inter alia the following matters: the informing of the detainee of the identity (name and/or number) of those present at the interview; the permissible length of an interview; rest periods between interviews and breaks during an interview; places in which interviews may take place; whether the detainee may be required to stand while being questioned; the interviewing of persons who are under the influence of drugs, alcohol, etc. It should also be required that a record be systematically kept of the time at which interviews start and end, of any request made by a detainee during an interview, and of the persons present during each interview.

The CPT would add that the electronic recording of police interviews is another useful safeguard against the ill-treatment of detainees (as well as having significant advantages for the police).

40. The CPT considers that the fundamental safeguards granted to persons in police custody would be reinforced (and the work of police officers quite possibly facilitated) if a single and comprehensive custody record were to exist for each person detained, on which would be recorded all aspects of his custody and action taken regarding them (when deprived of liberty and reasons for that measure; when told of rights; signs of injury, mental illness, etc; when next of kin/consulate and lawyer contacted and when visited by them; when offered food; when interrogated; when transferred or released, etc.). For various matters (for example, items in the person's possession, the fact of being told of one's rights and of invoking or waiving them), the signature of the detainee should be obtained and, if necessary, the absence of a signature explained. Further, the detainee's lawyer should have access to such a custody record.

41. Further, the existence of an independent mechanism for examining complaints about treatment whilst in police custody is an essential safeguard.

42. Custody by the police is in principle of relatively short duration. Consequently, physical conditions of detention cannot be expected to be as good in police establishments as in other places of detention where persons may be held for lengthy periods. However, certain elementary material requirements should be met.

All police cells should be of a reasonable size for the number of persons they are used to accommodate, and have adequate lighting (i.e. sufficient to read by, sleeping periods excluded) and ventilation; preferably, cells should enjoy natural light. Further, cells should be equipped with a means of rest (e.g. a fixed chair or bench), and persons obliged to stay overnight in custody should be provided with a clean mattress and blankets.

Persons in custody should be allowed to comply with the needs of nature when necessary in clean and decent conditions, and be offered adequate washing facilities. They should be given food at appropriate times, including at least one full meal (i.e. something more substantial than a sandwich) every day.[104]

43. The issue of what is a reasonable size for a police cell (or any other type of detainee/prisoner accommodation) is a difficult question. Many factors have to be taken into account when making such an assessment. However, CPT delegations felt the need for a rough guideline in this area. The following criterion (seen as a desirable level rather than a minimum standard) is currently being used when assessing police cells intended for single occupancy for stays in excess of a few hours: in the order of 7 square metres, 2 metres or more between walls, 2.5 metres between floor and ceiling.

Extract from the 6th General Report [CPT/Inf (96) 21]

14. The CPT welcomes the support for its work expressed in Parliamentary Assembly Recommendation 1257 (1995), on conditions of detention in Council of Europe member States. It was also most pleased to learn from the reply to Recommendation 1257 that the Committee of Ministers has invited the authorities of member States to comply with the guidelines on police custody as laid down in the 2nd General Report of the CPT (cf. CPT/Inf (92) 3, paragraphs 36 to 43).

In this connection, it should be noted that some Parties to the Convention are reluctant to implement fully certain of the CPT's recommendations concerning safeguards against ill-treatment for persons in police custody, and in particular the recommendation that such persons be accorded a right of access to a lawyer as from the very outset of their custody.

15. The CPT wishes to stress that, in its experience, the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest. Consequently, the possibility for persons taken into police

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104 The CPT also advocates that persons kept in police custody for 24 hours or more should, as far as possible, be offered outdoor exercise every day.

custody to have access to a lawyer during that period is a fundamental safeguard against ill-treatment. The existence of that possibility will have a dissuasive effect upon those minded to ill treat detained persons; further, a lawyer is well placed to take appropriate action if ill-treatment actually occurs.

The CPT recognises that in order to protect the interests of justice, it may exceptionally be necessary to delay for a certain period a detained person's access to a particular lawyer chosen by him. However, this should not result in the right of access to a lawyer being totally denied during the period in question. In such cases, access to another independent lawyer who can be trusted not to jeopardise the legitimate interests of the police investigation should be arranged.

16. The CPT also emphasised in the 2nd General Report the importance of persons taken into police custody being expressly informed without delay of all their rights.

In order to ensure that this is done, the CPT considers that a form setting out those rights in a straightforward manner should be systematically given to persons detained by the police at the very outset of their custody. Further, the persons concerned should be asked to sign a statement attesting that they have been informed of their rights. The above-mentioned measures would be easy to implement, inexpensive and effective.

Extract from the 12th General Report [CPT/Inf (2002) 15]

33. It is essential to the good functioning of society that the police have the powers to apprehend, temporarily detain and question criminal suspects and other categories of persons. However, these powers inherently bring with them a risk of intimidation and physical ill-treatment. The essence of the CPT's work is to seek ways of reducing that risk to the absolute minimum without unduly impeding the police in the proper exercise of their duties. Encouraging developments in the field of police custody have been noted in a number of countries; however, the CPT's findings also highlight all too often the need for continuing vigilance.

34. The **questioning of criminal suspects** is a specialist task which calls for specific training if it is to be performed in a satisfactory manner. First and foremost, *the precise aim of such questioning* must be made crystal clear: that aim should be to obtain accurate and reliable information in order to discover the truth about matters under investigation, not to obtain a confession from someone already presumed, in the eyes of the interviewing officers, to be guilty. In addition to the provision of appropriate training, ensuring adherence of law enforcement officials to the above-mentioned aim will be greatly facilitated by the drawing up of a code of conduct for the questioning of criminal suspects.

35. Over the years, CPT delegations have spoken to a considerable number of detained persons in various countries, who have made credible claims of having been physically ill-treated or otherwise intimidated or threatened, by

police officers trying to obtain confessions in the course of interrogations. It is self-evident that a criminal justice system which places a premium on *confession evidence* creates incentives for officials involved in the investigation of crime - and often under pressure to obtain results - to use physical or psychological coercion. In the context of the prevention of torture and other forms of ill-treatment, it is of fundamental importance to develop methods of crime investigation capable of reducing reliance on confessions, and other evidence and information obtained via interrogations, for the purpose of securing convictions.

36. The **electronic (i.e. audio and/or video) recording of police interviews** represents an important additional safeguard against the ill-treatment of detainees. The CPT is pleased to note that the introduction of such systems is under consideration in an increasing number of countries. Such a facility can provide a complete and authentic record of the interview process, thereby greatly facilitating the investigation of any allegations of ill-treatment. This is in the interest both of persons who have been ill-treated by the police and of police officers confronted with unfounded allegations that they have engaged in physical ill-treatment or psychological pressure. Electronic recording of police interviews also reduces the opportunity for defendants to later falsely deny that they have made certain admissions.

37. The CPT has on more than one occasion, in more than one country, discovered **interrogation rooms** of a highly intimidating nature: for example, rooms entirely decorated in black and equipped with spotlights directed at the seat used by the person undergoing interrogation. Facilities of this kind have no place in a police service.

In addition to being adequately lit, heated and ventilated, interview rooms should allow for all participants in the interview process to be seated on chairs of a similar style and standard of comfort. The interviewing officer should not be placed in a dominating (e.g. elevated) or remote position vis-à-vis the suspect. Further, colour schemes should be neutral.

38. In certain countries, the CPT has encountered the practice of **blindfolding** persons in police custody, in particular during periods of questioning. CPT delegations have received various - and often contradictory - explanations from police officers as regards the purpose of this practice. From the information gathered over the years, it is clear to the CPT that in many if not most cases, persons are blindfolded in order to prevent them from being able to identify law enforcement officials who inflict ill-treatment upon them. Even in cases when no physical ill-treatment occurs, to blindfold a person in custody - and in particular someone undergoing questioning - is a form of oppressive conduct, the effect of which on the person concerned will frequently amount to psychological ill-treatment. The CPT recommends that the blindfolding of persons who are in police custody be expressly prohibited.

39. It is not unusual for the CPT to find **suspicious objects** on police premises, such as wooden sticks, broom handles, baseball bats, metal rods, pieces of thick electric cable, imitation firearms or knives. The presence of

such objects has on more than one occasion lent credence to allegations received by CPT delegations that the persons held in the establishments concerned have been threatened and/or struck with objects of this kind.

A common explanation received from police officers concerning such objects is that they have been confiscated from suspects and will be used as evidence. The fact that the objects concerned are invariably unlabelled, and frequently are found scattered around the premises (on occasion placed behind curtains or cupboards), can only invite scepticism as regards that explanation. In order to dispel speculation about improper conduct on the part of police officers and to remove potential sources of danger to staff and detained persons alike, items seized for the purpose of being used as evidence should always be properly labelled, recorded and kept in a dedicated property store. All other objects of the kind mentioned above should be removed from police premises.

40. As from the outset of its activities, the CPT has advocated a trinity of rights for persons detained by the police: the rights of access to a lawyer and to a doctor and the right to have the fact of one's detention notified to a relative or another third party of one's choice. In many States, steps have been taken to introduce or reinforce these rights, in the light of the CPT's recommendations. More specifically, the right of access to a lawyer during police custody is now widely recognised in countries visited by the CPT; in those few countries where the right does not yet exist, plans are afoot to introduce it.

41. However, in a number of countries, there is considerable reluctance to comply with the CPT's recommendation that the right of **access to a lawyer** be guaranteed from the very outset of custody. In some countries, persons detained by the police enjoy this right only after a specified period of time spent in custody; in others, the right only becomes effective when the person detained is formally declared a "suspect".

The CPT has repeatedly stressed that, in its experience, the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest. Consequently, the possibility for persons taken into police custody to have access to a lawyer during that period is a fundamental safeguard against ill-treatment. The existence of that possibility will have a dissuasive effect upon those minded to ill treat detained persons; further, a lawyer is well placed to take appropriate action if ill-treatment actually occurs. The CPT recognises that in order to protect the legitimate interests of the police investigation, it may exceptionally be necessary to delay for a certain period a detained person's access to a lawyer of his choice. However, this should not result in the right of access to a lawyer being totally denied during the period in question. In such cases, access to another independent lawyer should be arranged.

The right of access to a lawyer must include the right to talk to him in private. The person concerned should also, in principle, be entitled to have a lawyer present during any interrogation conducted by the police. Naturally, this should not prevent the police from questioning a detained person on urgent matters, even in the absence of a lawyer (who may not be immediately

available), nor rule out the replacement of a lawyer who impedes the proper conduct of an interrogation.

The CPT has also emphasised that the right of access to a lawyer should be enjoyed not only by criminal suspects but also by anyone who is under a legal obligation to attend - and stay at - a police establishment, e.g. as a "witness".

Further, for the right of access to a lawyer to be fully effective in practice, appropriate provision should be made for persons who are not in a position to pay for a lawyer.

42. Persons in police custody should have a formally recognised right of **access to a doctor**. In other words, a doctor should always be called without delay if a person requests a medical examination; police officers should not seek to filter such requests. Further, the right of access to a doctor should include the right of a person in custody to be examined, if the person concerned so wishes, by a doctor of his/her own choice (in addition to any medical examination carried out by a doctor called by the police).

All medical examinations of persons in police custody must be conducted out of the hearing of law enforcement officials and, unless the doctor concerned requests otherwise in a particular case, out of the sight of such officials.

It is also important that persons who are released from police custody without being brought before a judge have the right to directly request a medical examination/certificate from a recognised forensic doctor.

43. A detained person's right to have the fact of his/her detention notified to a third party should in principle be guaranteed from the very outset of police custody. Of course, the CPT recognises that the exercise of this right might have to be made subject to certain exceptions, in order to protect the legitimate interests of the police investigation. However, such exceptions should be clearly defined and strictly limited in time, and resort to them should be accompanied by appropriate safeguards (e.g. any delay in notification of custody to be recorded in writing with the reasons therefore, and to require the approval of a senior police officer unconnected with the case or a prosecutor).

44. Rights for persons deprived of their liberty will be of little value if the persons concerned are unaware of their existence. Consequently, it is imperative that persons taken into police custody are **expressly informed of their rights** without delay and in a language which they understand. In order to ensure that this is done, a form setting out those rights in a straightforward manner should be systematically given to persons detained by the police at the very outset of their custody. Further, the persons concerned should be asked to sign a statement attesting that they have been informed of their rights.

45. The CPT has stressed on several occasions the role of judicial and prosecuting authorities as regards combating ill-treatment by the police.

For example, all persons detained by the police whom it is proposed to remand to prison should be physically brought before the judge who must decide that issue; there are still certain countries visited by the CPT where this does not occur. Bringing the person before the judge will provide a timely opportunity for a criminal suspect who has been ill-treated to lodge a complaint. Further, even in the absence of an express complaint, the judge will be able to take action in good time if there are other indications of ill-treatment (e.g. visible injuries; a person's general appearance or demeanour).

Naturally, the judge must take appropriate steps when there are indications that ill-treatment by the police may have occurred. In this regard, whenever criminal suspects brought before a judge at the end of police custody allege ill-treatment, the judge should record the allegations in writing, order immediately a forensic medical examination and take the necessary steps to ensure that the allegations are properly investigated. Such an approach should be followed whether or not the person concerned bears visible external injuries. Further, even in the absence of an express allegation of ill-treatment, the judge should request a forensic medical examination whenever there are other grounds to believe that a person brought before him could have been the victim of ill-treatment.

The diligent examination by judicial and other relevant authorities of all complaints of ill-treatment by law enforcement officials and, where appropriate, the imposition of a suitable penalty will have a strong deterrent effect. Conversely, if those authorities do not take effective action upon complaints referred to them, law enforcement officials minded to ill-treat persons in their custody will quickly come to believe that they can do so with impunity.

46. Additional questioning by the police of persons remanded to prison may on occasion be necessary. The CPT is of the opinion that from the standpoint of the prevention of ill-treatment, it would be far preferable for such questioning to take place within the prison establishment concerned rather than on police premises. The return of remand prisoners to police custody for further questioning should only be sought and authorised when it is absolutely unavoidable. It is also axiomatic that in those exceptional circumstances where a remand prisoner is returned to the custody of the police, he/she should enjoy the three rights referred to in paragraphs 40 to 43.

47. Police custody is (or at least should be) of relatively short duration. Nevertheless, conditions of detention in police cells must meet certain *basic requirements*.

All police cells should be clean and of a reasonable size[105] for the number of persons they are used to accommodate, and have adequate lighting (i.e. sufficient to read by, sleeping periods excluded); preferably cells should

105 As regards the size of police cells, see also paragraph 43 of the 2nd General Report (CPT/Inf (92) 3).

enjoy natural light. Further, cells should be equipped with a means of rest (e.g. a fixed chair or bench), and persons obliged to stay overnight in custody should be provided with a clean mattress and clean blankets. Persons in police custody should have access to a proper toilet facility under decent conditions, and be offered adequate means to wash themselves. They should have ready access to drinking water and be given food at appropriate times, including at least one full meal (i.e. something more substantial than a sandwich) every day. Persons held in police custody for 24 hours or more should, as far as possible, be offered outdoor exercise every day.

Many police detention facilities visited by CPT delegations do not comply with these minimal standards. This is particularly detrimental for persons who subsequently appear before a judicial authority; all too frequently persons are brought before a judge after spending one or more days in substandard and filthy cells, without having been offered appropriate rest and food and an opportunity to wash.

48. The duty of care which is owed by the police to persons in their custody includes the responsibility to ensure their *safety and physical integrity*. It follows that the proper monitoring of custody areas is an integral component of the duty of care assumed by the police. Appropriate steps must be taken to ensure that persons in police custody are always in a position to readily enter into contact with custodial staff.

On a number of occasions CPT delegations have found that police cells were far removed from the offices or desks where police officers are normally present, and were also devoid of any means (e.g. a call system) enabling detained persons to attract the attention of a police officer. Under such conditions, there is considerable risk that incidents of various kinds (violence among detainees; suicide attempts; fires etc.) will not be responded to in good time.

49. The CPT has also expressed misgivings as regards the practice observed in certain countries of each operational department (narcotics, organised crime, anti-terrorism) in a police establishment having its own detention facility staffed by officers from that department. The Committee considers that such an approach should be discarded in favour of a *central detention facility*, staffed by a distinct corps of officers specifically trained for such a custodial function. This would almost certainly prove beneficial from the standpoint of the prevention of ill-treatment. Further, relieving individual operational departments of custodial duties might well prove advantageous from the management and logistical perspectives.

50. Finally, the inspection of police establishments by an independent authority can make an important contribution towards the prevention of ill-treatment of persons held by the police and, more generally, help to ensure satisfactory conditions of detention. To be fully effective, visits by such an authority should be both regular and unannounced, and the authority concerned should be empowered to interview detained persons in private. Further, it should examine all issues related to the treatment of persons in custody: the

recording of detention; information provided to detained persons on their rights and the actual exercise of those rights (in particular the three rights referred to in paragraphs 40 to 43); compliance with rules governing the questioning of criminal suspects; and material conditions of detention.

The findings of the above-mentioned authority should be forwarded not only to the police but also to another authority which is independent of the police.