

ORIGINAL ARTICLE

Substitution treatment in European prisons: A study of policies and practices in 18 European countries

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Abstract

Objective. The objective of this study was to examine practices and policies in place for the provision of substitution treatment in prison in 18 European countries. *Methodology.* Across the 15 European member states (prior to 1 May 2004) and Czech Republic, Poland and Slovenia, interviews with ministerial representatives, professionals (i.e. service providers and security officials) working in prisons, and a total of 33 focus groups with a total of 132 male and 52 female prisoners were conducted. *Results.* Although constraints of access to substitution treatment for specific target groups only (e.g. HIV-positive opiate users) have largely vanished, substitution treatment is now offered to a broad cross-section of prisoners. The provision of this treatment still lags behind the standards of substitution treatment in the community (regarding access and continuity). In most countries, this form of therapy is most likely to be discontinued when entering prison. A treatment gap persists between prisoners requiring substitution maintenance treatment and those receiving it. Heterogeneous and inconsistent regulations and treatment modalities appear throughout Europe, sometimes within the same country or region. The concrete provision practice of substitution treatment in prison varies from one country to the other, from one prison to the other, within a medical team, and even from one doctor to another. Although psychosocial care was seen as a valuable additional and necessary part of the treatment to support the medical part of the substitution treatment in prison, it was found that such support was rarely provided. Compared to previous research, this study illustrates that the scope of substitution treatment has extended considerably across Europe. Across the board, a consensus surrounding the need to continue substitution treatment that had already been started in the community was apparent.

Keywords: *Substitution treatment, prison, methadone, buprenorphine*

Introduction

Substitution treatment mainly provided in the form of methadone (some buprenorphine and some other substances sporadically) is offered to opiate drug-dependent users as a harm reduction measure, i.e. to reduce or eliminate opiate use, to control and reduce

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infections related to drug use (HIV/AIDS, hepatitis, etc.), and to reduce mortality and decrease criminal behaviour (recidivism) after release. Prisoners with a history of drug use are as concerned by drug use, public and mental health issues as drug users in the community. Indeed, prisons are also constrained by drug use and drug-related issues.

As part of the research project, a literature review on substitution treatment in prison was conducted. Studies reported that substitution treatment is an effective harm reduction measure in prison. Reduced drug use (Bertram & Gorta, 1990; Shewan et al., 1994), together with reduced drug-related violence and recidivism (Bertram & Gorta, 1990) were reported among prisoners engaged in some type of methadone treatment. Needle sharing and drug-injecting behaviour reduced significantly among prisoners on a methadone maintenance treatment that lasted over 6 months (Mourino, 1994). Marco (1995) examined the situation in Spain and found that intravenous drug-using prisoners on a substitution treatment programme significantly reduced needle sharing. Darke et al. (1998) found that methadone maintenance treatment in and out of prison was related to reduced drug use and reduced HIV-risk taking behaviour, especially when offered within a thorough harm reduction approach. Mourino (1994) stated that long-term benefits would most likely be observed with a longer-term (no time limit) treatment. He also found that prisoners receiving a methadone dose of 50 mg or more were least likely to top it up with opiate-based drugs. Remaining in treatment also increased the chances for prisoners to contact general medical services. The author underlined the importance of combining substitution treatment with psychosocial care. Prisoners on a methadone maintenance treatment with a dose of more than 60 mg provided during the whole prison sentence were least likely to inject heroin, to share needles and to have HIV risk-taking behaviour whilst in prison (Dolan et al., 1998). These findings were later confirmed by Dolan et al. (2002) who recommended offering methadone maintenance treatment to heroin-using prisoners for the duration of their incarceration. Prisoners on a 12-month methadone maintenance treatment whilst incarcerated had a lower level of re-incarceration than heroin-using prisoners with no treatment (Johnson et al., 2001). Reduced rates of re-incarceration were also related to substitution treatment provided during prison sentence on a maintenance basis rather than detoxification basis (Levasseur et al., 2002; Sibbald, 2002). Prisoners released with higher methadone doses had lower levels of recidivism when compared to prisoners on lower methadone doses (Bellin et al., 1999). Magura et al. (1993) underlined that multi-drug use is often not acknowledged. Although methadone maintenance treatment may reduce opiates use, it does not have a direct impact on crack-cocaine use. Failing to address non-opiates use is likely to reduce the success outcome of drug treatment, such as methadone treatment.

Although prison staff often perceived methadone maintenance treatment negatively (see Allen, 2001, for prison officers' supportive attitude towards methadone) apprehending the development of a black market for methadone, no grounds for such fears were found (Gorta, 1987; Wale & Gorta, 1987). Decreased anxiety among prisoners on methadone maintenance treatment was actually reported, resulting in less irritable and easier to manage prisoners (Gorta, 1992; Herzog et al., 1993; Magura et al., 1993). Hume and Gorta (1998) found that prison staff often had little or no understanding of the objectives of methadone maintenance treatment in prison.

Hughes (2000) examined prisoners' perceptions of drug services in English prisons and found that treatment services varied largely across prisons in the country, from no treatment to the prescription of methadone, lofexidine, painkillers and/or sedatives. Although not receiving any type of treatment was problematic for many prisoners, especially when going

through withdrawal, some prisoners found faster detoxification (the ‘cold-turkey’ method) easier to deal with and welcomed not having to ‘withdraw’ from methadone. In another study, some prisoners felt ambivalent or negative about methadone maintenance treatment (Rosenblum et al., 1991). Prisoners who were on a substitution detoxification programme lasting a few weeks were in favour of a longer detoxification programme (BMRB International, 2001). Michel and Maguet (2003, 2005) examined the provision of substitution treatment in prison across France and found that practices varied from one prison to another according to local, organisational and healthcare teams’ resources and approaches. Prisoners reported finding substitution treatment arbitrary and confidentiality lacking, which was confirmed in another study conducted in Germany by Keppler et al. (2004).

Objectives

The *general objective* of the research was to examine practices and policies in place for the provision of substitution treatment in prisons in 18 European countries. The *specific objectives* were (i) to conduct a literature review on substitution treatment in prisons; (ii) to analyse policies and practices of substitution treatment in the community and in prison; (iii) to point out to issues related to cessation and continuation of substitution treatment prescription from the community into the prison setting; (iv) to identify examples of ‘Good Practice’ where substitution treatment is offered in prison, and (vi) to put forward recommendations on substitution treatment in prison.

Methodology

Qualitative methods using guided interviews and focus groups were used. This study is therefore not comparative or representative, but explored the field on three levels: (i) analysing material related to countries’ practices on substitution treatment, (ii) interviewing ministerial and non-governmental representatives and key persons in prisons or community health care services, (iii) interviewing prisoners. The study was meant as a first baseline study. Further in-depth research in the future is needed. National facilitators were identified through the ENDSP/ ENDIPP networks.¹ They were key individuals working in the national prison service who facilitated the research project, providing information and organising week-long field visits as requested by the researchers.

The research took place in the 15 European countries (EU member states prior to 1 May 2004), Czech Republic, Poland and Slovenia. A field study was conducted in all these countries except Luxembourg, where authorisation was not obtained. However, a country report for Luxembourg was drawn on the basis of published national data and literature. Because of time and resource constraints, two differing prisons suggested by the national facilitators were visited in each country, between March 2003 and May 2004, except for Greece and Sweden where one prison was visited, as substitution treatment is not offered in either of these countries.

There were three groups of participants:

- ministerial and non-governmental representatives;
- professionals working in prison; and
- prisoners.

(a) Ministerial and non-governmental representatives

Key individuals within governmental and non-governmental institutions concerned with substitution treatment in prison and located out of the prison were interviewed. Representatives included mainly health care management, training management, probation service, throughcare service and judges. In all the visited countries, health care in prison was under the management of the Ministry of Justice, except Spain and France, where the Ministry of Interior and Ministry of Health, respectively, manage prisoners' health services. Participants were asked open-ended questions in either face-to-face interviews or group interviews, according to available resources. Each interview lasted approximately 30–60 min.

(b) Health care professionals in prison

Professionals working in prison on the health and security levels, concerned with substitution treatment, were invited to take part in the study. Professionals were asked open-ended questions in either face-to-face interviews or group interviews, according to available resources and local organisation. Each interview lasted approximately 30–60 min. These professionals included the drug treatment team (i.e. medical doctor, psychiatrist, nurse), the psycho-social team (i.e. psychiatrist, psychologist, social worker, pedagogue, educator), guards, management team and the governor and/or deputy governor.

(c) Prisoners

Prisoners with a history of opiate use (especially heroin) and/or experiences in substitution treatment (prescribed or taken on the black market) while in prison and/or in the community were invited to take part in the study. Each group was as diverse as possible. In each prison a professional involved in substitution treatment and/or services for drug users, identified by the ENDSP national facilitators, facilitated the research visit and organised the interviews according to the researchers' requirements, which were communicated prior to the field visit. Prisoners were interviewed in a neutral room within the prison and in the sole presence of the researcher. Further to prisoners' consent, the interview or focus group was tape-recorded for data analysis purpose, and remained in the sole possession of the researcher. Open-ended questions were asked in focus groups with prisoners. Focus groups, which included on average 6 prisoners per group, lasted approximately 90 min. Although prisoners expressed no objections to taking part in focus group discussions, prisoners in France who wished to take part in the study preferred to be interviewed individually, not in a group. The methodology was thus adapted in order to respect the cultural difference and to give a voice to prisoners in France. In total, 33 focus groups in 33 prisons across 17 countries were conducted, reaching a total number of 184 prisoners.

Participants were interviewed in their native language either directly by the researchers (if they spoke the language) or via an interpreter. Some participants chose to express themselves in English even if it was not their native language. Participants were briefed and debriefed on the research goals and ethical issues. Their participation was voluntary, confidential and anonymous.

Analysis

Interview guidelines structured the themes in different broad topics. Qualitative data collected through the interviews and focus groups were analysed using content analysis

methods, which generated themes and categories. Because the results are primarily based on field visits conducted in a limited number of prisons with a limited number of participants, findings reflect the practice of the institutions that were visited and are not generalisable to the whole prison system of the visited countries. This study is therefore not representative.

Results²

(a) Policies and practices of substitution treatment in prisons

In line with the evolution of substitution treatment in the community, the treatment was first made available in prisons for prisoners with HIV/AIDS, other infectious diseases and pregnant prisoners. Substitution treatment is now offered to a broad cross-section of prisoners, although the provision in many countries still lags behind the standards of substitution treatment in the community. A treatment gap persists between those requiring substitution treatment and those receiving it and, in most of the countries studied, the coverage is patchy. Heterogeneous and inconsistent regulations and treatment modalities appear throughout Europe, sometimes even within one country. Nevertheless, compared to previous research, this study illustrates that the scope of substitution treatment has extended across Europe: at the time of the study, only Greece, Sweden, and the Czech Republic did not offer treatment in prisons.

Much variety was found in relation to methods of detoxification, both across Europe and within individual countries. The use of benzodiazepines was common and constituted an additional problem due to the intensified dependence, severe syndromes and difficulties to detoxify from them.

In contrast to community practice, many professionals believed that low doses of medication were sufficient on the basis that prisoners do take the full dose of medication and that the amount of other drugs used is significantly lower in prison.

The provision of information concerning substitution treatment, drug-use and prison policy was seen to be lacking in many prisons. Frequently, prisoners did not understand the goals being pursued through substitution treatment, nor why specific drugs or treatment methods (such as exclusion criteria) were used. This raises serious issues about the extent to which prisoners can be said to have given informed consent.

Although it is hard to secure anonymity and confidentiality within the prison context, attempts have been made to administer substitution treatment in a way that protects prisoners, either by putting all patients together in one wing or delivering substitution drugs discreetly along with other medication. Exceptions were found where prisoners complained of being openly and publicly identified as being on the treatment.

In several countries, specific training for doctors was not required, preventing professionals from responding to a fast-changing treatment environment and making necessary improvements. With most staff learning about substitution treatment on the job, additional training would be welcomed. It was reported that some training programmes focused on drugs and drug treatment in the community and were not targeted towards the prison setting.

It was found that the provision of substitution treatment differed not only from one country to another, but also from one region to another, from one prison to another, and from one prison physician to another. These differences seemed to reflect the historical, cultural, social, economic and political differences across and within European countries

and regions. This heterogeneity raised difficulties for the continuity of care within the prison setting, for instance, transferring from one prison to the other and from or to the community. Indeed, throughcare, i.e. health care provided *in liaison* with the community, was found to be limited in most countries, although in some countries sustainable cooperation links were established with outside institutions, including developing a link with an outside health care provider to enable prisoners to continue substitution treatment after their release. When such a link was missing in a country or prison, the health care team's tendency was to offer detoxification or no treatment during the prison sentence, ensuring that prisoners would not medically need the treatment on release.

On the basis of professionals and patients' reports, it was found that, in general, substitution treatment was positively associated with (i) the identification of and reaching out to drug users in prison, using imprisonment as a key period to offer health care and refer to community services; (ii) a reduction of overdoses in prisons and on release; (iii) overall, an efficient harm reduction measure; (iv) a 'softer' and more humane detoxification (versus 'cold turkey') for some prisoners, and stability through maintenance for others; (v) an improved health care, a decreased feeling of 'helplessness' for doctors, and follow-up of drug users; (vi) better management of opioid dependent prisoners; and (vii) prisoners' increased responsibility, awareness of and involvement in health care. However, substitution treatment was negatively associated with (i) being a substance (a drug) rather than a treatment, which relates to the idea that substitution treatment is just replacing one drug with another one and 'preserving' the drug dependence and drug use; (ii) being provided with little or no psycho-social support mainly because of a lack of resources, although the importance of providing such support tended to be acknowledged; and (iii) buprenorphine was seen at least in one country as a new drug used for traffic within the prison (i.e. entering the existing illicit drugs black market); the pill was crushed and sniffed or injected, similar to the practice out of prison. This misuse concerned a minority of prisoners but was of concern.

In general, prisoners reported that there was a lack of information on substitution treatment. Access to the treatment was often unclear and seemed arbitrary to them. The treatment was sometimes perceived to be a favour or reward for good behaviour from the prison rather than a health treatment from the medical service. Although some prisoners saw methadone or buprenorphine as just another drug, the majority understood the treatment as a support and coping tool when withdrawing from drugs. A 'love and hate relationship' was described on several occasions: prisoners were content to receive the treatment as a replacement to opiates, but at the same time strongly disliked it for not being the drug they primarily used and for its association with new issues and secondary side effects. The two most disputed points of prisoners' dissatisfaction related to the dosage, which was too high or too low, decreased too fast or was unchanged for too long, and the lack of psycho-social support. Some doctors argued that one should not be talking of high or low doses but rather of adequate dosage, i.e. corresponding to the patient's needs. On the one hand, prisoners often viewed prison as an opportunity to detoxify from drugs and end taking any type of medicine. Detoxification was thus not a problem as such; however, the detoxification pace was usually too rapid over an inappropriately short period of time. Furthermore, detoxification was too rigid and prisoners felt they needed to (further) discuss and understand their treatment with professionals. Prisoners reported needing detoxification that took into account individual needs. On the other hand, it was common for stabilised prisoners to wish to decrease their dosage rapidly; however, doctors often recommended a slower pace to decrease risks of relapse. The second point of dispute

reported by prisoners, including prisoners on a very high dosage of methadone maintenance, was related to the lack of psycho-social care. Prisoners valued psycho-social care and said their needs were not met. Most dissatisfaction was about the lack of support received. In general, prisoners were not satisfied with the 'single' distribution (i.e. with no psycho-social care support) especially when the treatment dosage was maintained at a relatively high level for a long period of time. It was found that the more integrated in a therapeutic type of treatment, with information and supervision, the more satisfied prisoners motivated to tackle their drug issues were.

(b) Issues related to cessation and continuation of substitution treatment prescription from the community into the prison setting

In most countries, substitution treatment is most likely to be discontinued when entering prison. The reasons for this include: (i) a basic drug-free orientation in prison, (ii) the perception of methadone (or any other substitution drug) as a psychoactive drug that is unsuitable for therapy, (iii) a lack of understanding of dependence as a chronic disease; and (iv) limited resources and expertise. Prisoners also demonstrated resistance due to: (i) a lack of understanding of the nature of substitution treatment; prison sentences are often viewed as a drug-free time with an expectation of withdrawal and subsequent relapse upon release; (ii) prisoners want to hide their drug use (partly because they fear prejudice and disadvantageous treatment if seen as drug users), which conflicts with the need to acknowledge drug use in order to receive treatment. Across the board, there was a clear consensus surrounding the need to continue substitution treatment previously started in the community. However, the length of the treatment and length of sentence both determined whether a treatment would be provided in prison. The initiation of substitution treatment within prison proved much more problematic. When it occurred, treatment was provided immediately upon admission to the prison or in the run up to release.

In some countries, substitution treatment was formally limited to a period of between 6 and 12 months. Elsewhere, such restrictions applied informally but were not codified in official guidelines or regulations. In other countries, no time limits existed and substitution treatment was offered on an individual basis. In Spain and Austria, substitution treatment was a standard practice. Psychosocial care was seen as an integral part of treatment and a vital complement to medical care. However, such support was rarely provided, primarily due to a lack of resources.

For prisoners on substitution treatment, imprisonment usually meant a change of doctor, a change of treatment type and form, and possibly the cessation of a treatment received in the community. Access to and continuity of substitution treatment in prison in many countries in Europe, compared to service provision in the community, was reported as inadequate, as the principle of the equivalence of care was seen as not being respected. Although psycho-social care was seen as an additional and necessary part of substitution treatment, it was found that such support was rarely provided, resulting in rare cases in the provision of 'therapeutic' treatment. In some countries, a whole team of professionals (i.e. psychologist, pedagogue, educator, social worker) worked with prisoners with a history of drug use on their drug issues. However, in a majority of countries, there was no funding for personnel resources, in which case substitution treatment tended to be 'just' a prescription and intake of a medicine with no psycho-social or rehabilitation support. Some doctors, who believed in delivering the treatment within a therapeutic approach, did not welcome this practice of single distribution and felt that their role was minimised to that of a 'drug provider' or 'drug dealer'.

(c) Examples of 'good practice' where substitution treatment is offered in prison

On a positive note, examples of good practice were found in relation to (i) guidelines on clinical management and the treatment of substance use (e.g. Austria: Pont, Resinger and Spitzer, 2005), (ii) structures for substitution treatment, e.g. regular meetings between social workers, nurses, doctors and psychologists, (iii) networking with community substitution treatment services, (iv) the specific treatment needs of women are met according to the complexity and severity of the drug use of women admitted to prisons (e.g. Palmer, 2003).

(d) Recommendations on substitution treatment in prison

On the basis of these findings, recommendations for improvements in the quality of substitution treatment have been elaborated. As part of the study, recommendations were put forward.

It was recommended to:

- expand the availability of and access to substitution treatment, as well as the quality of services;
- offer specific treatment meeting female prisoners' needs considering the complexity and severity of their drug use;
- ensure continuity of care when transferred from one prison to another;
- ameliorate the provision of throughcare (i.e. linking with the community) and community-based services;
- provide on-going training and support to staff;
- improve greatly continuous psycho-social support to prisoners; and
- offer a variety of treatment options (detoxification, maintenance, therapeutic, methadone, buprenorphine).

Conclusions

Prisons systems were found to be slow in responding to epidemics of viral infectious diseases (such as HIV and hepatitis) and injection drug use. However, substitution treatment is more and more seen as an adequate response to the risks and harm of opiate-dependent prisoners as it can reduce (i) heroin use, drug injection and needle sharing, (ii) participation in the prison-based drug trade, and (iii) opiate-related mortality soon after release from prison. Substitution treatment can lead to increased participation in drug treatment following release from prison, and a significant reduction in serious drug charges. Offenders participating in substitution treatment displayed lower readmission rates overall. More broadly, the prison system benefits through a reduction in withdrawal symptoms upon admission, a restricted drug trade and increased productivity among prisoners. The existing studies indicate that continuity of care is required to maintain any benefits acquired.

In order to ensure equivalence of health care, (i) a major expansion of maintenance is needed in many countries to meet the needs of prisoners, (ii) substantial efforts have to be made to improve the quality of services, and (iii) better links and continuity of care are needed between prisons and the range of community-based services.

This research indicates that the goal of achieving a drug-free state for all patients jeopardises the achievement of other important objectives, such as preventing or treating

HIV/hepatitis infections, prevention of overdose and relapse after release, which should be afforded greater priority as policy objectives.

Low and high threshold programmes should be considered, emphasising harm reduction goals (e.g. prevention of relapse after release, prevention of infectious diseases), where high threshold programmes would be equipped with additional means and resources (e.g. psycho-social care and support) and would require greater commitment and engagement. The specific treatment needs of women must be met according to the complexity and severity of the drug use of women admitted to prisons.

Ongoing contributions from patients are valuable in order to improve the quality of health care. Most prisoners have had previous, personal experience of prison health care and substitution treatment inside prison and in the community (either in the form of detoxification or maintenance). They are willing and able to make substantial and valuable comments on the service delivery.

In many countries, health care was not monitored adequately; only rough estimates on the scope and quality of substitution treatment were available. In almost all countries visited, there was a lack of evaluation in which the needs of the patients were taken into consideration as well as the views of the service providers. For any improvements to be seen, additional work must be done on patients' needs, service provision and enhanced links with community services.

Acknowledgements

This research project was part of one of the activities of Cranstoun Drug Services' networks, the 'European Network of Drug Services in Prisons' (ENDSP) and was partly funded by the European Commission. The authors are grateful to the European Commission, Cranstoun Drug Services and ENDSP/ENDIPP, the Director Generals of the Prison Services and Health Ministries in the different countries, national facilitators, national experts, interpreters and all the participants for their support with the study. The full report is available on line at www.endipp.net.

Notes

- 1 ENDSP, the European Network of Drug Services in Prisons, and CEENDSP, the Central Eastern European Network of Drug Services in Prisons (networks managed by Cranstoun Drug Services) merged in 2004 with the 'The European Network on HIV and Hepatitis Prevention in Prison', to become the 'European Network on Drug and Infections Prevention in Prison' (ENDIPP).
- 2 Results of the literature review are also included in the introduction.

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