FACULTY OF PSYCHOLOGY
AND EDUCATIONAL SCIENCES

RESEARCH CLUSTER ON ADDICTION AND RECOVERY

'MY FIRST 48 HOURS OUT': CONTINUITY OF HEALTH AND PSYCHOSOCIAL CARE FOR DRUG USERS AFTER RELEASE FROM PRISON IN FOUR EUROPEAN COUNTRIES

Prof. Dr. Wouter Vanderplasschen
Ghent University
Dept. of Special Needs Education
Research group on Addiction and Recovery

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Heino Stöver, Daniela Jamin
Orphée Sys, Wouter Vanderplasschen
Marie Jauffret-Roustide, Laurent Michel, Philippe Trouiller
Mariana Homem, Vânia Mendes & Andreia Nisa

DRUG USE AND RISK BEHAVIOUR IN PRISONS

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SOME COMMON FINDINGS

- High lifetime rates of drug use + harmful use among prisoners (31% ever injected) (EMCDDA, 2015)
- High rates of substance use in prisons across the EU
- High risk of overdose and death immediately after release ("*First 48 hours*") (Farrell and Marsden, 2008)
  - due to high relapse rates and lowered tolerance
  - due to discontinuity of care
  - 60% of drug-related deaths in first 12 weeks after release (Merrall et al., 2010)
- Lack of care and support immediately after release
- Large differences between countries, regions and prison settings around Europe

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THE PRINCIPLE OF EQUIVALENCE FOR PREVENTION AND CARE

- Clear gap between (inter)national legislation & policies and actual practices
  - ≈ UNODC and WHO guidelines
- *Drug users/prisoners are entitled to the same services in prison as in the community and to continuity of care before and after prison”* (Belgian Law of principles for the prison system, 17/1/2005)

Michel *et al. BMC Public Health* (2015) 15:1093
DOI 10.1186/s12889-015-2421-y

RESEARCH ARTICLE Open Access

Insufficient access to harm reduction measures in prisons in 5 countries (PRIDE Europe): a shared European public health concern

Laurent Michel[1,2,3*], Caroline Lions[4,5,6], Sara Van Malderen[7], Julie Schiltz[8], Wouter Vanderplasschen[8], Karina Holm[9], Torsten Kolind[9], Felice Nava[10], Nadja Weltzien[11], Andrea Moser[11], Marie Jauffret-Roustide[12], Olivier Maguet[13], Patrizia M Carrieri[4,5,6], Cinzia Brentari[14] and Heino Stöver[14]

STUDY AIMS AND OBJECTIVES

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OVERALL AIM

– *“To address the gaps in continuity of care for long-term drug users in prison and upon release, by supporting life-saving interventions for the prevention of overdose and the reduction of other risks related to drug use, and for the establishment of a treatment trajectory that is not interrupted upon release.”* (Stöver et al., 2019)

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MORE SPECIFICALLY

- Produce and disseminate knowledge and good practices on continuity of care
- Two dimensions:
  - Continuation of medical care and drug treatment (e.g. provision of OST, ART & HCV treatment)
  - Continuity of social support: case management, transitional care or throughcare

METHODS

STUDY DESIGN

- Multi-country qualitative study
- Interviews and focus groups with
  - prisoners and ex-prisoners (n=104)
  - professionals inside & outside prison (n=70) in 4 EU-countries (BE, FR, DE & PT)

Inclusion criteria

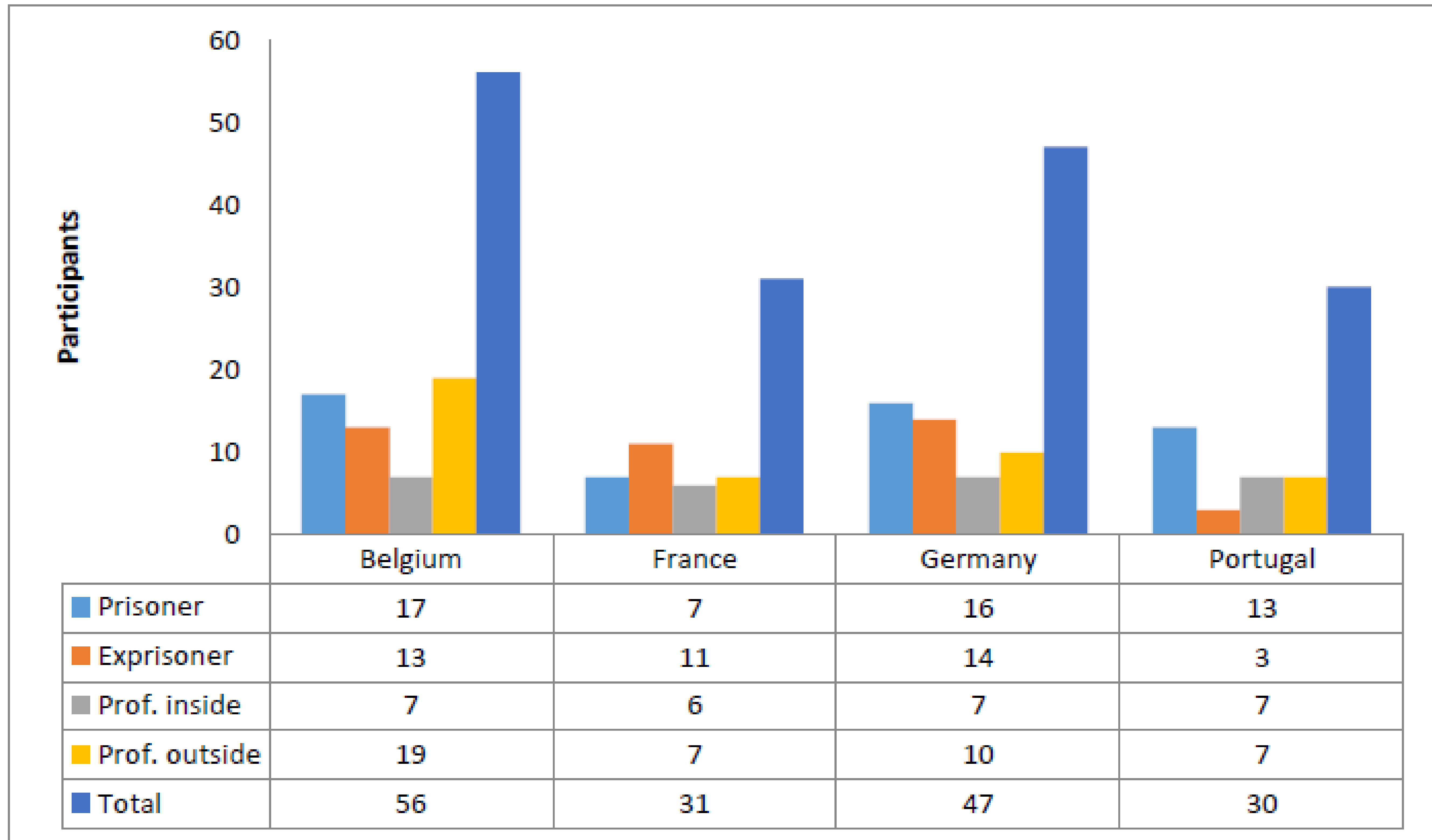
  - Recent/regular users of illegal drugs (other than cannabis)
  - At least one previous sentence (last sentence <6 months ago)
  - Mastering national language to do an interview
  - Voluntary participation and informed consent

  - 10 EUR incentive
  - Common interview scheme
  - Semi-structured interviews (29-120 minutes)
  - All interviews were transcribed and analyzed with Nvivo
  - Scientific committee and ethical approval

STUDY PARTICIPANTS

- Users:
  - 67 prisoners and 37 ex-prisoners
  - 16 women and 88 men
  - Average age 36.7 years
  - On average, 5.3 detention periods and 86.4 months in prison
  - Primary drugs: cocaine and heroin

- Professionals inside & outside prison:
  - 27 prison staff + 43 professionals working in the community
  - Average age: 43.2 years and 11.8 years of work experience



	Belgium	France	Germany	Portugal
Prisoner	17	7	16	13
Exprisoner	13	11	14	3
Prof. inside	7	6	7	7
Prof. outside	19	7	10	7
Total	56	31	47	30

RESULTS

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FEATURES OF DRUG USE IN PRISON

- Availability differs from prison to prison, but access to cannabis is easy in all countries
  - Often tolerated as “*prisoners are less agitated then*”
  - Drug use to cope with stress and negative feelings
- Differences in drug use between prison and community
  - Rather ‘downers’ than ‘uppers’
  - Changes in frequency and intensity
  - Misuse of medication
- Negative consequences when discovered: reported to prison authorities, exclusion from OST, …

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MEDICAL CARE AND SUPPORT UPON PRISON ENTRY

- All prisoners seen by different prison staff + systematic screening for tbc and drug use (not in BE); mental health screening in France
- Long waiting times for medical consultations (except OST) + lack of psychiatric care
- Acute interventions and pharmacotherapy, no attention for underlying symptoms
- Continuity not a problem upon entry (OST), mainly when released:
  - no prescription or dose provided; need to start-up again
- Drugs still a taboo topic, obligation to report
- Health promotion material is available, but not provided proactively
- Very few harm reduction initiatives (no access to clean equipment or naloxone, except in DE)

PSYCHOSOCIAL SUPPORT IN PRISON

- Psychosocial support is discontinued at entry
- Prison and community services provide support, but numerous structural barriers:
  - Long waiting times and waiting lists
  - After first contact, difficult to access psychosocial services
  - Insufficient + no proactive support inside
  - Prisoners do not know which services to address
- Due to difficulties in accessing services, many give up
- No systematic support around release (BE & PT)

SPECIFIC TYPES OF SUPPORT

- Housing: priority!
  - Need an address, but not controlled for
  - Unknown release date, especially for short-term/remand prisoners
- Work and education
  - Stigma and criminal record
  - Little support in case of short sentence
- Finances and benefits
  - "*Life is expensive in prison without income*"
  - Entitlement to benefits and ID card after prison (e.g. FR)
- Drug treatment
  - Look for it yourself!
  - Almost no peer support, NA/AA in some prisons (FR, DE)
  - Linkage with community services in BE
- Leisure time and relationships
  - Access to sports and leisure activities very limited (FR, PT)
  - Support from friends and family

CHALLENGES AT RELEASE

- Individual
  - Back to “the rush of society” + many expectations (e.g. administration) at release
  - Positive/negative impact of the social network
  - Mental health needs
  - Motivation for change and fear for relapse
    - “*I felt like I needed to party for 2-3 days*”

- Structural
  - Lack of housing and employment (stigma)
  - Need for health insurance + continuation of OST
  - Huge gap between supoort inside and outside prison
  - Late changes in date of release => dropped in society without follow-up or health coverage

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SPECIFIC PREPARATIONS FOR RELEASE

- Reintegration plan mainly for long-term prisoners
  - Prisoners have to take initiative themselves
  - No systematic planning, but some release management opportunities in DE
  - Preparations for release started late (FR)
  - Nice in theory, but in practice: “seek it out upon release”

- Linkage with community services
  - Lack of awareness of available services

- Little or no OD prevention
  - “*Literally released without anything*”

- Coordination of care (prison-community; medical-psychosocial)
  - Prison (punishment, security, suspicion) vs. Treatment (trust, support)
  - Medical and psychosocial prison services
  - Prison and community services: systematic contact needed, anticipated date of release

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CONCLUSION

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WHAT IS REALLY NEEDED?

- No or little continuity of care upon prison entry and after release:
  - Equal service provision in prison as in the community!
  - Good quality prison services (medical + psychosocial support, but also housing, employment, …)
  - Better collaboration and networking between services inside and outside
    - Reintegration plan, OD prevention, smooth transitions
    - Communication, case management/buddy system, throughcare, …
  - Revisit ‘prison’ concept?! Detention houses, “*support rather than security first*”

- Continuity of support after prison needed to:
    - Prevent relapse and overdose
    - Consolidate change after release
    - Promote recovery and reintegration in the community

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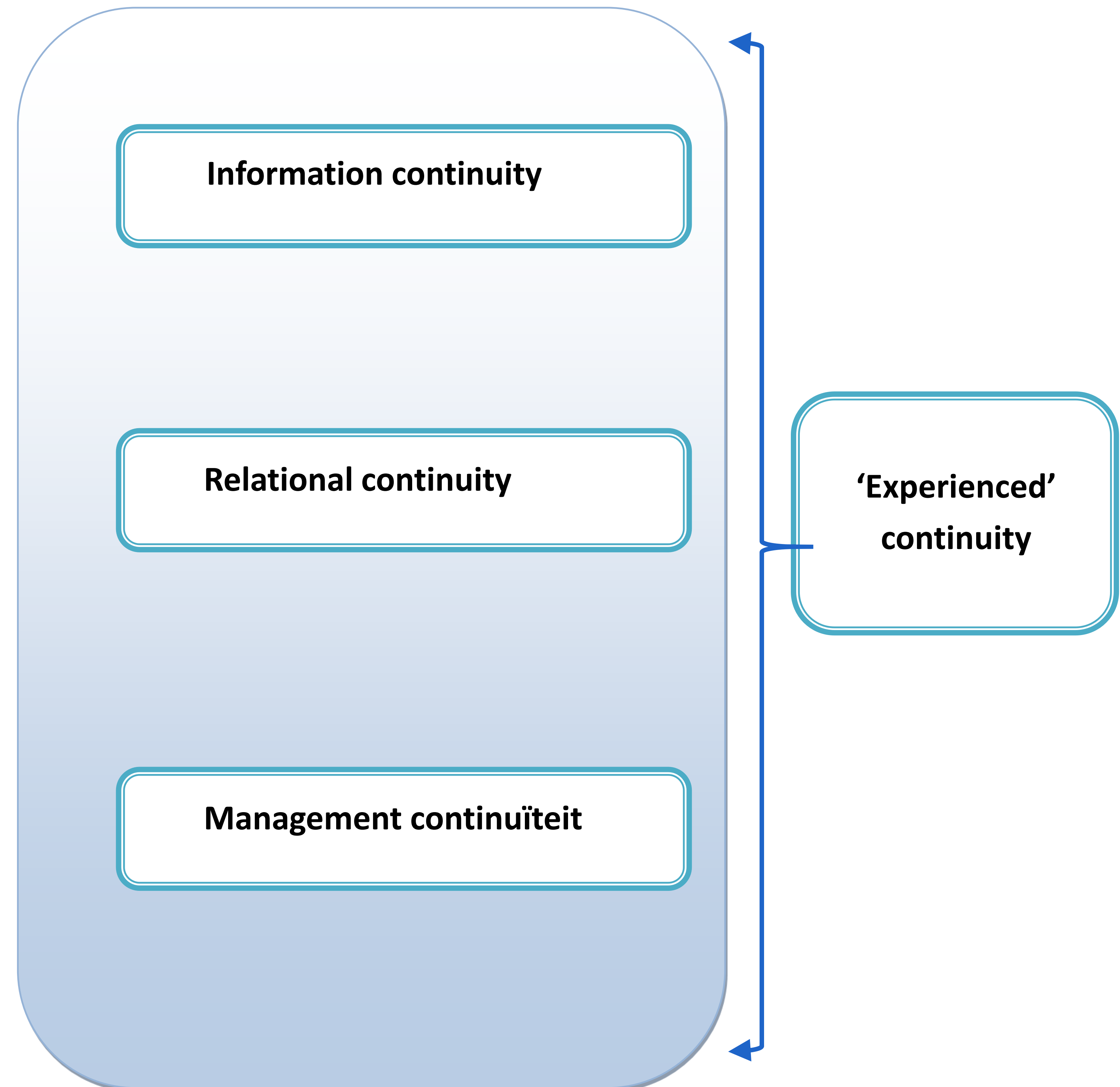
CONTINUITY OF CARE (HAGGERTY ET AL., 2003; FREEMAN & HUGHES, 2010; NAERT ET AL., 2017)



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Prof. dr. Wouter Vanderplasschen

DEPARTMENT OF SPECIAL NEEDS EDUCATION

E Wouter.Vanderplasschen@ugent.be
T +32 9 331 03 13
M +32 476 96 13 19

www.orthopedagogiek.ugent.be/en

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