Access to the Opioid Substitution Therapy in Georgian Prisons:

The Focus on Current Challenges and Barriers

Institute of Addiction Studies,
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& Alternative Georgia

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This report has been prepared by the study team of the Institute of Addiction Studies at Ilia State University (ISU) and the Addiction Research Centre - Alterative Georgia. The study team is fully responsible for the report content. Any opinions expressed herein in no event shall be regarded as reflecting the position of the Centre for Training and Consultancy or Bread for the World.

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Acronyms

HIV	Human immunodeficiency virus
ICD 10	International Classification of Diseases, 10th Revision
OST	Opioid substitution therapy/treatment
IDUs	Injecting drug users
Nvivo	Qualitative data analysis software
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Access to the Opioid Substitution Therapy in Georgian Prisons: The Focus on Current Challenges and Barriers

SUMMARY

Introduction

Opioid substitution therapy/treatment (OST) is one of the most effective approaches to opioid addiction treatment. OST programs are an effective way to significantly reduce illegal drug use, HIV-related risky behaviors, overdose deaths, criminal activities, financial burden and other kinds of stress faced by drug users and their families. Furthermore, the OST programs recruit injecting drug users (IDUs), who would otherwise have no access to medical facilities, and are therefore gateways to healthcare services, involving IDUs in HIV testing, antiretroviral therapy, treatment of TB, HCV and other infections. The OST programs are supported by the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and the United Nations Program on HIV / AIDS (UNAIDS). Methadone and buprenorphine have been included on the WHO list of essential medicines. However, doubts and myths about OST are still widespread in many developing countries where abstinence-oriented detoxification is often considered the only legitimate treatment.

The OST coverage has increased dramatically in recent years with 12,179 people, including 763 prisoners, involved in the program in 2018. Despite the expanding coverage of harm reduction (HR) in the community and OST services, the access is still limited to drug users in the penitentiary system.

Aims and Objectives

While the HR and OST services expand the coverage in the wider community, they remain barely accessible for prisoners as OST programs are available only in two Georgian prisons as a short-term (3 to 5 months) detoxification course. Consequently, even those inmates who were receiving OST before incarceration have to discontinue with rapid dose reduction. Therefore, the study focuses on the challenges and barriers to adequate implementation of OST in prisons, analyzing experiences of former beneficiaries of OST programs in prisons and experience of experts in this field. It also analyzes international standards and recommendations and the regulatory framework of Georgia, and offers recommendations to ensure access to long-term OST for prisoners.

Methodology

Desk review and qualitative study methods have been used for this study. The desk review involved analysis of international guidelines and regulations in force in Georgia, while the qualitative study included focus group discussions and individual in-depth interviews in Tbilisi, Telavi, Batumi, Zugdidi and Kutaisi (45 participants), including:

- Two focus group discussions with 10 participants and 12 individual interviews with drug users who had received methadone-assisted detoxification in prison and were involved in the community OST programs at the time of the study (in Tbilisi and Batumi);
- Individual in-depth interviews with 6 drug users, who had received methadone-assisted detoxification in prison and did not enroll in the community OST programs at the time of the study, but continued using drugs (in Tbilisi, Zugdidi, Kutaisi, Batumi and Telavi); and
- Seventeen individual in-depth interviews with heads of civilian OST centers (Buprenorphine and Methadone) and addiction specialists from Tbilisi, Zugdidi, Kutaisi, Batumi and Telavi,

representatives from the National Center for Disease Control &Public Health and former as well as current medical staff from OST in penitentiary system

We also planned to conduct individual interviews with prison healthcare authorities, substance abuse counselors, and medical staff of the probation and social services, but failed to receive a consent from the Minister of Justice in response to our two written requests. Instead, we decided to conduct interviews with people, who had formerly worked as medically assisted detoxification staff and substance abuse counselors in prison (three in-depth interviews).

Data were analyzed using inductive approach including thematic and content analysis. According to the results recommendations were elaborated.

Results

Desk review results

Drug dependence has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs despite harmful consequences.

Forced abstinence from drugs cannot cure drug addiction. Effective treatment decreases future drug use and drug-related criminal behavior, can improve the individual's relationships with his or her family, and may improve prospects for employment. Furthermore, treatment saves lives. Nine out of 10 untreated prisoners with drug dependence relapse to drug use after release.

Treatment that is of insufficient quality and intensity or that is not well suited to the needs of offenders may not yield meaningful reductions in drug use and relapse prevention. Untreated substance abusing offenders are more likely than treated offenders to relapse to drug abuse and return to criminal behavior. This can lead to re-arrest and re-incarceration, jeopardizing public health and public safety and taxing criminal justice system resources.

When a drug-using offender comes into contact with the criminal justice system, it is an opportunity to encourage him/her to receive appropriate treatment. This can be done either by referral to treatment, or by interaction between the criminal justice system and the health care system to enable the person to receive treatment. The response of the criminal justice system would vary depending on whether the person would take up the treatment option as well as on the reasons for prosecution. Given the additional risks and costs associated with the imprisonment, alternative measures should be applied wherever possible from both public health and criminal justice perspectives. Provision of evidence-based treatment as an alternative to conviction or punishment would not only help reduce prison-related risks but would also decrease recidivism and relapse rates of drug using individuals involved with the criminal justice system

Implementation of OST programs in Georgian prisons is regulated by Joint Order No. 92 N01-26n of July 14, 2016 of the Minister of Corrections and Probation and the Minister of IDPs from the Occupied Territories, Labor, Health and Social Welfare Approving the Implementation of Substitution therapy Programs for Opioid Dependent Persons in Penal Institutions". The order allows for detoxification assisted with substitution medicines in prisons No 2 and No 8 and declares the ministry's commitment to implement all measures necessary for introducing short-term and long-term substitution therapy in prisons in early 2018. Yet the order was later amended by order №148/№01-74/n of December 29, 2017 postponing the deadline for the implementation of the short-term and long-term OST until January 1, 2020.

Two important principles for health interventions in prison are equivalence of care to that provided in the community and continuity of care between the community and prison on admission and after release. This implies that all appropriate prevention, harm reduction and treatment services need to be available within prisons and a particular attention should be paid to service provision around admission and release.

The principle of equivalence of care obliges prison health providers to provide prisoners with care of a quality equivalent to that provided for the community in the same country, including harm reduction interventions, such as needle and syringe exchange programs and drug treatment. Barriers, whether legal

or structural, should be overcome to guarantee high quality treatment and care for prisoners.

Continuity of care between services in the community and in prison applies both on entry to prison and on release. It should also apply to drug treatment, including OST and all types of health care. Many European countries have partnerships between prison health services and providers in the community to facilitate health education and treatment interventions in prison and ensure continuity of care on prison entry and release. To meet these basic requirements, prison admission routines need to include systems to identify individuals with high treatment needs immediately upon arrival. In addition, proper needs assessments and follow-up reviews are necessary to ensure that treatments are matched to individual needs. Continuity of post-custody care reduces risks of reoffending and relapse. Drug dependence treatment, like treatment of other chronic diseases, should involve diagnostic and planning. One of the goals of treatment planning is to match evidence-based interventions to individual needs at each stage of drug treatment.

Results of the Qualitative study

According to the OST staff, 2 to 15 patients of community OST programs come in contact with the criminal justice system every year. Within 24 hours after getting in temporary detention facilities, the patients are escorted by correctional officers to OST sites to receive their medicines. According to the respondents, inmates often asked for methadone or Suboxone® while in temporary detention, yet there were several cases of when patients refused from taking medication for specific reasons.

Most of the respondents had participated in community OST programs before the arrest, so they encountered no problem with receiving OST in prison. Such patients are reportedly provided with their daily medication even when in temporary detention. Experience is different with those who did not participate in community OST prior to detention. One of the respondents said that prison stuff did not believe he used drugs and refused to detox him.

There is no OST program in women's facilities, making it difficult for pre-arrest OST beneficiaries to receive even methadone-assisted detox treatment in prison. Women are taken to the Gldani Prison for daily methadone treatment.

All the respondents appreciated the availability of the methadone-assisted detoxification program in prisons, saying it improved their situation significantly. They said that the main motivation for joining the program was to alleviate the abstinence syndrome and relieve its symptoms.

One respondent (*former inmate from Kutaisi prison*) had to discontinue the methadone-assisted detoxification while in prison because he had tuberculosis and had to be transferred to the Ksani facility, where most of convicts with TB are held and where no methadone-assisted detoxification was available. He said he had gone through very hard times, as the drugs they used to manage withdrawal symptoms were ineffective.

None of the respondents reported the availability of pre-release transition programs. They said they had had interviews with psychiatrists or psychologists, but were offered no pre-release treatment for drug using offenders.

The respondents did not mention any barriers to post-release enrolment on community OSTs, yet noted a difference: if released from prison while still on detox, an ex-inmate can re-enroll on the community OST program the same day, because all patients have a place ‘booked’ for them in community OSTs for a month. Yet if released after serving the full sentence, the community OST re-enrolment procedure for them would be similar to that for those joining OST for the first time, i.e. they would have to get an urine test to prove consumption of opioids and to obtain a health certificate (Form #100); and this prompts them to use drugs in order to have a positive urine test.

The subuxone program staff say that given the particular properties of this medication it is vitally important for them to quickly receive information about in-prison methadone doses administered to the patient. Because of the transfer from the opioid agonist methadone to the combination of the agonist-

antagonist buprenorphine and antagonist naloxone, doctors have to ask patients to wait for several days, to "miss a dose", before they put them on the Suboxone® program.

Community OST representatives also said that former prisoners tend to ask for a rapid increase in dosage. They said they often had to increase doses on the first day of the treatment at patients' requests. They believe it is due to the rapid dose reduction and insufficient duration of detoxification in prison. Consequently, patients who are involved in post-release community OST ask for higher doses from the very first day. The prison methadone program staff have no right to prescribe any drugs other than methadone. If a patient develops certain symptoms, a psychiatrist or an outsourced drug counselor examine the patient and prescribe other necessary medication.

Conclusions and recommendations

Equal access to services for detainees and prisoners, including women

Over the past decade, Georgia has achieved a remarkable success in implementing, expanding, and ensuring financial sustainability of OST programs in the civic sector and has now committed to providing similar services in prisons. Yet access to harm reduction, including long-term OST, is still limited in detention centers and prisons. With reference to *Werner v. Germany*, it is recommended that the government of Georgia would speed up the introduction of long-term OST in detention centers and ensure geographical accessibility of these services. The infrastructure and security procedures of prison OST services are mainly designed for male prisoners and do not address the specific needs of female inmates. A particular focus should be made on women's prisons, and female prisoners should be provided with access to OST services similar to those available in the wider community.

An effective demand reduction strategy should include a broad selection of these interventions. As prisoners are at different stages of change in relation to their drug use and since the treatment should be matched to individual needs, a wide range of services is needed.

Monitoring and advocacy by the civil society and communities

According to ministerial order No. 92/No01-26n of July 14, 2016, the Ministry was to take all necessary measures to implement short- and long-term maintenance therapy in prisons by early 2018, yet the order was amended by order No148/№01-74/n of December 29, 2017 postponing OST implementation until January 1, 2020. This report was prepared in December 2019, i.e. less than a month before the deadline, yet the study could identify no signs of implementation. Thus, there is a real risk that the measures would be postponed again, so the civil society and community need to enhance compliance monitoring and advocacy to promote implementation.

Policy dialogue for the introduction of alternatives to punishment

Existing international experience and best practices confirm the effectiveness of measures alternative to punishment in terms of drug use, harm reduction and public safety. As noted in the report, there are different types of alternatives that can apply to different stages of the criminal justice process from arrest to sentencing. It is recommended that a policy dialogue be launched with participation of officials, policy makers, experts, civil society and community representatives for Georgia to take effective steps toward introduction of alternatives to punishment that are already used in the EU member states.

Changes in the regulatory framework

The definition of the *opioid dependence syndrome* in the national clinical guidelines for "Opioid Substitution therapy with Methadone" differs from that in the International Classification of Diseases and Health Problems (ICD-10). In particular, the national guidelines requires that patients eligible for participation in the substitution therapy programs be diagnosed with "active dependence". There is no definition of "active dependence" and practicing doctor-narcologists perceive this as a reuirment to identify track of opioids in person's urine. This discrepancy between the national guidelines and the ISD-10 sometimes makes it difficult to diagnose and enroll patients in the OST, which in turn may lead to relapses.

Need for effective data exchange protocols between the criminal justice system and the civilian sector

The availability of a mechanism for timely and continuous exchange, coordination, and referral of data between public and private agencies is one of the prerequisites of effective and continuous treatment. Therefore, all health records containing information on in-prison methadone-assisted detoxification or other medical services (Form #100) should be issued directly to the inmates upon release to spare them the need for obtaining the records from an intermediate agency, as this could prevent them from timely enrolling on the OST (Suboxone®) program.

Introducing a multidisciplinary approach for managing OST patients

The described of the TB patient undergoing OST-treatment in prison proves the need to use a multidisciplinary approach for making decisions meeting the needs and best interests of the patient. The need to discontinue one treatment (in this case OST) in order to receive another (in this case treatment for TB) is against the principle of equivalence of care. Besides, abrupt termination of methadone-assisted detoxification could seriously deteriorate the patient's condition. There are no provisions in the existing legislation regarding in-prison OST treatment of individuals who need treatment for other chronic or concurrent diseases. It is recommended that such cases be considered and the management of concurrent diseases associated with opioid dependence would be prescribed in the existing laws or regulations to ensure compliance with the principle of continuity and equivalence of care.

Promotion of pre-release and post-release harm reduction and care programs

Preparation for release begins while still in prison and continues after release. There are no pre-release programs available in Georgia, although international experience shows that the lack of such programs increases the risk of post-release relapses and overdosing. It is crucial that the National Probation Agency, the Crime Prevention Center and other governmental or non-governmental organizations with a mandate to provide support to former prisoners would interact to achieve shared goals.

Introduction

Background

Opioid substitution therapy/treatment (OST) is one of the most effective approaches to opioid addiction treatment. OST programs are an effective way to significantly reduce illegal drug use, HIV-related risky behaviors, overdose deaths, criminal activities, financial burden and other kinds of stress faced by drug users and their families. Furthermore, the OST programs recruit injecting drug users (IDUs), who would otherwise have no access to medical facilities, and are therefore gateways to healthcare services, involving IDUs in HIV testing, antiretroviral therapy, treatment of TB, HCV and other infections. The OST programs are supported by the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and the United Nations Program on HIV / AIDS (UNAIDS). Methadone and buprenorphine have been included on the WHO list of essential medicines. However, doubts and myths about OST are still widespread in many developing countries where abstinence-oriented detoxification is often considered the only legitimate treatment.

The first OST program in Georgia was launched in late 2005 with the support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Since then, the treatment coverage has been rapidly developing. By July 1, 2017, the Global Fund's OST program had completely transitioned to the national budget funding. The services became free and beneficiaries no longer had to copay, which significantly improved access to OST services in the country. The OST coverage has increased dramatically in recent years with 12,179 people, including 763 prisoners, involved in the program in 2018 (Beselia et al., 2019). Despite the expanding coverage of harm reduction (HR) in the community and OST services, the access is still limited to drug users in the penitentiary system. Prisoners are much more vulnerable to drug-related harm and risky drug use behaviors (e.g., sharing of the injecting paraphernalia) than IDUs in the general population; consequently, they need to have at least equal access to the OST programs. In Georgian penitenciary system methadone treatment is available only in two facilities - Tbilisi Prison No 8 and Kutaisi Prison No 2 - as a short-term methadone-assisted detoxification course provided for newly arrived prisoners (Beselia et al., 2019), which deprives the inmates of the right to more effective treatment. Prisoners who were receiving OST prior to incarceration have to discontinue the treatment against their will. According to the UN data, 90 per cent of prisoners with the history of drug use are likely to return to drug use after the release unless they have access to effective treatment in prison (UNODC, 2003). In addition, incidence of overdose is significantly higher among released prisoners, who did not receive adequate treatment while in prison (Merrall et al., 2010). Drug-related deaths after release are mainly associated with change in tolerance to opioids. For this reason, during the first two weeks of release, the risk of death is 12 times higher for released prisoners than for the rest of population and 90 per cent of post-release deaths are caused by drug overdose (UNODC / WHO, 2013). International experience shows that 58 per cent of heroin users, not covered by OST programs in prison, get rearrested within the first 12 months of release (EMCDDA, 2015).

Aims and Objectives

Restricted access to the OST services in the penitentiary is a critical challenge in terms of human rights protection. According to international standards, prisoners retain the right to high quality medical services, including unrestricted access to prevention and harm reduction programs. Commonly accepted prisoners' health and rights regulations, such as the UN Standard Minimum Rules for the Treatment of Prisoners (SMRs), urge the governments that restriction of prisoners' access to harm reduction services grossly violates the international human rights law. In the recent few years, increased coverage and

improved access to harm reduction services for prisoners have been mentioned among the key priorities of the EU Drug Strategy, (Council of the European Union, 2012).

While the HR and OST services expand the coverage in the wider community, they remain barely accessible for prisoners as OST programs are available only in two Georgian prisons (Beselia et al., 2019) as a short-term (3 to 5 months) detoxification course. Consequently, even those inmates who were receiving OST before incarceration have to discontinue with rapid dose reduction. According to the UN, most of these prisoners are likely to relapse after the release because of the early dropout of treatment. Therefore, the study focuses on the challenges and barriers to adequate implementation of OST in prisons, analyzing experiences of former beneficiaries of OST programs in prisons and experience of experts in this field. It also analyzes international standards and recommendations and the regulatory framework of Georgia, and offers recommendations to ensure access to long-term OST for prisoners.

Methodology

Design of the Study

Desk review and qualitative study methods have been used for this study. The desk review involved analysis of international guidelines and regulations in force in Georgia, while the qualitative study included focus group discussions and individual in-depth interviews in Tbilisi, Telavi, Batumi, Zugdidi and Kutaisi (45 participants), including:

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- Individual in-depth interviews with 6 drug users, who had received methadone-assisted detoxification in prison and did not enroll in the community OST programs at the time of the study, but continued using drugs (in Tbilisi, Zugdidi, Kutaisi, Batumi and Telavi); and
- Seventeen individual in-depth interviews with heads of civilian OST centers (Buprenorphine and Methadone) and addiction specialists from Tbilisi, Zugdidi, Kutaisi, Batumi and Telavi, representatives from the National Center for Disease Control &Public Health and former as well as current medical staff from OST in penitentiary system

We also planned to conduct individual interviews with prison healthcare authorities, substance abuse counselors, and medical staff of the probation and social services, but failed to receive a consent from the Minister of Justice in response to our two written requests. Instead, we decided to conduct interviews with people, who had formerly worked as medically assisted detoxification staff and substance abuse counselors in prison (three in-depth interviews).

Potential participants were recruited with support of the Mental Health and Drug Abuse Prevention Center assisted by the Counseling and Information Center “Uranti” and Harm Reduction Centers “Imedi”, “Xenon”, and “Step to the Future”.

Focus group discussions continued for an hour on average, while the interviews lasted for 20-30 minutes. The discussions and the interviews were recorded and transcribed.

Study Ethics

The study approval was issued based on the confidentiality and privacy assessment conducted by the Research Ethics Committee of the ISU School of Arts and Sciences. All interviewers were briefed on the study objectives and privacy issues. A voluntarily signed informed consent was obtained from each participant prior to the interview to confirm his/her willingness to participate in the study. Two participants refused from audio recording, so their interviews were shorthanded. All the interviews and focus group discussions were conducted in private, isolated and dedicated rooms to ensure a confidential and cozy environment for the respondents. Drug users and beneficiaries involved in the study received GEL 20 to cover for the travel time and costs. Similar compensation was offered to those who helped with recruiting potential respondents. Small souvenirs were presented to the health professionals to compensate for the time spent for the study.

Data Analysis

Transcripts of audio files and textual data were analyzed in the qualitative data analysis software NVivo.10 (https://www.qsrinternational.com/nvivo/nvivo-products), based on the inductive method of qualitative analysis (thematic and content analysis). The method involved coding of key topics and open (axial) coding of textual data. The first-level open codes then included newly generated subthemes, which helped improve the coding process. Quantitative evaluation of the source (transcripts) and word coding and comparative analysis of clustering and coding matrices were performed for data visualization.

A total of 93 hierarchical codes were generated by four independent evaluators who encoded transcripts that contained information provided by 45 respondents. Each code was used five times on average (at least once and no more than 12 times) in one transcript. Each transcript was generally coded with 14 different codes (at least 6 and no more than 24 codes) on average 28 times (at least 9 and more than 77). The 93 hierarchical codes were used 871 times. The most frequently coded information was OST experience in prison (duration, enrolment procedures, documentation, etc.), post-release return to civilian OST services or information on transfer from the civilian sector to prison. Cluster analysis of the transcripts indicates the similarity of coding, in particular, thematically similar information provided by respondents was coded similarly.

Limitations

A small-scale qualitative study may fail to fully reflect the situation across Georgia or generalize the results, but information provided by 45 individuals from five different cities may describe general OST trends in those cities. Drug use is a sensitive topic and respondents might have abstained from providing full information, yet all the interviews and discussions were conducted in a comfortable and confidential environment, and on several occasions group discussions were replaced with individual in-depth interviews at participants’ request.

Desk Review Results

Drug Dependence Treatment in Prisons

Drug Use and Prison Population

According to 2018 World Drug Report, about 5 per cent of the adult population had consumed drugs at least once in 2017. One in ten is a drug dependent needing treatment (UNODC, 2018b). Drug use, including problematic drug use, is relatively widespread in the penitentiary system. About a half of the EU prison population use illegal drugs at some moment in their lifetime (Zurhold, Haasen, & Stöver, 2005). Of seventeen European countries that have published data on drug use in prison, 16 per cent of the prison population in Romania and 79 per cent in England, Wales and the Netherlands had used an illegal drug at least once in their lifetime before the arrest. In nine countries, drug use exceeded 50 per cent (EMCDDA, 2012). Systematic reviews of international studies, dominated by the US surveys, show that 10-48 per cent of male inmates and 30-60 per cent of female inmates used illegal drugs in the month before incarceration (Fazel, Bains, & Doll, 2006). An international prison population review reported 25-50 per cent of inmates diagnosed with severe drug-related problems, including opioid dependence (WHO Regional Office for Europe, 2014).

Prison and civilian populations differ significantly in terms of heroin use experience with less than 1 per cent of general population (0.3 per cent in Europe) having consumed heroin at least once in their lifetime. Of thirteen European countries that provided information to the study, in eight countries prevalence of heroin users among prisoners varied from 15 to 39 per cent (EMCDDA, 2012). Lifetime prevalence of injecting drug use was substantially higher among prisoners than in general population. Pre-arrest injecting drug use in Ukraine ranges from 37 to 47 per cent (Boci et al., 2017). Between 2 and 38 per cent of prisoners in Europe ever used injectable heroin or other drugs at least once before the arrest.

Drug Dependence Mechanisms or Why Punishment Cannot Prevent Drug Use

Drug dependence is a brain disease that affects behavior. Drug dependence has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs despite harmful consequences. Scientists have also found that chronic drug use alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicted persons are at a high risk of relapse to drug use even after long periods of abstinence and why they persist in seeking drugs despite the consequences (National Institute on Drug Abuse (NIDA), 2014; UNODC, 2018a).

Why cannot punishment prevent drug use? The abovementioned changes in brain anatomy and chemistry explain why drug dependent individuals persist in using drugs even when facing serious legal problems. Those who are not addicted to drugs (i.e. recreational users) and can manage their drug consumption are not susceptible to strict drug control measures. The risk of detection by the police is indeed low, yet improving the detection rate would be unrealistically expensive (UK Drug Policy Commission, 2012). In the US, cannabis users have a small chance of being arrested for cannabis use in 1 out of 3,000 episodes (Reuter et al., 2009). Applying this approach to Georgia with about 52,000 problem drug users we can assume that an average rate of an injection per day is one injection. The 5,000 positive urine drug tests reported by the MIA in 2018 suggest that IDUs face the risk of arrest in 1 out of 2,300 drug-use episodes. The actual risk is even lower, as the 5,000 positive tests also include non-injectable drugs, mainly cannabis. This probability is obviously too low to support the assumption that a person would stop using drugs for fear of punishment.

Why do people involved with the criminal justice system continue using drugs? The answer to this question is associated with neurobiological, psychological, social and environmental factors. Repeated use of addictive substances eventually alters the functioning of the brain. Brain changes, which accompany the

transition from voluntary to compulsive drug use, affect the brain's natural inhibition and reward centers, causing the addicted person to use drugs in spite of the adverse health, social, and legal consequences (Baler & Volkow, 2006; Chandler, Fletcher, & Vol. 2009; Volkow et al., 2010). Returning to people, environments or activities associated with prior drug use may trigger strong cravings and cause a relapse. Stress can also be a trigger. Forced abstinence from drugs cannot cure drug addiction. Unfortunately, many prison doctors, nurses, and health professionals believe that inmates can be cured by forced abstinence (WHO Regional Office for Europe, 2014). Persons in abstinence, including those who have not used drugs for a long time in prison, also need to learn how not to return to drug use after release.

Why should drug dependence treatment be provided to offenders? The case for treating drug-abusing offenders is compelling. Drug abuse treatment improves outcomes for drug abusing offenders and has beneficial effects for public health and safety. Effective treatment decreases future drug use and drug-related criminal behavior, can improve the individual's relationships with his or her family, and may improve prospects for employment. Furthermore, treatment saves lives. Nine out of 10 untreated prisoners with drug dependence relapse to drug use after release (UNODC, 2003). A retrospective study of more than 30,000 Washington State inmates found that during the first 2 weeks after release, the risk of death among former inmates was more than 12 times higher than among other residents, with drug overdose being the leading cause (Binswanger et al. 2007).

Note! Treatment that is of insufficient quality and intensity or that is not well suited to the needs of offenders may not yield meaningful reductions in drug use and relapse prevention. Untreated substance abusing offenders are more likely than treated offenders to relapse to drug abuse and return to criminal behavior. This can lead to re-arrest and re-incarceration, jeopardizing public health and public safety and taxing criminal justice system resources. Treatment is the most effective way for interrupting the drug abuse/criminal justice cycle for offenders with drug abuse problems (NIDA, 2014).

Why are alternatives to incarceration recommendable? Drug use is interconnected with crime in a number of ways: (1) possession and use of drugs is a drug-related crime; (2) the offence of drug supply may be committed in order to obtain drugs or money to purchase them; (3) an offence can be committed under the influence of drugs; (4) there are offences related to drug dealing, such as violent clashes between organized gangs of drug dealers. Drug users primarily commit the first three categories of crime. In the majority of EU Member-States, most widespread drug-related crimes are mainly the use and possession of cannabis, while problem drug users are more likely to come into contact with the justice system for robbery, theft or assault to get money for the drugs (EMCDDA, 2012). Problem drug users are often repeat offenders, who constitute a significant part of prison population. For this group, detention may be a chance of receiving treatment, as service providers do not have an easy access to problem drug users. In-prison treatment eventually results in improved health and lower risks for the community after release (EMCDDA, 2012).

International drug conventions do not require mamber states to use imprisonment as a sanction for those using controlled drugs. The conventions recognize that offenders with drug use disorders (drug using offenders) need medical treatment and social support and encourage the use of alternative measures to conviction and punishment to help such people manage their drug-related problems. Yet, a significant number of drug offenders face incarceration for drug use and possession. The UNODC reports that 18 per cent of the global prison population are people incarcerated for personal drug use (UNODC, 2016). While criminal sanctions undoubtedly deter some people from drug use, those with severe drug use disorders do not fear criminal sanctions, and higher incarceration rates fail to decrease drug use in the wider community. At the same time, incarceration has a severe impact on the drug users, their families and communities, and can further deteriorate the health and social conditions that underpin their drug use. More and more states are looking for ways to increase the number of people receiving effective treatment for drug addiction and to decrease the number of those incarcerated.

When a drug-using offender comes into contact with the criminal justice system, it is an opportunity to encourage him/her to receive appropriate treatment. This can be done either by referral to treatment, or

by interaction between the criminal justice system and the health care system to enable the person to receive treatment. The response of the criminal justice system would vary depending on whether the person would take up the treatment option as well as on the reasons for prosecution. Given the additional risks and costs associated with the imprisonment, alternative measures should be applied wherever possible from both public health and criminal justice perspectives. Provision of evidence-based treatment as an alternative to conviction or punishment would not only help reduce prison-related risks but would also decrease recidivism and relapse rates of drug using individuals involved with the criminal justice system (UNODC, 2018a).

What are the alternatives to punishment? There are many different alternatives to punishment that are applicable at different stages of the criminal justice procedure, from arrest to conviction. In a recent European Commission-funded study conducted by RAND Europe, thirteen different types of alternatives to punishment (or coercive sanctions) were identified across all 28 EU member states. Those ranged from a simple caution, warning or no action to a range of options that generally involved some element of drug treatment. Those are:

- caution/warning/no action;
- diversionary measure;
- dissuasion commissions for drug addiction
- suspension of investigation/prosecution with a treatment element;
- suspension of court proceedings with a treatment element;
- suspension of sentence with a treatment element;
- drug court;
- drug treatment;
- probation with a treatment element;
- community work with a treatment element;
- restriction of liberty with a treatment element;
- intermittent custody/release with a treatment element;
- parole/early release with a treatment element.

Alternatives to punishment are recognized as having the potential to reduce drug-related harms by referring drug-using offenders to programs that may help them handle their drug problems that often underpin their offending. It also prevents the damaging effects of criminal conviction and, possibly, imprisonment, and saves the associated costs of the state (EMCDDA, 2017). Alternatives to punishment are available in every EU Member State, and all include at least one drug treatment option (EMCDDA, 2017).

What health interventions in prison should be like?

The principles of equivalence and continuity of care. Two important principles for health interventions in prison are equivalence of care to that provided in the community and continuity of care between the community and prison on admission and after release. This implies that all appropriate prevention, harm reduction and treatment services need to be available within prisons and a particular attention should be paid to service provision around admission and release (EMCDDA, 2017).

The principle of equivalence of care obliges prison health providers to provide prisoners with care of a quality equivalent to that provided for the community in the same country, including harm reduction interventions, such as needle and syringe exchange programs and drug treatment. Barriers, whether legal or structural, should be overcome to guarantee high quality treatment and care for prisoners.

Continuity of care between services in the community and in prison applies both on entry to prison and on release. It should also apply to drug treatment, including OST and all types of health care. Many European countries have partnerships between prison health services and providers in the community to facilitate health education and treatment interventions in prison and ensure continuity of care on prison entry and release. To meet these basic requirements, prison admission routines need to include systems to

identify individuals with high treatment needs immediately upon arrival. In addition, proper needs assessments and follow-up reviews are necessary to ensure that treatments are matched to individual needs.

Continuity of post-custody care reduces risks of reoffending and relapse. Studies show that offenders who did not receive drug abuse treatment in prison or after release were more likely to reoffend as they face a lot of post-release challenges and stressors, including reuniting with family members, securing housing, and complying with criminal justice supervision requirements (I. A. Binswanger et al., 2011). Even the many daily decisions that most people face can be stressful for those recently released from prison not to mention other barriers such as a loss of support from family and friends. Individuals trying to recover from drug addiction may experience a relapse, or return to drug use. Triggers for drug relapse and reoffending are varied; common ones include mental stress and associations with peers and social situations linked to drug use. Treatment providers should collaborate with criminal justice staff to prevent this and help them break old patterns of thinking and behaving and to provide new skills necessary to avoid drug use and criminal behavior. Release from prison is a critical time for these people, as the risk of overdose greatly increases in the post-release period, when ex-prisoners may resume using heroin while their tolerance to opioids is reduced (I. Binswanger et al., 2012; Ingrid A. Binswanger et al., 2007; EMCDDA, 2011).

Review studies conducted in Australia, Europe and the US show that 6 out of 10 post-release deaths are related to drug use. The authors conclude that the risk of drug-related deaths increases in the first two post-release weeks, and continues to increase at least until the fourth week (Merrall et al., 2010). A study carried out in the UK (England and Wales) also shows that 6 out of 10 post-release deaths were caused by drugs and the risk was particularly high in the first and second weeks of release (Farrell & Marsden, 2008). A study conducted in Ireland showed a high death risk among released drug-using offenders in 1998 and 2005 with 25 per cent of 105 deaths occurring within the first week and 18 per cent after the first week yet within a month of release (Lyons, Walsh, Lynn, & Long, 2010).

What kind of treatment and other health services should be provided to incarcerated drug abusers?

Drug services in prison may be divided into the following categories: assessment, prevention, counseling, drug free and substitution/maintenance (methadone or buprenorphine) treatment, self-help groups and peer-support interventions, harm reduction, pre-release and post-release care programs (UNODC, 2008). It is important to understand that drug dependence (opiates, cocaine, tobacco, alcohol, or other psychoactive substances) is not criminal or hedonistic behavior, but a chronic disease characterized by a long process of relapses and stabilization efforts that require continuous care and support.

Drug dependence treatment, like treatment of other chronic diseases, should involve diagnostic and planning. One of the goals of treatment planning is to match evidence-based interventions to individual needs at each stage of drug treatment. It is obvious that drug treatment services and interventions strategies cannot develop separately (in isolation) without interaction with other relevant initiatives and strategies. It is important that the prison drug strategy be part of the national drug strategy (World Health Organization Regional Office for Europe, 2005).

How long shall drug abuse treatment last for individuals involved in the criminal justice system?

One of the most reliable findings in the treatment studies is that lasting reductions in criminal activity and drug use are related to the length of treatment (NIDA, 2014). Studies have shown that treatment provided in prison and continued in the community after release can reduce the risk of reoffending as well as relapse to drug use. Treatment in prison can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post-incarceration.

International Standards and Commitments for Drug Dependence Treatment in the Criminal Justice System

Importance of access to OST in the criminal justice system was recognized internationally decades ago. In 1993, the World Health Organization published *Guidelines on HIV Infection and AIDS in Prisons* (World

Health Organization, 1993) reading as follows: *"Drug-dependent prisoners should be encouraged to enroll in drug treatment programs while in prison, with adequate protection of their confidentiality. Such programs should include information on the treatment of drug dependency, and on the risks associated with different methods of drug use. Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons".*

The goals of treatment are to: 1) reduce the intensity of drug use or its cessation, 2) improve functioning and wellbeing of the affected individual, and 3) prevent future harms by decreasing the risk of complications and reoccurrence (UNODC, 2018a). Treatment should aim at making prisoners healthier by the moment they leave prison than they were when entering it. The best treatment outcome would be to stabilize their psychosocial status and to continue post-release treatment. It is recognized that adequate drug treatment in prison can reduce both drug use and crime rates. According to the Lisbon Agenda for Prisons, *"positive experience from in-prison treatment helps inmates to continue treatment after release, reduces relapse rates and related health risks, and also reduces delinquency recidivism"* (Uchtenhagen, 2006).

According to the "Principles about the provision of services in prisons" (WHO Health in Prisons Project and Pompidou Group of the Council of Europe 2001): "…there should be health services in prisons which are broadly equivalent to health services in the wider community"(WHO Regional Office for Europe, 2001) - the principle of equivalence. The European Prison Rules include a set of recommendations on the organization and provision of healthcare and on the qualifications and duties of the medical staff. The principles stipulated in the Prison Rules apply equally to the provision of healthcare for problems related to drug use. Under the 'principle of equivalence', prisoners shall have access to the health services available in the country, without discrimination on the grounds of their legal situation; the prison health staff shall have adequate training and be able to identify mental health problems; and those in need of specialized treatment not available in prison shall be transferred to external institutions" (EMCDDA, 2012).

Equal and universal access to drug abuse treatment should be considered in the context of protection of universal human rights. In the recent case of *Wenner v. Germany*[1], the applicant alleged that Bavarian court's refusal to grant him drug substitution therapy during his imprisonment had amounted to inhumane treatment in breach of Article 3 of the European Convention of Human Rights. On September 1, 2016, European Court of Human Rights delivered a judgment, recognizing actions of the Bavarian court as breach of Article 3[1] - Prohibition of Torture ("No one shall be subjected to torture or to inhuman or degrading treatment or punishment"). Court considers that drug withdrawal as such causes serious physical strain and extreme mental stress to a manifest and long-term opioid dependent, which may attain the threshold of Article 3. Refusing, him the alleviation of his intense neurological pain with an existing and medically necessary treatment constituted inhuman treatment. This precedent may be regarded as a warning to any country where people in detention are denied access to health services, including long-term substitution therapy.

The United Nations General Assembly (UN, 1990), UNAIDS/WHO (WHO, 1993) and UNODC (UNODC, 2006, 2008), similarly define the principle of equivalence by stating that there should be health services (including harm reduction services) in prisons which are broadly equivalent to health services in the wider community.

Following are drug dependence treatment interventions recommended by the United Nations Office on Drugs and Crime (UNODC, 2010 *Drug Dependence Treatment: Interventions for Drug Users in Prisons*. Vienna, Austria: https://www.unodc.org/docs/treatment/111_PRISON.pdf).

Drug Dependence Treatment and Care in Prison (UNODC, 2010)

The demand reduction components of the prison drug strategy may include:

- advice and information services;
- drug education;
- pharmacotherapies – detoxification, abstinence oriented and maintenance treatments;
- risk reduction programmes;
- psychosocial programmes including family based initiatives – structured groupwork, counseling/psychotherapy and residential drug treatment programmes (also known as rehabilitation programmes or “rehab”);
- drug free wings;
- physical activity and sports programmes;
- support groups.

An effective demand reduction strategy should include a broad selection of these interventions. As prisoners are at different stages of change in relation to their drug use and since the treatment should be matched to individual needs, a wide range of services is needed. However, if a prison system is only able to provide some of these services then ‘something is better than nothing’. Even with scarce funding, it is still desirable to provide at least two of these interventions.

Structured groupwork interventions may include for example:

- motivational enhancement
- relapse prevention
- prerelease

Counselling and psychotherapy services may be provided as stand-alone services or in conjunction with other interventions.

Various therapeutic models may be offered including cognitive behavioural and 12-Step programmes.

- Cognitive-behavioural residential treatment
- 12-step residential treatment
- Therapeutic Communities (TCs)

Support groups should be considered for prisoners

- as part of detoxification programmes;
- on pharmacotherapy treatment;
- engaged in psychosocial programmes (e.g. abstinence and prison drug rehabilitation programmes);
- having completed psychosocial programmes (e.g. abstinence and prison drug rehabilitation programmes);
- awaiting release.

Country Approaches

The treatment provided while imprisonment may help reduce drug use and engage in treatment after release. In recent years, many European countries have enhanced the provision of drug treatment and care, especially OST, in prisons, as many international and European institutions consider prison health to be an integral component of public health.

In England, since 2008, an integrated drug treatment system (IDTS) has been implemented in all adult prisons, with the aim of improving the coordination of planning and delivery of all drug treatment interventions, both clinical and psychosocial. The IDTS aims to improve collaboration between prisoners and

the prison system through an individual treatment plan, and to ensure continuity with community treatment at both the start and finish of custody. Each prison has its own drug and alcohol strategy, and a review of this is carried out annually. Also in the United Kingdom, a prison drug treatment strategy review was carried out, under which an independent expert group assessed rehabilitation measures for drug users in prison and on release with regard to their effects on reducing drug-related crime and rehabilitating offenders, and came forward with recommendations for an evidence-based approach to prison drug treatment (Prison Drug Treatment Strategy Review Group, 2010). In Portugal, the provision of healthcare, treatment and harm reduction measures is ensured using collaboration procedures between the health and justice ministries. In the majority of European countries, drug treatment in prisons is provided by staff employed by the prison administration. However, it is also common for prison administrations to collaborate with a range of community-based providers, public health services or non-governmental organizations. In the Netherlands, mixed teams are the main providers of all types of drug treatment in prisons, and in the United Kingdom, they are the main providers of opioid substitution treatment. In Greece, non-governmental organizations are the only provider of drug treatment in prisons (EMCDDA, 2012).

In a majority of EU countries, new inmates are routinely assessed for drug use and drug-related problems. The common approach is a clinical assessment carried out by a medical doctor, psychiatrist or psychologist in order to ascertain a diagnosis of drug dependence and mental health problems, but in some countries standardized tests, questionnaires and interviews are used for this purpose. In Sweden, all prisoners are classified by prison personnel with regard to level of dependence, with a follow-up Addiction Severity Index interview when needed. In Spain, Italy and the Netherlands, social workers and psychologists carry out a multidisciplinary assessment, evaluate psychological, social and legal areas and draw up an individual care plan. The medical consultation upon prison entry is also used as a first opportunity to inform prisoners about treatment and prevention, raise risk awareness, distribute prevention materials, including hygiene kits and condoms, and make referrals to specialized drug treatment and care services (EMCDDA, 2012).

What is the role of medications in treating substance-abusing offenders?

Long-term opiate use results in a desensitization of the brain's opioid receptors to endorphins, the body's natural opioids. Opioid agonist or partial agonist medications, which act at the same receptors as heroin, morphine, and endorphins, tend to be well tolerated and can help an individual remain in treatment. For example, methadone, an opioid agonist, reduces the craving that otherwise results in compulsive use of heroin or other illicit opioids. Methadone treatment has been shown to be effective in decreasing opioid use, drug-related criminal behavior, and HIV risk behavior. (NIDA, 2014). Maintenance therapy is a basic approach used to treat opioid dependence in all EU member states. Europe had about 654,000 patients in opioid substitution treatment in 2018, covering about half of the estimated population of opioid dependent individuals (EMCDDA, 2019).

How effective is the opioid substitution therapy?

Opioid substitution therapy is a cost effective method. It is estimated that every euro invested in OST saves 4-7 euros because of decreased drug-related offenses, criminal prosecution costs and theft. When savings cover health care, the ratio between the cost of OST and full savings can be as high as 1 to 12. Studies showed that with adequate dosing (at least 60-80 mg of methadone or 12-16 mg of buprenorphine per day) and in-prison treatment, OST programs reduce injecting drug use and sharing of syringes and needles thus reducing the incidence of HIV and blood borne infections. Data from 21 studies have been analyzed in a systematic review to assess OST effectiveness (Hedrich et al., 2012). The authors conclude that prison treatment benefits are similar to those of community treatment. In particular, prison treatment provides an opportunity for recruiting problematic opioid users in treatment, reducing drug use and risky behavior, and potentially lowering the risk of overdose post-release. In some countries, post-release overdose deaths and

suicides in prisons have become triggers for OST introduction. In order to prevent post-release relapse and overdose, it is recommended that a stable dose of agonist medication be achieved prior to release (Stöver & Marteau, 2012).

What are the positive effects of OST in prisons?

Ultimately, positive effects of OST both in prison and in the civilian sector include the following:

- Prisoners receiving OST no longer seek other drugs, thereby improving prison security;
- In-prison OST significantly reduces delinquency recidivism after release;
- Offenders who underwent OST while in prison are more likely to continue treatment post-release than those who underwent detoxification in prison;
- Breaches of security, non-medical use of psychotropic drugs, and acts of violence are less common in prisons participating in OST programs than in other prisons;
- Both prisoners and prison staff report positive effect of OST on prison life;
- OST ensures day-to-day contact between healthcare providers and prisoners, thus promoting relationships for other health services to build on (such as HIV prevention and others);
- Evidence suggests that abrupt cessation of OST increases self-harm and suicide risks.

Since opioid use is a relapsing disorder, medically assisted detoxification alone is not enough for achieving long-term positive effects. The positive effects of OST can be maximized by:

- Retaining people on OST;
- Prescribing high rather than low doses of methadone;
- Focusing on long-term engagement in OST rather than on abstinence;
- Offering counseling, diagnostics and treatment of concurrent diseases and tackling social problems;
- Strengthening therapeutic relationships between healthcare professionals and patients to reduce the risk of non-prescribed drug use.

Legal Framework for OST Programs in Georgia

Regulation of OST Programs in the Wider Community

In Georgia, the term “substitution therapy” is legally defined as “drug dependence treatment using a substitute drug – pharmaceutical product having cross dependence and cross tolerance towards the drug to which the addiction syndrome has developed”.[1]

Pharmaceutical products allowed for use in the substitution therapy programs in Georgia include methadone hydrochloride and a combination medicine Buprenorphine, Naloxone. The following types of substitution therapy are available in Georgia:

- Short-term medically assisted detoxification - treatment with a substitute drug with gradual dose reduction, lasting maximum for a month;
- Long-term medically assisted detoxification - treatment with a substitute drug with gradual dose reduction, lasting for more than a month;
- Short-term substitution therapy - treatment with stable doses of a substitution drug maximum for 6 months;
- Long-term substitution therapy - treatment with stable doses of a substitution drug for more than 6 months;

[1] Order #01-41 / n of July 3, 2014, of the Minister of IDPs from the Occupied Territories, Labor, Health and Social Affairs of Georgia, “On the Implementation of the Special Drug Replacement Therapy Program” https://www.matsne.gov.ge/ka/document/view/2374811?publication=0.

- In special cases, inpatient treatment using a substitution drug.

The goals and objectives of the substitution therapy are defined as improving physical and mental condition of people with opioid dependence and achieving remission, promoting social integration, preventing blood borne infections, public risk reduction, etc.

According to Paragraph 5 "Grounds and Criteria for Patient Inclusion in the Drug Substitution Treatment Program" (Ministerial Order #01-41/n of 2014 "On the Implementation of the Special Drug Substitution Treatment Program"), patients eligible for participation in the substitution treatment program have to be diagnosed with opioid dependence syndrome (active dependence[2]) and meet at least one of the criteria listed in Paragraph 5 (b):

- Persons aged 21 years and older;
- Injecting drug users;
- HIV-positive persons;
- Pregnant women;
- Foreign citizens/migrants who have been receiving drug substitution therapy before arrival in Georgia;
- Persons released from custody or detention, who have been receiving drug substitution therapy by the time of release.

The national clinical management standard (guidelines) on "Opioid Substitution Therapy with Methadone", approved by Order #03-137/o of June 20, 2016 of the Minister of Labor, Health and Social Welfare of Georgia, reads that according to the Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10), the opioid dependence syndrome (code F11.2) is a cluster of physiological, behavioral, and cognitive phenomena in which the use of opioids takes on a much higher priority for a given individual than other behaviors that once had greater value. The definition provided by the national guideline and the ICD-10 does not include "active dependence".

Regulation of OST Programs in the Criminal Justice System

Provision of in-prison health services in Georgia is regulated by a number of key healthcare laws, including the Law of Georgia on Healthcare, the Law of Georgia on Patient Rights, the Law of Georgia on Narcotic Drugs, Psychotropic Substances, Precursors and Narcological Aid, and others; also by specific laws, such as the Imprisonment Code; ministerial orders related to the provision of healthcare services in the penitentiary system (including orders by the Minister of Justice, Minister of IDPs from the Occupied Territories, Labor, Health and Social Welfare, etc.), and other regulations.

Joint Order #92 №01-26/n of July 14, 2016 of the Minister of Corrections and Probation and the Minister of Health and Social Welfare Approving the Implementation of the Substitution therapy Program for Accused/Convicted Persons with Opioid Dependence"[3], sets out a number of program eligibility criteria (Paragraph 4), specifically:

1. Opioid substitution therapy program shall enroll only patients diagnosed with the opioid dependence syndrome (active dependence).
2. Patients younger than 18 years shall not be allowed for participation unless for short-term and long-term detoxification.
3. Short-term and long-term opioid substitution therapy program shall enroll patients who were enrolled in a corresponding OST program in the civilian sector at the moment of incarceration.

[2] Active dependence is not defined in any regulatory documents that were available to the study team. Respondents for this study reported that based on a verbal agreement between narcologists the "active dependence" means the presence of opioid metabolits in urine. We were unable to determine what was the bases sfor uch an unoficcial verbal agreement.

[3] https://matsne.gov.ge/ka/document/view/3311363?publication=0

The order ***says nothing*** about the treatment of accused/convicted persons with the opioid withdrawal syndrome who have no active dependence symptoms and do not participate in an OST program in the civilian sector.

Implementation of OST programs in Georgian prisons is regulated by Joint Order No. 92 N01-26n of July 14, 2016 of the Minister of Corrections and Probation and the Minister of IDPs from the Occupied Territories, Labor, Health and Social Welfare Approving the Implementation of Substitution therapy Programs for Opioid Dependent Persons in Penal Institutions".[4] The order allows for detoxification assisted with substitution medicines in prisons No 2 and No 8 and declares the ministry's commitment to implement all measures necessary for introducing short-term and long-term substitution therapy in prisons in early 2018. Yet the order was later amended by order №148/№01-74/n[5] of December 29, 2017 postponing the deadline for the implementation of the short-term and long-term OST until January 1, 2020.

Persons involved in the criminal justice system can enroll on the OST program free of charge. The program has a provider, responsible for recruiting a medical board of minimum three health professionals, including at least one doctor-narcologist. The board is responsible for making decisions related to the substitution therapy, including enrolment of patients, discontinuation or completion of treatment. All decisions are made by majority vote.

As mentioned above, the accused/convicted persons should be enrolled in the OST program by decision of the medical board, provided they meet the above criteria and give their written consent. If they refuse from participation in the program, this also should be done in writing. If enrolled, they should sign a bilateral agreement with the provider, defining rights and obligations of both sides. At the weekends, enrollment-related decisions should be made by an on-duty doctor-narcologist, who should notify at least one member of the medical board. The decision should be approved no later than the following business day. The provider shall submit the list of enrollees to the prison administration that should ensure their safe participation in the program. The treatment should be carried out according to the following standards:

- The initial dose and the regimen should be determined by the doctor-narcologist and then approved by the medical group;
- A member of the medical group should provide to the chief physician information on the accused/conducted person's enrollment/non-enrollment in the program, discontinuation and/or completion of the course of treatment;
- Patients should take medication under the electronic supervision in the presence of a security officer;
- If an accused / convicted person is transferred for treatment to prison hospital or community hospital, hospital administration should be informed in writing about his/her participation in the OST within 24 hours of the transfer;
- In case of patient's transfer to a medical unit or a facility, a member of the medical group should fill in the patient's medical record and should hand a portion of substitution medication sufficient for the patient's stay (maximum for 7 days at a time) to the medical unit or facility upon their request. In a medical unit, a patient should take the medication under electronic supervision in the presence of a security officer. Having taken the medication, the patient together with the doctor and the security officer should sign a special confirming form. In a medical facility, administration of the medication should be medically supervised and recorded by a doctor. In both cases, the medication should be transported by the unit/facility director. The order states that patient's body fluids should

[4] In 2017, this order was renamed as "Joint order approving the implementation of substitution treatment programs for opioid dependent persons in penal institutions" (Order N64-N01-47n of the Minister of Corrections and Probation and the Minister of IDPs from the Occupied Territories, Labor, Health and Social Welfare), https://matsne.gov.ge/ka/document/view/3311363?publication=0.

[5] https://matsne.gov.ge/ka/document/view/3963680?publication=0.

be tested "according to necessity", but fails to specify necessity criteria. Collection of biological fluids is electronically supervised.

Decision on treatment completion is taken by the medical board based on patient's assessment. Reasons for early termination of treatment include patient's request, patient's transfer or release from prison, or exclusion from the program. A patient can be excluded from the program for the following reasons:

- Use of a non-prescribed first-line drug or gross violation of the treatment regimen (being rude to the medical staff, stealing or selling narcotic drugs, etc.);
- Systematic violation of the bilateral agreement. After violating the agreement for the first time, the prisoner would be warned of possible exclusion from the program and would sign a protocol together with a medical board member. In case of repeated violation, the board shall consider the patient's exclusion. For gross misconduct, the prisoner may be excluded from the program after the first violation.
- For inmates receiving OST when released, the doctor-narcologist and/or the program manager should immediately notify the service provider, who should prepare all necessary documents for the patient to continue OST in the civilian sector.

Results of the Qualitative Study

Study Participants

Healthcare Providers

Interviews were conducted with methadone and Suboxone® substitution therapy providers and doctor-narcologists from five cities of Georgia. Professional experience of the respondents ranged from two to 15 years. The majority of doctor-narcologists had both Suboxone® and methadone experience, which significantly enriched their knowledge of the study topic.

Beneficiaries

Interviews were conducted with different OST patients who had received methadone-assisted detoxification in penal institutions in the period of 2009-2019. At the time of the study, some of them were receiving OST in the civilian sector, whereas others were using drugs. Based on results of the interviews, the recent decade can be divided in two subperiods – 2009-2013 and 2013-2019 – that differ significantly according to the experiences of the beneficiaries.

From Detention to Imprisonment

Healthcare Providers

According to the OST staff, 2 to 15 patients of community OST programs come in contact with the criminal justice system every year. Within 24 hours after getting in temporary detention facilities, the patients are escorted by correctional officers to OST sites to receive their medicines. According to the respondents, inmates often asked for methadone or Suboxone® while in temporary detention, yet there were several cases of when patients refused from taking medication for specific reasons.

"I had a patient who was getting high doses by the time of arrest, but did not ask for substitution therapy. I was surprised, so he explained that if he had asked for it they would have transferred him to Kutaisi, but he preferred to stay in Batumi".

"After the arrest some did not even mention that they were on the program, so when they put them in the detention facility, they somehow managed to cope with the abstinence [here withdrawal] symptoms, got through it somehow".

Once a patient is transferred from a detention facility to prison, the community OST site no longer participates in his/her treatment and has to send the patient's medical files to the new facility, including his/her health certificate (Form #100), medical records and medication chart indicating the substitute drug dosing.

Beneficiaries

The respondents described their experience in prison, procedures they went through and the time they started receiving OST in prison. The enrolment procedure appeared to be simple for those who participated in the community OST programs and the situation remained unchanged for them after 2013. Meanwhile, those who were not involved in such programs had different experience, as they had no access to prison OST programs until 2013. In 2013, the situation changed, and a prisoner claiming to have an opioid dependence, would be enrolled in methadone-assisted detoxification program provided the claim was confirmed by a medical conclusion.

Most of the respondents had participated in community OST programs before the arrest, so they encountered no problem with receiving OST in prison. Such patients are reportedly provided with their daily medication even when in temporary detention. Experience is different with those who did not participate in community OST prior to detention. One of the respondents said that prison stuff did not believe he used drugs and refused to detox him. Another one noted that he was included in methadone-assisted detoxification program after being transferred from a temporary detention facility to prison. This case reveals a serious barrier to enrolling on the methadone-assisted detox program that depends on the consumed drug. Specifically, if a person is taking a short-acting opioid (e.g., heroin, raw opium), the 72-hour temporary detention in most cases (including when the drug was last used before arrest) is sufficient for drug metabolites to become unidentifiable in the patient's urine. Thus if a person is not involved in the community OST, it is difficult for him or her to receive substitution therapy, especially as many do not confess to abusing drugs so no medication is provided to them. Upon their transfer from temporary detention to prison, convicts pass medical examination and their access to methadone-assisted detoxification somewhat depends on the opioid presence in their urine, as confirmed by the second respondent's case, who was using a long-acting opioid - methadone (diverted (street) methadone, not the one provided in the OST program). Thus, 64 hours into the temporary detention, his urine test showed the presence of opioids and he joined the detox program.

Fear of severe pain associated with withdrawal is the main motivation for the respondents to enroll on the detox program. Besides, receiving detox is beneficial as the treatment also helps cope with general anxiety and stress related to imprisonment, and communication with medical staff is perceived as positive experience by prisoners.

"When they first got me in 2013, I wasn't on the program and I was dopesick, but they didn't believe me; I was on Baclofen then and they wouldn't prescribe methadone if you used Baclofen. I also used Gabagamma and raw opium, and I think I used Krokodil too and they didn't believe I was dopesick, but I was out in seven days, and I wasn't planning to get back so soon, but then suddenly I got there

for three months and they didn't put me on the program either, but when I went back (to prison in 2014) I already was receiving OST so I continued with the program, with methadone".

Patients involved in Suboxone® treatment programs in the civilian sector have to change the medication once they get involved in the criminal justice system, as Suboxone® is only available in the civilian sector. Ex-prisoners with such experience had no serious complaints, mentioning that the prison OST had considered the fact, but they mentioned occasional misdosing.

"What I didn't like was the wrong dose they prescribed when they transferred me from the subutex program. I felt sick for about a week; I would rather have stayed in the previous program. I had to take methadone for six months. I didn't like it at all".

It is noteworthy that there is no OST program in women's facilities, making it difficult for pre-arrest OST beneficiaries to receive even methadone-assisted detox treatment in prison. Women are taken to the Gldani Prison for daily methadone treatment. It is also difficult for women who were not receiving OST before the arrest to receive detox treatment in prison, as they cannot prove active dependency, so they have to go through severe withdrawal without any medication.

"There was no methadone program available there. There was one in Gldani only, so I told the prison administration to send a responsible person to Gldani to fetch, let's say, a week's supply instead of taking me there every day. But they wouldn't listen, so they had to send a car to take me there every day, and I spent time waiting for the car".

"Yes, I had serious problems. I literally had to fight my way to the program. But my friend had to go through withdrawal without any medication, as they didn't accept her in the program".

All respondents had known about the prison OST before the imprisonment. They had learn it from peers and/or in the street. Upon admission, the prison doctor asks all the newcomers if they consume drugs or participate in a community OST program.

"The doctor sees you the same day… and first asks you and then makes calls to make sure that you're really on the medication and asks about the dosage. Or else, they do tests and after they show that you're on medication, they check your dose at the previous OST site. You might be lying and saying you took 300 when you took only 50. They have to check it, you see".

"I had no idea about it and they asked me whether I wanted to continue with detox. I said I was eager to get it, but they put me on it for only two weeks".

Methadone-Assisted Detoxification in Prison

Beneficiaries

Those respondents, who were in prison before 2013 had negative experience of the methadone-assisted detoxification program. They said prison officers could remove you from the program for violating prison regulations or for any other action they considered inappropriate, i.e. they used it as a means of intimidation and punishment.

"It was like an unbreakable rule. You continued with the dose you were on when you arrived. It was in the good times already, starting with 2012, after Saakashvili. It wasn't so good under Saakashvili".

"That was a short but a very bad period. It's much better now than it was then".

Former prisoners with post-2013 experience have a better perception about the prison OST; they note a better attitude of the staff and think that the prison policy changed for the better and became more patient-oriented. Before 2013, the detox course lasted only for 2 months with a very rapid dose reduction, but after 2013, the course duration exceeded 5 months. Yet, the respondents mostly agree that the methadone-assisted detox course was not sufficient to relieve the abstinence syndrome. Most of the interviewed spoke negatively about the need to undergo a "compulsory" detoxification regardless of their will, as they believe all prisoners should be offered a choice between a methadone-assisted detoxification and a long-term OST.

"It was OK when they cut down my dose to 30 mg, but when they cut it even more it was not enough so I felt dopesick in the morning".

"It's scary when they cut down your dose. We fear the ending of the detox".

All the respondents appreciated the availability of the methadone-assisted detoxification program in prisons, saying it improved their situation significantly. They said that the main motivation for joining the program was to alleviate the abstinence syndrome and relieve its symptoms. Some expressed no willingness to continue treatment post-release.

"Yes, sure. The detox should not be a must. We sent a letter to Sofo[6], said it should be free will. Let's say, a person is serving two years, so let him have the same medication he had before the arrest. Their response was, they were not sure they could change it for now".

"The good thing about it is that they help you to get off it, but they should give you more time. Instead, they take you to another place the same day, where you're the only one person feeling dopesick and that's too bad. It's better to be with those who's feel the same, it's easier to go through it together. So, they just need to give us more time".

The case of a TB patient

One respondent (West of Georgia) had to discontinue the methadone-assisted detoxification while in prison because he had tuberculosis and had to be transferred to the Ksani facility, where most of convicts with TB are held and where no methadone-assisted detoxification was available. He said he had gone through very hard times, as the drugs they used to manage withdrawal symptoms were ineffective.

"I spent nine days in the Kutaisi prison. I had tuberculosis, so they took me to Ksani. So, I was taking detox drugs for ten days and then I had to quit. Nobody would bring them to me from Kutaisi to Ksani, and there is no detox in Ksani. I has to be available in all facilities… There is a TB zone in Ksani, where they take all those who had had TB or have active TB at the moment, but there is no methadone detox there. Take my situation, I'm on detox and I have TB, so they take me there and

[6] Sofio Kiladze, Chair of the Human Rights and Civil Integration Committee in the Parliament of Georgia

they give me Sedalgin and the stuff and they kill my liver… A neurologist saw me and prescribed 150 gr of Gabapentinum but how can it help you when you're on 65 mg of methadone".

The TB patient's case was discussed with the medical staff, who said that he potentially had an active form of tuberculosis or his condition had been so bad that TB treatment was the priority at the moment. Otherwise, the discontinuation of the methadone-assisted detoxification was clinically unjustified.

"TB treatment might have been a health priority at that moment so he had an active or a severe form. I have patients, who are receiving OST, but if their condition seriously deteriorated, some vital signs, such as blood pressure, breathing, pulse, heartbeat and others, would take priority over the abstinence syndrome. I think that in that case the doctor considered TB treatment a priority. Sometimes, you have to give priority to somatic health".

Community OST staff mentioned geographic accessibility as one of potential barriers in this case. In Tbilisi such case would be handled in Gldani facility where OST detox is available and there is a special unit for TB patients too.

"Prison location could be a reason. The program operates in the Gldani and Kutaisi prisons. I think there were territorial, geographic reasons for the patient to be taken to a facility where no substitution therapy was available."

"I don't think that the problem was created by the prison hospital. They wouldn't have denied treatment under any circumstance, but the patient was in Ksani, so he would have had to be conveyed to his old prison for daily treatment. Yet, I think they should have provided at least a short-term detox. I think it was medically wrong".

Post-Detoxification Period

Ex-prisoners note that before 2013 OST doctors provided no medication or help to post-detox patients, while those who were in prison in 2014-2015 have a different experience, saying they were prescribed sedative and sleeping drugs to alleviate post-detox discomfort. After methadone-assisted detoxification, they had access to a psychiatrist, a doctor and appropriate medication; yet, they still speak negatively about the process, as it was compulsory. Discomfort was mainly reported by patients who had received short-term methadone-assisted detox with rapid dose reduction.

"I spent a year and a month in prison of which the detox lasted for 44 days. Then I had post-detox insomnia for about three months".

"I was in prison for four years and the detox lasted for two months, and I had very hard times afterwards".

"It was more or less OK when I was on detox, but then I was on my back for 20 days and they would give me nothing".

Pre-Release Transition Programs for Patients with Pre-Arrest Drug Use

None of the respondents reported the availability of pre-release transition programs. They said they had had interviews with psychiatrists or psychologists, but were offered no pre-release treatment for drug using offenders.

> *"There was nothing of the kind. They used to have a psychologist there and I saw him when I had nothing else to do, but we didn't talk about psychological stuff then. They say they do it now, but I did not need it, and there was nothing like pre-release preparation there. They just ask you when you're going to be out and that's it".*

> *"They gave us a booklet, nothing else, but there was a large-scale amnesty declared at that time, so who cared. The booklet was about social reintegration".*

> *"I have been in jail for five times since 1991, and there has been nothing there [here: transition treatment program]".*

> *"Nobody can prepare you. Five out of ten think they'll get back to it [here: drug abuse] after release".*

Respondents noted that availability of a pre-release transition program in prison would really be effective.

> *"It would be more effective in prison than after release. When you're there you think different, you think you're going to change your life after you're out. Eighty per cent don't change anything afterwards, but still they think about it and they really want to change".*

Post-Release Experience and Barriers for Prison OST-Receiving Patients

A large percentage of OST providers say most of the patients that were on OST at the moment of release enroll on community OST programs after release. If a person applies to a community OST program within 10 days after release, he/she is automatically enrolled without any need for submitting additional documentation. The medical staff refer to this as "re-enrolment". Prison OST ends with sending the patient's clinical report and prescription card with the dosage to the community OST service. Ten days after the release, the patient has to submit Form #100 to re-enroll on the community OST program. Unlike methadone program patients, Suboxone® patients cannot re-enroll on the community OST immediately. Prison OST programs send all clinical reports and prescription cards to the Center for Mental Health and Prevention of Addictions, which quickly and easily exchanges this information with the methadone program. Yet subuxone patients need to come to the Suboxone® site themselves in order to submit their documents for enrolment on the Suboxone® treatment program. The subuxone program staff say that given the particular properties of this medication it is vitally important for them to quickly receive information about in-prison methadone doses administered to the patient. Because of the transfer from the opioid agonist methadone to the combination of the agonist-antagonist buprenorphine and antagonist naloxone, doctors have to ask patients to wait for several days, to "miss a dose", before they put them on the Suboxone® program. The waiting time depends on the previously administered methadone dose, so the doctors need to see the health certificate (Form #100) in order to calculate the medication dose precisely. Yet it usually takes time to issue the certificate, so some patients start using street drugs instead.

"As long as we were part of an integrated system, all issues were addressed over the phone and prisons emailed all health records directly to us. The Global Fund was involved with it then. Today the program is supervised by the Mental Health Center, which is a state-owned agency. So now patients have to go to the Center, take Form #100 and the release documents and bring them to us. It takes time to issue the form, so, patients have to start looking for drugs in the street. In the meantime, they can be rearrested or get in some trouble. They come out of prison on low doses, so the risk of a street drug overdose is very high".

Community OST representatives also said that former prisoners tend to ask for a rapid increase in dosage. They said they often had to increase doses on the first day of the treatment at patients' requests. They believe it is due to the rapid dose reduction and insufficient duration of detoxification in prison. Consequently, patients who are involved in post-release community OST ask for higher doses from the very first day.

The respondents did not mention any barriers to post-release enrolment on community OSTs, yet noted a difference: if released from prison while still on detox, an ex-inmate can re-enroll on the community OST program the same day, because all patients have a place 'booked' for them in community OSTs for a month. Yet if released after serving the full sentence, the community OST re-enrolment procedure for them would be similar to that for those joining OST for the first time, i.e. they would have to get an urine test to prove consumption of opioids and to obtain a health certificate (Form #100); and this prompts them to use drugs in order to have a positive urine test.

Interaction between the Civilian and Prison Methadone Programs

Health professionals from community OST programs said they communicate with prison OST mainly by email and by phone. Some respondents said they also have meetings and discussions.

"We all gather at our Centre, people from the community-based and prison programs, because the Centre is the managing entity. …If there are some vital issues to discuss, we can meet every month, if there are no urgent issues, we meet once in 2 or 3 months".

Community OST staff is not involved in patient treatment in prison, although some give advice to their prison counterparts on some patient cases.

"I'm not involved in treatment, but I keep in touch with the prison doctor, inform him on typical changes in patient's condition, emotional state, and advise him on what to primarily pay attention to, on the patient's main problem, and on other things necessary for adequate treatment".

The respondents also mentioned certain communication problems. Thus, prison personnel cannot use mobile phones in prison and have to leave them at the guard desk, so one cannot get in touch whenever necessary.

"Sometimes I call and can't reach him. I send an email but get no reply, because they are prohibited from using communication means in prison. I think the coordinator has access to the email, but not always. This delays the process for a while, sometimes for a day, and if there are holidays or day-offs than the delay is even longer. But since we knew each other personally, I used to call in the evenings for the interests of the patient. Yet there were occasions when I could not enroll a patient the same day he applied because I had no documents from prison".

"It would be good if the prison healthcare staff had a constant access to communications and had all necessary documents in order. If a patient says he took a certain dose while in prison a couple of days ago, we need a documented proof to decide correctly on the necessary dose and the need for enrolment. Holidays and day-offs are particularly problematic in this sense".

The prison methadone program staff have no right to prescribe any drugs other than methadone. If a patient develops certain symptoms, a psychiatrist or an outsourced drug counselor examine the patient and prescribe other necessary medication.

"They do have narcologist on the program, but they have no right to prescribe any drugs apart from methadone, for example, sleep pills or any medicines for diarrhea. Prison narcologist can only prescribe methadone for detoxification".

There are both formal and informal relationships between OST doctors in the community and in prison. They share patient histories and exchange information about doses and treatment. Yet doctors from the Suboxone® program noted that the communication between the prison and community OST programs could be better. Most of the interviewed health professionals believe that inmates should have an opportunity to engage in long-term (maintenance) treatment should they want to and if necessary.

"They factually get forcibly detoxed, you see. Not all the patients are ready for abstinence. Substitution therapy involves harm reduction too. Some patients told me they were not ready for abstinence. A patient who has been in the program since its opening told me he was very comfortable and had no problems because of it. He got married, has children, has a job, and is going to stay in the program lifelong. If he were incarcerated, they would make him quit the medication in three months. They might force him to abstinence but once he was out he would surely have a relapse, because I know what his disposition is like."

"They want a long-term treatment, and another thing, dose reduction during the detox implies discomfort. For some reason, a patient had been taking a certain dose before imprisonment, the dose that his body needed, and was not ready for detoxification. If he wanted or was ready for it he would have undergone detox before the arrest."

A small proportion of respondents said long-term maintenance program would be good, but need to be managed and supervised carefully.

"Of course [detoxification] is not enough, but there should be no opportunity for freely changing or increasing doses. If we increase doses to substance dependent patients, our medication itself can cause harm. I mean it needs to be managed very carefully, multidisciplinary approaches are always more effective, especially in such circumstances. Substitution therapy is a good treatment, but needs to be managed and supervised very carefully."

One of the respondents mentioned MoJ's order introducing long-term maintenance treatment in prisons in 2019.

"There is a ministerial order on replacing the long-term detox with the substitution therapy. The order should have come into effect in 2019, but some barriers emerged; the Ministry of Justice invited foreign experts to carry out a study, and, as far as I know, the study is over. Despite certain barriers

*– I haven't read the expert opinion and cannot talk about the barriers and risks they have identified – the experts recommend that **substitution therapy should be implemented in prisons as its benefits would be greater than possible risks."***

Very few respondents (including an OST manager who had no medical background) believe that methadone-assisted detoxification in prisons is sufficient, current regulations are satisfactory and there is no need for long-term OST.

"Everything works well, there are no barriers and there are normal relationships and communication."

"No, believe me, if we did that, everybody would want the maintenance treatment. Our aim is help them kick the habit painlessly. Prison is not supposed to create comfortable conditions and provide drugs to offenders. I don't think it would be right."

Former Staff of the Prison Methadone Program Comments on the Need for a Long-Term Maintenance Therapy in Prison

The study involved interviews with OST physicians and doctor-narcologist, who formerly worked for the prison methadone treatment program. According to the respondents, the prison program covered all opioid dependent prisoners willing to enroll and all those who had enrolled in the community methadone program before the arrest. If patient's urine tested negative for substances, he or she underwent clinical examination (withdrawal symptoms, needle marks). Sometimes physicians disregarded the regulations and kept patients in the program longer or recruited more patients than they should. They literally fought to include patients who failed to meet the established criteria (active dependence) yet had obvious signs of drug abuse.

Most patients wanted to stay in the program for a long time, but had to do with detox, except for a small group of HIV-positive prisoners who remained in the program. Doctors noted that after the detox was over, prisoners had an access to psychiatrists, doctor-narcologist and other medical staff, who could prescribe appropriate medicines. However, upon completion of the program, the methadone program staff could no longer see and consult the former patient. The staff seemed to be unhappy with the fact that they were limited in communicating and counseling patients covered by the same program.

Most of the interviewed drug counselors believe that long-term OST should be available in prisons, even though many beneficiaries had told them that short-term methadone-assisted detox had made them to stay free from drugs.

"I know some said after release they had kicked the habit in prison and they wouldn't have had managed without being forced into it, because they were on 100 mg when they started the treatment. So, there seems to be something positive in compulsion, I guess."

Former prison OST doctors see the need for a long-term maintenance therapy in prison. Yet that would require more human resources and space. They are critical of the fact that there is no methadone program available in the women's facility. Narcologists also spoke negatively about the duration of the in-prison methadone-assisted detoxification program and said that prisoners can quickly switch to other psychotropic drugs that pose a risk. Patients receiving long-term OST prior to arrest
who have to receive rapid detox in prison may face severe mental health problems and need psychotropic medications to manage these conditions.

“There was a case when a patient who had been in the program for 8 years, went to prison, and had substitution therapy discontinued in two months. He developed a severe psychosis.”

Previous Attempts to IntroduceLlong-term Maintenance Treatment in Georgian Pprisons

In 2018 within the Global Fund funded programme in Georgia funds were allocated to support the introduction of long-term opioid substitution program in prisons. Funding was intended to cover the costs of building a physical infsrastructure in prisons and supporting medical staff salaries at the initial stage of program implementation. The State was considered to take over the financial support at later stages. This initiative was supported by the Country Coordinating Mechanism (for the Global Fund supported programs) that was chaired by the Minister of Health of Georgia. The Ministry of Justice (MOJ) and Interagency Coordinating Council to Combat Drug abuse engaged in the process as soon as the leadership of the Penitentiary Department (under the MOJ) showed reluctance in implementing this initiative. Number of meetings were conducted to discuss barriers that hindered the implementation of long-term OST in a prison system. Representatives of the Penitentiary Department although approving the initiative on a level of rethoric, stated that the system was not ready to provide long-term treatment in all prisons. Main reasons that were named were insufficient physical infrastructure and lack of qualified medical personnel. They also stated that the initiative could have been implemented starting from 2020 under the overall reform of the penitentiary system. At the same time the leadership of the health system of the Penitentiary Department stated multiple times that they perceived detoxification and (forced) abstinence as a cure from addiction. This suggests that apart from possible infrastructural barriers, the principal obstacle for introducing long-term OST in Georgian prisons can be an insufficient knowledge of the nature of drug dependence and treatment principles and approaches by the leadership of prison health system.

Conclusions and Recommendations

Equal access to services for detainees and prisoners, including women

Over the past decade, Georgia has achieved a remarkable success in implementing, expanding, and ensuring financial sustainability of OST programs in the civic sector and has now committed to providing similar services in prisons. Yet access to harm reduction, including long-term OST, is still limited in detention centers and prisons. With reference to *Werner v. Germany*, it is recommended that the government of Georgia would speed up the introduction of long-term OST in detention centers and ensure geographical accessibility of these services. The infrastructure and security procedures of prison OST services are mainly designed for male prisoners and do not address the specific needs of female inmates. A particular focus should be made on women's prisons, and female prisoners should be provided with access to OST services similar to those available in the wider community.

Monitoring and advocacy by the civil society and communities

According to ministerial order No. 92/No01-26n of July 14, 2016, the Ministry was to take all necessary measures to implement short- and long-term maintenance therapy in prisons by early 2018, yet the order was amended by order No148/№01-74/n of December 29, 2017 postponing OST implementation until January 1, 2020. This report was prepared in December 2019, i.e. less than a month before the deadline, yet

the study could identify no signs of implementation. Thus, there is a real risk that the measures would be postponed again, so the civil society and community need to enhance compliance monitoring and advocacy to promote implementation.

Policy dialogue for the introduction of alternatives to punishment

Existing international experience and best practices confirm the effectiveness of measures alternative to punishment in terms of drug use, harm reduction and public safety. As noted in the report, there are different types of alternatives that can apply to different stages of the criminal justice process from arrest to sentencing. It is recommended that a policy dialogue be launched with participation of officials, policy makers, experts, civil society and community representatives for Georgia to take effective steps toward introduction of alternatives to punishment that are already used in the EU member states.

Changes in the regulatory framework

The definition of the *opioid dependence syndrome* in the national clinical guidelines for "Opioid Substitution therapy with Methadone" differs from that in the International Classification of Diseases and Health Problems (ICD-10). In particular, the national guidelines requires that patients eligible for participation in the substitution therapy programs be diagnosed with "active dependence". There is no definition of "active dependence" and practicing doctor-narcologists perceive this as a reuirment to identify track of opioids in person's urine. This discrepancy between the national guidelines and the ISD-10 sometimes makes it difficult to diagnose and enroll patients in the OST, which in turn may lead to relapses.

Need for effective data exchange protocols between the criminal justice system and the civilian sector

The availability of a mechanism for timely and continuous exchange, coordination, and referral of data between public and private agencies is one of the prerequisites of effective and continuous treatment. Therefore, all health records containing information on in-prison methadone-assisted detoxification or other medical services (Form #100) should be issued directly to the inmates upon release to spare them the need for obtaining the records from an intermediate agency, as this could prevent them from timely enrolling on the OST (Suboxone®) program.

Introducing a multidisciplinary approach for managing OST patients

The described of the TB patient undergoing OST-treatment in prison proves the need to use a multidisciplinary approach for making decisions meeting the needs and best interests of the patient. The need to discontinue one treatment (in this case OST) in order to receive another (in this case treatment for TB) is against the principle of equivalence of care. Besides, abrupt termination of methadone-assisted detoxification could seriously deteriorate the patient's condition. There are no provisions in the existing legislation regarding in-prison OST treatment of individuals who need treatment for other chronic or concurrent diseases. It is recommended that such cases be taken into account and the management of concurrent diseases associated with opioid dependence would be prescribed in the existing laws or regulations to ensure compliance with the principle of continuity and equivalence of care.

Promotion of pre-release and post-release harm reduction and care programs

Preparation for release begins while still in prison and continues after release. There are no pre-release programs available in Georgia, although international experience shows that the lack of such programs increases the risk of post-release relapses and overdosing. It is crucial that the National Probation Agency, the Crime Prevention Center and other governmental or non-governmental organizations with a mandate to provide support to former prisoners would interact to achieve shared goals.

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