Chapter

Illegal Addictive Substances among Prison Inmates in the Czech Republic

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Abstract

The paper describes illegal substance abuse by inmates in prisons in the Czech Republic and gives the readers information about the results of initial research on this hardly avoidable issue. The paper brings interesting findings in this field and describes new ways of prevention and treatment, which is dealt with by prison directorates not only in the Czech Republic.

Keywords: prisons, detoxification units, illegal substance, drug policy, therapeutic communities

1. Introduction

Initial research work focusing on the issue of illegal addictive substance abuse in Czech prisons started to emerge in the first half of 1990s. Interesting were the results of one of the first researches done in 1992 where the authors found out that the age structure of addicted prison inmates and the other inmates did not differ. The authors estimate that the total number of illegal drug users is around 4% but some internal sources say 6% because only the users who met the addiction criteria based on international classification were included in the basic file, i.e. those who showed the signs of addiction only in terms of medicine, which is only one of many possible aspects of illegal drug use [1]. As far as the spectrum of substances used is concerned, stimulants, benzodiazepines, cannabinoids and opioids dominate distinctly. Then barbiturates, amphetamines, cocaine and THC. If we tried to divide a group of prison inmates into groups based on drugs used, the order would be as follows:

a. Juveniles – marihuana, methamphetamine, hashish, Rohypnol, inhalants, psilocybin mushrooms, LSD, heroin.

b. Women - methamphetamine, marihuana, Rohypnol.

c. Men - marihuana, methamphetamine, heroin, MDMA (ecstasy).

d. Recidivists - marihuana, methamphetamine, heroin, hashish, MDMA, LSD, cocaine, ephedrine, psilocybin mushrooms, Rohypnol.

Drug use in prison takes all forms including smoking, snuffing, swallowing, sniffing or intravenous application. There is a lower probability of intravenous

application among juvenile criminals than among adults, and in prison population there is a higher probability of intravenous application among women than among men [2]. Several studies in prisons revealed that about one third of imprisoned adult men applied drugs intravenously. A question arises in this respect about the access to sterile kits for intravenous application of drugs, hygienic standards and possibility of spreading infectious diseases. Pharmaceutical drug addiction represents a specific category of addiction. These include pharmaceuticals with analgesic, hypnotic and anxiolytic effects typical of the population of addicts who are dependent on these medications in the long term. Long-term use may result in psychological or somatic dependence. Medications used most frequently include analgesics, nonsteroidal anti-inflammatory drugs and hypnotics (e.g. Rohypnol) [3].

2. Users of illegal substances in prisons

There are many individuals in prisons who used illegal addictive substances – drugs – before they were imprisoned [4]. Up to 75% of them admitted to committing crime in order to get drugs or money to buy them. Statistical Yearbook 2010 of the Czech Republic Prison Service states that the total number of drug addicts registered by the medical service was 10,763. If this number means the lifelong prevalence of drug use, we could say that it is almost 50% in prison population. However, we cannot say that almost every other prison inmate is a drug addict. In 2010, there was a representative study conducted in prison population with the involvement of the Prison Service of the Czech Republic and National Monitoring Center for Drugs and Drug Addiction. Data was collected in all prisons from a sample of inmates, which amounted to 2,000 people. Based on the results of existing studies, experience from abroad and qualified estimates, we can suppose that the drug use in prison population is significantly higher than in general population. Many times the prison inmates learn to use drugs when they are imprisoned. Prison staff tries to prevent the inmates from using drugs, but despite that the drug abuse in prison is still increasing. Before 1989, various pharmaceutical drugs were also abused in Czech prisons. Some penologists, doctors, psychologists but also prison psychiatrists use the term pharmacophobia, which means literally "using and fighting against" pharmaceutical drugs. For example, medications like Dinyl, Algena, Solutan, Spasmoveralgin or Sedolor or Phenobarbital were popular in prison history especially in 1970s. Then in 1990s, so-called benzodiazepines got ahead; namely Rohypnol, Diazepam, Alnagon, Nitrazepam or Oxazepam and many other medications were popular. If a prison doctor gives the prison inmates too many medications simultaneously - this phenomenon is called polypharmacy – it can easily lead to pharmaceutical drug abuse. However, drug addicts in prison currently try to get hard drugs into prison or possibly even make them there. Less appropriate terms are sometimes used for drug addiction like narcomania or toxicomania; a more modern term is use, which means drug use in acceptable quantity, and abuse or misuse or overuse of drugs associated with addiction. Drug addicts in prison are medically registered and the prison staff should safeguard their abstinence regimen. Medications that are given to prison inmates must be prescribed only by doctors, and only supervising officers or healthcare staff may dispense them. The basic condition for effective treatment of prison inmates is a quality preparation of this activity. First, it is necessary to map the inmate's initial condition at the beginning of imprisonment. This is done with the team cooperation of a doctor or other specialists, a psychologist, special education teacher, social worker or a priest [5].

3. Drug policy of the Czech Republic prison service

Drug policy of CR PS is governed by a regulation. This regulation stipulates the application of drug policy of CR PS, sets rules, organization, record-keeping, methods and forms of treatment of inmates who have a history of substance abuse, including narcotics and psychotropic substances or their precursors, and people who have no drug history but they can be considered endangered by them [6].

The PS drug policy is implemented by the following specialized wards established in detention facilities and prisons:

a. Drug prevention center,

b. Drug-free zone with standard regimen,

c. Drug-free zone with therapeutic regimen,

d. Specialized ward for compulsory treatment whose function is governed by the internal regulation.

e. Specialized ward for care of inmates with personality disorders or behavioral disorders caused by substance abuse, whose function is governed by the internal regulation [7].

4. Care for drug Addicts in prisons

There are drug-prevention centers in prisons, standard and therapeutic drug-free zones are available, and drug users get treatment including detox and substitution therapy. This function is provided by the CR Prison Service.

5. Drug services in prisons

Services of prevention, therapy and aftercare for drug users started to develop in the Czech Republic in 1990. At the end of 1990s, there was a relatively comprehensive system of preventive programs. Communication with prison managements started to develop and first projects started to emerge, focusing exclusively on working with clients in prisons. There are 36 prisons in the Czech Republic, including detention facilities. Nine of these places offer methadone therapy to prison inmates. A few years ago, 15 non-profit organizations provided their services in 30 prisons and detention facilities. Their work consisted in health-oriented interventions, including addiction counseling and drug addiction therapy, and also in the preparation of prison inmates for their release, and in arranging for aftercare upon release. General Directorate of the CR Prison Service has an "action plan in drug policy" in place, which in one of its parts focuses particularly also on the area of harm reduction. There are drug-prevention centers in prisons, drug-free zones are available and drug users get therapy including detox and substitution therapy. They are provided by the Prison Service (hereinafter PS) and many of the services are also provided by non-profit organizations. Measures taken by PS are divided into 3 areas. In the area of drug supply reduction, beside drug addiction monitoring, creation of drug-free zones and preventive medical examinations, stress is put mainly on the analysis of medical records, performance of initial medical examinations in order to find clues of drug application and on making the indication and

administration of addictive medications more restrictive. As far as primary prevention is concerned, there are antidrug programs, initial training courses for new prison staff and regular in-service training for healthcare staff. As far as secondary and tertiary prevention is concerned, the prison service staff takes upgrade training courses and drug prevention centers are established. The important fact is that prison inmates have the same right to healthcare access as the rest of the population, including assistance and therapy provided to drug users. From the medical, therapeutic and educational point of view, there are 4 groups of prison inmates based on treatment in prisons:

a. Inmates with no prior drug experience who do not want to get the experience even in prison. Within the treatment and harm reduction program, these inmates should be strictly placed in drug-free zones with a zone model designed to protect the group of inmates not using drugs from the drug users.

b. Inmates with no prior drug experience but who are likely to resort to drug as one of the possible consequences of imprisonment. For them the drug is a means of stress release and dealing with life in a crowded and often violent environment. This group, within the treatment and harm reduction program, is treated in the same way as the first group but the drug prevention education is more intensive.

c. Inmates who used drugs before imprisonment but who are trying to quit. Medical and therapeutic system of treatment is applied to these inmates.

d. Inmates who used drugs before imprisonment and who do not want to quit even in prison. This could be resolved by separating these inmates from the others and try to prevent their smuggling and corruption attempts by all available legal means.

Other groups may include drug dealers, who do not use drugs, and people who were ordered compulsory treatment. Of course the drug availability in prisons is not comparable with the availability out of prisons. Different types of treatment do not exclude each other but can complement each other and meet different needs of clients. In order to provide differentiated approach to serving a sentence, the prison team implements several types of antidrug measures and programs. These include the following:

- Detoxification performed in prison hospitals;
- Establishment of so-called drug-free zones and specialized wards where tutors, a special education teacher, psychologist, social worker, therapist and a doctor work;
- Programs for the implementation of compulsory drug addiction and alcoholism treatment;
- Drug prevention centers;
- Substitution therapy;
- Harm reduction programs;
- Participation of therapists from the staff of non-profit organizations.

Upon request of the prison service, the services in prison are currently focused on abstinence. For the time being, the harm reduction approach is applied mainly in the form of information. Drug services in prisons are provided by non-profit organizations. This practice is based on legislative capabilities of interest groups to operate in prison [8].

6. Screening

The accused and the convicted are tested for the presence of addictive substances in the body. One of the reasons is to check compliance with the drug prohibition. This information may indicate therapy or other antidrug intervention and last but not least it indicates whether the rules of therapy are followed. Two basic types of tests are performed, one for reference using a set to detect addictive substances or their metabolites in urine, and a confirmation analysis performed by an accredited toxicology laboratory mostly using a chromatographic method. Possibility of detecting some of the addictive substances in urine:

- Amphetamines: 2–5 days (depending on urine pH)
- Heroine, morphine: 2–5 days
- Cannabis: 2–5 days (occasional user), 10–30 days (chronic user)
- Cocaine: 2–3 days
- LSD: up to 5 days
- Methadone: 14 days

Initial medical examinations of inmates at the start of detention and inmates at the start of imprisonment that exceeds 4 months include the test. This is used to monitor a probable proportion of drug users in prison population. This testing is also used to verify the anamnestic information given by the inmates at the initial medical examination and becomes part of the person's medical records. Another category of testing includes randomly systematic testing and so-called targeted testing [9].

7. Detoxification units

Detoxification units are designated for handling withdrawal symptoms and intoxication with addictive substances that do not require intensive care in another facility, e.g. in an intensive care unit. Detoxification units are most often separate units within hospitals or parts of facilities for medium-term or long-term treatment. Clients in substitution programs are detoxified most often as outpatients. The target group includes namely clients who need to reduce their drug tolerance because of their health or social situation but they are not motivated to abstain or to start other therapy, then clients who are dangerous to themselves or to their surroundings because of intoxication or withdrawal symptoms, or possibly clients for whom it is necessary to distinguish between intoxication and mental illness. The detoxification units should provide pharmacologic treatment of states of acute intoxication, withdrawal syndrome and somatic complications. Detoxification includes overall assessment of client's condition, and laboratory testing, pharmacotherapy,

psychotherapy, social work and structured program are used. Withdrawal symptoms when opiates and opioids are withdrawn often look dramatic. As the opioid withdrawal symptoms make the patient crave the drug, the patient often overacts the signs and symptoms in order to get higher doses of medications. Clinical symptoms are often compared to those of flu as far as appearance and severity are concerned. Opiates and opioids with longer biological half-life cause longer and milder withdrawal state, while opioids with shorter half-life cause short withdrawal state but with more severe symptoms. The withdrawal state upon withdrawal of heroin and morphine usually starts 6–8 hours after the last dose, it peaks on the second and third day and lasts approximately 7–10 days. The withdrawal state upon methadone withdrawal starts 1–3 days after the last dose and lasts one to three weeks. The most standard detoxification methods:

1. Detoxification by methadone;

2. Detoxification by clonidine;

3. Detoxification by buprenorphine; Symptomatic detoxification - combination of Diazepam, beta blocker, spasmolytic (e.g. Algifen);

4. Detoxification without medication, a so-called "dry method" - based on an assumption that the memory of unpleasant withdrawal without medication will prevent relapse [10].

8. Drug counseling center of the Czech Republic prison service

A drug counseling center, which is established in all prisons, is an advisory body of the prison director. The counseling center collects statistical data from the antidrug area, deals with the issues in the area of drug abuse prevention, including treatment of users and non-users in terms of general principles of safety and treatment of people placed in detention facilities and prisons. The drug counseling center is established by a respective prison director.

The staff of the drug counseling center usually consists of specialized prison employees such as:

a. Psychologist,

b. Special education teacher,

c. Social worker,

d. Tutor - therapist,

e. Head physician of the healthcare center or other healthcare worker delegated by the head physician [11].

9. Drug-free zones

Drug-free zones are established based on Act. No. 169/1999 Sb., Prison Act, and based on the internal regulation that stipulates the rules for the establishment and functioning of drug-free zones. The goal is to prevent the contact of prison inmates

with addictive substances and their users. These zones are separated from the other accommodation areas and the above-standard amenities make it possible to apply a drug-free regimen and serve differentiated sentences. Only the inmates with no drug history who do not want to be exposed to the other users' pressure are placed there. They voluntarily undergo reference testing, which detects the drug presence. The drug-free zone is established in order to minimize possible contacts of inmates with drugs, to apply drug-free regimen and to enable serving differentiated sentences for imprisoned drug users for the sake of reducing health and social risks of their addiction. The drug-free zone in prison is established and disestablished by the managing director of penology. The drug-free zone is a separated complex, which includes accommodation facilities, culture room, room for self-service activities and possibly other facilities such as work rooms, multi-purpose rooms, workstations, dining room, walking premises. The inmate is placed in a drug-free zone upon inmate's written request if the established criteria are met and if there is vacancy in the drug-free zone. The request includes inmate's statement in which the inmate undertakes to voluntarily follow the rules and principles of behavior stipulated in the drug-free zone regulations. The inmate is removed from the drug-free zone if he/she provably abused a drug or refused to have his/her abstinence checked or refused to have a body fluid sample taken. The inmate is usually removed also for the following reasons:

a. Got a disciplinary punishment,

b. Refused to participate in compulsory activities or repeatedly failed to perform under the treatment program,

c. Other serious reasons are found,

d. Asked for removal from the drug-free zone.

In the drug-free zone project, in the individual training plan and in the employment contract the prison director, upon motion of the detention and imprisonment department manager, sets the competence and scope of obligations for each specialized employee who treats inmates in the drug-free zone. The goal of placing inmates in the drug-free zone is to create conditions for them to abstain in prison. A standard drug-free zone is usually established in the accommodation area separated from the other inmates. The methods and forms of treatment consist in taking standard approach in safety, psychology and pedagogy, which affects the inmate's view of the drug, motivates him/her to abstain, and to have a healthy lifestyle while being in prison as well as afterward. The following inmates are placed in a standard drug-free zone:

a. Those who did not use drugs but can be considered endangered by them,

b. Those who used drugs and now are motivated to voluntarily abstain,

c. Those who used drugs prior to going to detention facility or prison and who successfully completed a therapeutic and educational program in a specialized prison ward for inmates with personality disorders or behavioral disorders caused by addictive substance abuse and who currently abstain [12].

10. Therapeutic drug-free zone

A therapeutic drug-free zone is established for the purpose of targeted therapeutic and other specialized influence on inmates to achieve abstinence or

possibly motivate them to undergo treatment or at least to reduce the harm arising from drug use [13]. The therapeutic drug-free zone is established in the accommodation area separated from the other inmates. The following inmates are placed in the therapeutic drug-free zone:

a. Those who used drugs in the past and are motivated to cooperate in a therapeutic program with the goal to minimize relapse and harm arising from drug use,

b. Those who used drugs prior to going to detention facility or prison, who completed treatment or therapeutic and educational program in a specialized prison ward for inmates with personality disorders or behavioral disorders caused by psychotropic substance abuse and who are interested in additional specialized treatment.

11. Treatment of drug addicts in prison

A specialized ward for compulsory drug addiction treatment, alcoholism treatment and gambling treatment in a prison for women in Opava was established in 1999 and was designated for women with minimum security, medium security and high security, while a specialized department for men was established later, in 2004, and only for sentenced men with medium security. Placement in this department is voluntary or treatment is ordered by court pursuant to Section 351 of the Criminal Procedure Act with the cooperation of the Directorate-General of the Czech Republic Prison Service. An inmate who was placed in the specialized department and to whom the court ordered a compulsory treatment, is obligated to undergo this compulsory treatment. The length of stay in the specialized department for compulsory treatment is based on the therapeutic program; it depends on inmate's personality and performance in the individual treatment program. The program is usually planned for a minimum of seven months but the stabilization stage may be extended as needed, depending on capacity, to last up to one year. One-year stay is usually recommended on average, which means placement of an inmate in the specialized department for drug addicts a year before parole or a year before the release from prison. The inmate may be placed in the specialized department no sooner than one month upon completion of methadone substitution therapy, which also takes place in Opava prison [14]. So the inmate's ongoing methadone substitution therapy is one contraindication for placement in this department and the other contraindication is epilepsy. An inmate who was ordered a compulsory treatment by court may be placed in the specialized department for compulsory treatment while serving a sentence, but also an inmate who was not ordered a compulsory treatment by court but the inmate has a provable history of addictive substance abuse, including alcohol and gambling and wants to undergo this therapeutic program in the specialized department upon request. A large number of special therapeutic practices are used. Psychotherapy, practicing, training and education with the use of a regimen component are applied when working with inmates. All of these methods are based namely on a positive expectation on client's part, health and illness interpretation, realizing the negative impact arising from patterns of pathological behavior [15]. Also, the methods are based on a therapeutic relationship that includes interest, trust and acceptance, but it also strives for support in finding motivation to abstain and creating inmates' own views of the drug addiction harmfulness. Inmates interested in longer therapy get it in individual form because the number of such inmates is not high enough to always run the therapeutic groups [16].

12. Therapeutic communities in prisons

Different authors agree that the environment and culture in prison are favorable for TC to be used because they bring to the prison environment a completely different paradigm than the host institution has. The fact is that the imprisonment itself is contrary to the basic principles of TC, mainly the principle of voluntariness and responsibility. The TC model, in contrast with the imprisonment, provides a complex of behavioral, cognitive, emotional and relational stimuli that lead to a change of self-concept and support maturation and socialization. Thus the initial conditions for TC are worse in prisons than anywhere else. In spite of these problems, it is possible to establish a community in prison with a high degree of joint control and ongoing process of social learning. In the last years, 10 treatment centers were established in Czech prisons for the treatment of inmates' drug addiction by abstinence. It is based on the standards for residential treatment in TC, including the phase format and therapeutic, educational, working and leisure-time components of a daily regimen. Efficient TC factors should be used in treatment programs as much as possible. Principles of this concept are currently applied in at least 4 out of 10 existing treatment centers, which, however cannot be confirmed from direct sources of the Czech Republic Prison Service because the term "therapeutic community" is not used there [17].

13. Substitution therapy

The principle of the substitution (replacement) therapy is to replace illegally gained addictive substances with a substance (medication) that has a longer effect, similar properties and effects, with known concentration like the drug used, without toxic ingredients and it is applied orally. This type of substance is called agonist. This treatment was originally about administering the substance that was used, e.g. heroin. The preparations are currently prescribed by a doctor; methadone – a synthetic opiate in the form of tincture, and buprenorphine in the form of tablets are used most frequently as opiate agonists [18]. Substitution therapy of opioid addiction was introduced in the Czech Republic Prison Service in 2006 when a pilot project in two prisons started, one in the Detention Facility Prague Pankrác and the other in Příbram Prison. After successful completion of this pilot project, the substitution therapy was gradually extended to eight other prisons where substitution therapy centers were established. The whole project of substitution therapy introduction was designed from the very beginning to enable implementation under common conditions of our prisons, i.e. under the conditions of standard sentence or detention. So no special wards were established where all patients undergoing substitution therapy would be jointly placed. Substitution therapy in the Czech Republic Prison Service is usually implemented in the form of outpatient treatment. The criterion for including an inmate in substitution therapy is addiction to substances from the opioid group where the therapy by abstinence is impossible or where it was repeatedly unsuccessful. Another criterion is that only a prison inmate who is or was undergoing substitution therapy in a healthcare facility out of prison may be included in the substitution therapy. So the substitution therapy is not initiated in prison. Methadone is usually the medication used for substitution therapy. Substitution therapy is provided in a total of ten prisons where substitution therapy centers are established. The prevalence of infectious diseases and namely viral hepatitis B and C is higher in prison population than in normal population. Injection drug users are certainly a high-risk group as far as spreading of infectious diseases is concerned. The biggest non-governmental service provider

for problematic drug users and drug addicts in the Czech Republic is SANANIM, which runs not only CADAS but also for example two therapeutic communities, a low-threshold center, daycare center, aftercare center or a program of prison services and others. The effectiveness or success of therapy does not depend only on a given substitution substance but also on the related context and accompanying components of the therapy. Psychosocial interventions can contribute significantly to the success of the substitution therapy [19].

14. Harm reduction (risk minimization)

The term harm reduction was originally used only in connection with measures and programs focused on mitigating the adverse health effects of narcotics and psychotropic substances. However, this term is currently used in connection with the strategies that contribute to the mitigation of potential health and social risks and harm caused by using all types of drugs, including interventions in drug supply and demand. The target group is represented by problem or injection drug users who are the biggest threat to public health. The basic characteristic of the harm reduction model is pragmatism. Instead of trying for absolute elimination of drugs and their use, it tries to work with them in a way to minimize the negative consequences of such behavior. This approach originated as a response to emerging HIV/AIDS, which started to spread among injection drug users. That is why under these programs the drug users get the used needles and syringes changed for clean ones, they are informed about the principles of less risky drug use, safe sex, etc. Introduction of harm reduction into the prison environment is a controversial topic. Nevertheless, as proven by the foreign research results, harm reduction in the prison environment may significantly contribute to limiting the spread of contagious diseases like HIV/AIDS or hepatitis C (hereinafter VHC). Viral hepatitis C infection is widespread among injection drug users. One of the main effects of the "war against drugs" is a high number of imprisoned drug users. At the same time, injecting drugs remains a widespread phenomenon in prisons. Introduction of the needle change program turned out to be an effective measure for harm reduction - minimized needle sharing and subsequently the transmission of HIV and VHC among the injection users and their sexual partners. A number of countries introduced these programs into selected prisons [20].

15. Release from prison and conclusion

The client usually encounters increased stress and challenging period on 2nd or 3rd day upon release from prison. The foreign experience and also the Czech experience show that the highest-risk period for criminal recidivism and drug relapse is the first 48 hours. These people were used to dealing with all the euphoria, stress and problems by taking drugs and it is therefore necessary to help them stabilize. It turns out that the plans created in the prison environment have to be adjusted most of the time depending on specific conditions of the client upon release from prison that were not known at the planning stage. Also, clients' resolutions, motivation and ideas often change and it is necessary to work with it flexibly. It is therefore important to take advantage of the trust that formed between the clients and the project staff and help the clients manage the highest-risk period of 48 hours after the release mentioned above and then at least another 1–2 months with the goal of providing effective direct medical and post-penal care. Moreover, these clients are double stigmatized. Both by their drug history and by their criminal past, which

makes their social inclusion upon release from prison more difficult and deepens their social exclusion. It is necessary to realize that hardly any group of people is forced to communicate with so many institutions like drug users in conflict with the law – police, courts, prison service, medical and contact facilities, probation officers, etc., whereas each of the institutions has different demands and view of the particular person. Antidrug policy of the Prison Service and overall practice of the antidrug services for imprisoned drug users have to be perceived as part of a wider framework of professional treatment of prison inmates. The fact that a sentenced person is addicted to substances or is a drug user may be perceived in penal practice from a few aspects. Drug use and related behavior is a serious health risk, i.e. it is a behavior that potentially compromises the health of the person but also the person's surroundings. Drug use also represents a serious safety risk as it can be expected that the person addicted to substances out of prison will try to get the drug also in prison and use it there. One of the main goals of prison systems in developed countries is to reduce the criminogenic risk of imprisoned people, specifically to reduce the probability that the particular individual, when released from prison, will commit the same or even more serious crimes than before the imprisonment. The Czech Republic Prison Service thus contributes significantly to the society protection by monitoring the situation with imprisoned drug users and mainly by offering professional intervention in the area of drug prevention to people at risk, i.e. it provides so-called antidrug services to them [21].

16. Results of studies in the Czech republic

According to the research, it was found that addictive substances were used by more than half of the respondents during VTOS. These were mostly meth, THC, alcohol and benzodiazepines. 18% of respondents mentioned the method of injecting addictive substances in prison and 9% of respondents stated the sharing of application aids. According to the majority of respondents, sexual intercourse takes place in prison and the possibility of protection against sexually transmitted diseases is low. Of the 81% of respondents who were tested for infectious diseases during VTOS, 48% of respondents suffered from an infectious disease, most often hepatitis C. The possibilities of preventing infectious diseases in the prison environment appear to be insufficient. There is interest in substitution treatment, but it is little offered [22].

17. Conceptual and strategic basis of access to imprisoned drug users in the world and in the Czech Republic

During the Special Session of the UN General Assembly (UNGASS) in 2016 was approved the document "Our common commitment to tackling and tackling the world drug problem effectively mu "(Our joint commitment to effectively addressing and countering the world drug problem). United Nations Standard Minimum Rules for the Treatment of Prisoners Minimum Rules for the Treatment of Prisoners), the so-called Mandel Rules13, that health care services should be organized in close relation to public health care and in a way that ensures the continuity of treatment and care, including drug treatment The World Health Organization (WHO) adopted a Position Paper on Prisons in 2004, drugs and harm reduction (Status Paper on Prisons, Drugs and Harm Reduction). This document follows on from the Joint Statement of the WHO and the Pompidou Group of the Council Prisons, Drugs and Society of 2001. Document identified as one of the main principles of providing services to imprisoned users drug comparability of health services

in prison and at large - the so-called principle of equivalence. A separate section of the WHO Prisons and Health document is devoted to drug use and treatment of prison addiction. The basic rule in this area is to respect the goal of drug services in prisons, which is a precondition for prisoners to leave prison healthier than they were when they started serving their sentences [23]. Prisoners should be psychosocially stabilized at the end of their sentences and their treatment should continue after release. The issue of the treatment of drug users in prison is also addressed in its documents by the United Nations Office on Drugs and Crime (UNODC). In his publication Drug Dependence Treatment: Interventions for Drug Users in Prison summarizes the findings and examples of good practice in this area [24].

18. New development of the National Drug Strategy in Europe

4 EU Member States (Czech Republic, Estonia, Hungary, Finland), Turkey and Norway adopted new drug action plans in the second half of 2007. The documents cover a period of 3–4 years and, with the exception of the Turkish action plan, were preceded by other plans or programs. In 2007, Spain adopted a complementary national action program against cocaine (2007–2010). In 2008, 3 more Member States adopted new policy documents. The first Italian Drugs Action Plan has a time frame of one year, followed by a four-year Action Plan (2009–2012), which will be synchronized with the new EU Drugs Action Plan. Malta's first national drug document does not set a timeframe of almost 50 measures. The new 10-year UK drugs strategy (2008–2011) is complemented by a three-year action plan (2008–2011) setting out key actions [25].

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