Drogenkonsum in Geschichte und Gesellschaft
Drug Use in History and Society

| 7

Ulla Pape | Heino Stöver | Ingo Ilja Michels [Eds.]

Social Work and Health in Prisons

Studies from Central Asia and China

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Prof. Dr. Heino Stöver
Dr. Ingo Ilja Michels

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Foreword

Worldwide, over 11 million people are held in prisons and other closed settings on any given day. Due to substandard prison conditions and healthcare in many parts of the world, the health of incarcerated people is often worse upon release than upon entry.

Being deprived of liberty does not mean being deprived of fundamental human rights including freedom from torture and other cruel, inhumane or degrading treatment, and the right to health and healthcare of the same standard as available in the community.

An ongoing challenge in treating all people in prison with respect for their inherent dignity and value as human beings, as enshrined in the United Nations' Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), is prison overcrowding.

High occupancy levels within prison facilities are conducive to misconduct, infractions and violence, and contribute to higher transmission rates of infection including HIV, tuberculosis and viral hepatitis – and recently, COVID-19 – than in the community. Overcrowding also means that the often already limited human, financial and medical resources are too thinly spread to be able to ensure prisoners' physical and mental health and integrity, let alone support rehabilitation and social reintegration.

Establishing a sustainable health strategy in prison starts with political commitment to implement criminal justice and penal reform such as non-custodial measures and reducing prison overcrowding. It includes integrating prison health into public health to expand the pool of healthcare resources and expertise and improve prison health standards.

Such a strategy also involves upscaling data collection and analysis of infection rates, gender-specific needs, mental health and drug use disorders, education levels, vocational skills, and the availability and accessibility of responsive services. And last but not least, it requires the meaningful engagement of civil society organizations as essential partners in addressing the health and rehabilitation prospects of people in prison.

This work details how regions in Central Asia have been addressing challenges and making progress in implementing global prison standards, with instructive country examples.

We hope that this publication will help relevant authorities to improve living conditions and access to treatment and care for people in prison, in line with international standards to promote and protect the health and rights of this vulnerable population.

Ehab Salah, MD

Advisor for Prisons and HIV

United Nations Office on Drugs and Crime

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1 Introduction: Social Work and Health in Prisons – Key Challenges and Developments

Ulla Pape, Heino Stöver, Ingo Ilja Michels

> *'The degree of civilization in a society can be judged by entering its prisons.'*
> Fyodor Dostoevsky, *The House of the Dead* (1862)

This publication deals with the development of social work and health in prisons in Central Asia and China. The focus on social work in prison might seem odd at first sight. The topic is difficult, as the relations between social work services for people in prison and the management of penal institutions are fraught with tension and conflict. Whereas prison institutions operate on the logic of correction and control, social work and health services in these institutions are geared (or should be geared) towards providing assistance and acceptable minimum standards of health to the prison population (Matejkowski et al., 2014).

In Central Asia and China, these inherent tensions regarding social work and health in prisons are especially pronounced. The countries of Central Asia inherited a large prison system from the Soviet era, when this region had been one of the preferred locations for Gulag camps and forced displacement (Applebaum, 2003; Khlevniuk, 2004). After the end of the Soviet Union, prison reform in the newly independent countries of Central Asia has not been an easy endeavour. On the contrary, in the context of political and economic crisis, prison reform has not been prioritised by the governments in this region. Due to authoritarian trends in the region, with many prisoners incarcerated for political reasons, the Central Asian prisons became overcrowded hotspots of growing drug use and HIV epidemics (Walcher, 2005; Thorne et al., 2010; Vagenas et al., 2013). Since the 1990s, international human rights organisations have been reporting about widespread violations and even torture in the penitentiary systems of Central Asian countries (IWPR, 2011; HRW, 2012). The development of China's penal system has not been easier, as frequent reports about forced labour and compulsory treatment centres show (Khalid, 2021; OHCHR, 2022).

Despite these difficult circumstances, however, there are also signs of cautious progress. Some Central Asian countries have taken first steps towards prison reform and engaged in a dialogue with international orga-

nisations (UNODC, 2019). Most notably, Kyrgyzstan and Tajikistan have introduced medication-assisted treatment (MAT) and needle and syringe programmes (NSPs) in their penitentiary systems to conquer the spread of infectious diseases (Moller et al., 2009; Azbel et al., 2018). Kazakhstan has reduced its prison population from 78,029 in 2000 to 29,403 in 2020, a decrease of 62% in two decades (WPB, n.d.). Similarly, Kyrgyzstan and Tajikistan have managed to lower their incarceration rates and improve prison conditions. Kyrgyzstan and Kazakhstan have also been successful in setting up rehabilitation services. In Uzbekistan, too, there have been first signs of improvement with regard to the conditions in the penitentiary system: since 2016, the new president has released a number of political prisoners, and in 2019, the notorious Jaslyk prison was closed (HRW, 2019). Observers, however, criticise the process of prison reform in Central Asia for being slow and superficial. Some of the intended institutional changes appear to have stalled (HRW, 2018).

An important proponent of prison reform in the region of Central Asia and China is the United Nations Office on Drugs and Crime (UNODC), which is the global custodian of the UN Standard Minimum Rules for the Treatment of Prisoners ('the Mandela Rules'), the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders ('the Bangkok Rules'), and the United Nations Standard Minimum Rules for Non-custodial Measures ('the Tokyo Rules') (UNODC, 2019). The agency promotes the implementation of these global prison standards and encourages prison reform programmes that are guided by international human rights considerations (UNODC, n.d.). In the region of Central Asia, UNODC advises government authorities on new probation services, prison staff training curricula, and the implementation of prison-based rehabilitation programmes with UNODC support (UNODC, 2019). In China, collaboration focuses on HIV/AIDS prevention and care initiatives among drug users in prison settings (UNODC, n.d.). Overall, key concerns with regard to prisons include the overcrowding of correctional facilities, general violence and human rights violations against prisoners, prison health issues such as drug use and the spread of infectious diseases, and the prevention of religious extremism among detainees (UNODC, 2019).

This volume discusses the prospects of humanising the prison system in Central Asia and China, with all its existing limitations and contradictions. A key focal point is social work and health services in prison settings, including drug rehabilitation, medication-assisted treatment, needle and syringe exchange programmes, and other health interventions. The volume follows a broad approach to the topic, covering all types of correctional institutions and services, including probation and prison rehabilitation

programmes (UNODC, 2019). We aim to provide an overview of the development of social work and health in the prisons for the entire region, even if there are significant differences in data availability across the countries. The contributions of the volume focus on a number of key research questions:

1) What kind of social work and health services are provided in the penitentiary system of the countries of Central Asia and China?
2) What barriers and challenges for social work and health are there in the penitentiary system?
3) How can these challenges be addressed to ensure basic human rights and health standards in the penitentiary system?

The publication is divided into three parts. The first part presents the global framework of prison standards and its application in different country settings.

Chapter 2, 'The Global Framework for Social Work and Health in Prisons' by Ulla Pape and Heino Stöver, presents the most important international standards and discusses the global framework for the promotion of prisoners' rights and humane prison conditions. Special attention is paid to the question of how international standards are applied to advocate for the adoption of acceptable minimum standards in closed institutions. In addition to studying the role of international organisations and non-governmental organisations (NGOs), the chapter looks into the main areas for international action on improving prison conditions, including the prohibition of torture, the restriction of solitary confinement, and the promotion of prison health.

Chapter 3, 'Women in Prisons and the Bangkok Rules – A Practical Guide for Social Workers' by Ulla-Britt Klankwarth and Simon Fleißner, draws attention to social work practice and demonstrates how human rights agreements can be made useful for the social workers in closed institutions. The authors show how the Bangkok Rules can be applied to improve the conditions for women in prisons.

The second part of this publication includes four country studies that delve deeper into the development of prison reform in the region of Central Asia and China. Each country case study comprises information about the prison system, the prison population, and the development of social work and medical programmes in the penitentiary system.

The first case study is Chapter 4, 'China: Social Work and Health in the Penitentiary System' by Hang Su, which analyses the development of social work and health in in the penitentiary system in China. The author argues that social rehabilitation in China remains insufficient and

incomplete, as community work is not sufficiently coordinated among institutions. As a result, social work in the penitentiary system in China is still at a relatively preliminary stage, and many aspects of social work need to be improved, especially with regard to medical care, education, vocational training, psychological counselling, and social support.

Chapter 5, 'Kazakhstan: Social Work and Health in the Penitentiary System' by Dinara Yessimova, Mariya Prilutskaya, Dalida Mukasheva, Medet Kudabekov, Sandugash Ismagulova, and Zhanar Shaidullina, provides a comprehensive account of the development of social services in the Kazakh prison system. The chapter studies the development of prison reform in Kazakhstan and argues that the introduction of alternatives to imprisonment, for example in the development of probation services, are of key importance in reforming Kazakhstan's prison system.

Chapter 6, 'Kyrgyzstan: Social Work and Health in the Penitentiary System' by Nurgul Musaeva, Jarkyn Shadymanova, Eric Orosaliev, and Cholpon Omurakunova, deals with the development of social work and health in the Kyrgyz penitentiary system. In contrast to other countries of the region, Kyrgyzstan has developed a broad range of harm reduction services in closed institutions. The authors conclude that Kyrgyzstan has made efforts to improve its criminal law mechanisms and its prison system to ensure a better observation of human rights. An important aspect in prison reform is the course towards the development of humanitarian values and the adherence to international standards for the treatment of prisoners. However, there are still major gaps in the implementation of international standards. Most importantly, prisoners are still facing problems regarding access to quality medical care and drug treatment in Kyrgyzstan.

The last country case study is Chapter 7, 'Uzbekistan: Social Work and Health in the Penitentiary System' by Sergey Soshnikov and Heino Stöver, which examines the efforts to reform the prison system in Uzbekistan. The authors argue that many prisons in Uzbekistan do not have the trained social workers or other mental health and social service professionals to provide the level of support that is needed. In addition, many prisons have limited access to programmes and services that can support successful reintegration into society.

The third part contains additional case studies and cross-cutting issues, such as resocialisation services in Kazakhstan and needle and syringe programmes in Kyrgyzstan, which can serve as models for other countries in the region.

Chapter 8, 'Compulsory Drug Treatment in China' by Hang Su, deals with a specific form of closed institution in China: the centres for compulsory drug rehabilitation. These centres provide compulsory treatment to

drug users as a form of mandatory treatment of drug dependency. Hang Su argues that compulsory drug rehabilitation centres suffer from a lack of co-operation between different institutions, of social work interventions, and of qualified social workers as staff members in the centres. According to Hang Su, compulsory drug rehabilitation centres could overcome existing barriers if they strengthen community support in drug recovery and make use of social organisations.

Chapter 9, 'Compulsory Drug Treatment in Kazakhstan' by Mariya Prilutskaya, focuses on the strengths and weaknesses of compulsory drug treatment in Kazakhstan. Similar to China, the country runs centres for mandatory treatment of drug addiction. Kazakhstan's compulsory treatment system was inherited from the Soviet Union and has since been reformed. The author argues that more attention should be paid to the development of evidence-based approaches in drug treatment, with the aim to not only reduce the symptoms of addiction but also to promote the well-being and social adaptation of the patients and their families. It is worth mentioning that medication-assisted treatment (MAT), although available outside the prison system, has been neither implemented nor even discussed within the prison system.

Chapter 10, 'Resocialisation Programmes in Kazakhstan' by Dalida Mukasheva, Medet Kudabekov, Dinara Yessimova, Nurlan Tulkinbayev, and Anna Konvisar, turns to the issue of rehabilitation, which is part of the ongoing prison reforms in Kazakhstan. The authors present the empirical results of a study on rehabilitation and social adaptation services for persons released from prison and compare the implementation of these services to international prison standards. The authors show that Kazakhstan has increased efforts in social rehabilitation to reduce its prison population and facilitate better social adaptation for ex-detainees. The reforms require the state and the administration of penitentiary institutions in Kazakhstan to change their approaches to working with people, as can be seen in the Inside-Out Prison Exchange Program. However, the authors demonstrate that Kazakh state institutions do not sufficiently involve non-profit organisations in the development of social rehabilitation programmes.

Chapter 11, 'Legal and Regulatory Frameworks of Social Work with Drug Users in Kyrgyzstan' by Tynchtyk Estebes uulu, discusses the development of social work services for drug users in the prison system in Kyrgyzstan. The author argues that despite a number of positive changes, Kyrgyz state policy still does not meet the challenges related to drug use within the prison system due to the criminalisation of drug use. State services should therefore invest in a broadening of harm reduction services in the prison system.

Chapter 12, 'Syringe Exchange Points in the Penitentiary System of Kyrgyzstan' by Heino Stöver and Jarkyn Shadymanova, presents another case study from Kyrgyzstan. The authors discuss the history of the implementation of needle exchange programmes as one important form of harm reduction in Kyrgyz prisons and show that the coverage of needle exchange programmes lags far behind the recommendations of international organisations. More efforts are therefore needed to increase the coverage and access to harm reduction services among drug users in the Kyrgyz prison system, which is one of the very few programmes of this kind worldwide.

Chapter 13, 'Naloxone as Overdose Prevention in the Prison Setting and in the Community. A Comparison of the Situation in Germany, Kyrgyzstan, and China' by Zhyldyz Bakirova, Tynchtyk Estebes Uulu, Simon Fleißner, Ulla Pape, Heino Stöver, and Hang Su, deals with the use of naloxone as an emergency medication for drug overdoses in the prison system. Naloxone programmes aim to increase the availability of naloxone in emergency situations by administering the medicine to opioid-using peers as well as their family members and friends. The chapter is a comparative study of the prison systems in different countries. The starting point is the pilot programme 'Take-Home Naloxone', which was introduced in three federal state in Germany in 2021. The comparison shows that Kyrgyzstan also has a naloxone programme to combat overdose mortality, which already started in 2008.

Chapter 14, 'Medication-Assisted Treatment in Prisons' by Heino Stöver and Ingo Ilja Michels, discusses the development of drug-treatment services for drug-using people living in prisons. The authors show that drug use is prevalent throughout prison populations. Despite advances in prison-based drug-treatment programmes, access and quality often remain substantially poorer than in the community. The authors present examples for the effective use of MAT in the prison system and recommend upscaling the implementation of these services in order to respond to the needs of people in prison more fully.

All in all, this book gives – for the first time – a comprehensive overview of the situation of prisoners in closed settings in Central Asia and China, focusing on drug-using prisoners and the specific responses of the prison administrations and NGOs, if they exist in these settings. The contributions show that in the countries discussed, promising steps have been taken towards the introduction of a more human approach to health and social care for prisoners, mostly accompanied by a reduction in the number of prisoners, the introduction of probations services in order to better resocialise people released from prisons, and the introduction of evi-

dence-based interventions – at least in some countries (medication-assisted treatment for opioid dependent prisoners, needle exchange programmes, provision of naloxone, etc.) – that have been suggested by the United Nations (2020). However, a lot of work still needs to be done in order to comply with international standards. The authors of this volume analyse the main obstacles that need to be overcome in order to meet international standards of prison health and social care.

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2 The Global Framework for Social Work and Health in Prisons

Ulla Pape, Heino Stöver

The conditions in prisons and the rights of prisoners have always been an issue of contentious debate. In this debate, the principles of humane treatment and security have often been set against each other. Imprisonment is the greatest restriction of freedom and can only be justified in exceptional cases. According to UNODC, there are five theoretical justifications of criminal punishment: retribution, incapacitation, deterrence, rehabilitation, and reparation (UNODC, 2019). Whereas retribution justifies punishment on the basis that all offenders deserve to be punished, incapacitation assumes that the state has a duty to protect the public from future wrongs or harm. Deterrence, in turn, justifies punishment on the basis of preventing future crimes, while rehabilitation presupposes that punishment can change the offender's behaviour and thereby prevent future crime (UNODC, 2019). Finally, reparation justifies punishment on the premise that crimes should be corrected through a form of replenishment by the offender to the victim (UNODC, 2019). It is important to note that an imprisonment is a restriction of individual freedom but does not entail the restriction of other human rights. Therefore, all efforts to humanise the prison system start with the principle that the human rights of those in prison must be protected.

Guaranteeing prisoners' rights is not an easy task. In fact, people living in prisons are among the most vulnerable and marginalised population groups and face a multitude of social, psychiatric, and general medical challenges (Matejkowski et al., 2014). Worldwide, more than 10.77 million people are held in penal institutions, either as pre-trial detainees or having been convicted and sentenced (Fair & Walmsley, 2021). Key concerns in correctional institutions include poor conditions, lack of care, health issues, overcrowding, and violence (Matejkowski et al., 2014). Compared to the general population, prison inmates have higher rates of poverty, alcohol and drug addiction, and mental health problems (Matejkowski et al., 2014). In his seminal study, Johnson (1987) described the prison as a place of suffering: 'Prisons can be seen for what they are, as settings in which the average inmate does indeed suffer. Rehabilitation can be

defined as equipping offenders to cope with the pains of imprisonment in mature ways, not wasting away but rather growing through the adversity posed by imprisonment' (p. 162). International efforts have been of key importance for improving the conditions in prisons.

This chapter discusses the global framework for the promotion of prisoners' rights and humane prison conditions. It addresses three questions: which regulations were developed to guide prison conditions worldwide, who are the main international actors involved, and what are the key issues in the debate on prison reform? With this analysis, we aim to provide the basis for discussing the prospects of humanising the prison system in Central Asia and China.

The chapter is structured as follows. Firstly, we provide an overview of the relevant international standards and explain how international organisations have been advocating the development of acceptable minimum standards in closed institutions. Secondly, we look into the role of international actors in promoting prison standards, most importantly the United Nations and its various agencies and offices that deal with various aspects of prison conditions. Furthermore, we will discuss the contributions of non-governmental organisations in advocating for prisoners' rights. Thirdly, we present the most important debates focusing on acceptable conditions in the prison system, including the mitigation of its adverse social and health consequences. Finally, in the conclusion, we will discuss the implementation of international prison standards in the region of Central Asia and China and the collaboration between international organisations and the governments of the region.

1. International Prison Standards

This first section provides an overview of the relevant international prison standards. These standards were developed as minimum standards that the prison system should aim to meet. Although states commit to the rules on a voluntary basis and thus the rules do not have any binding legal force, they serve as focal points for international action on improving prison standards around the world. As so-called 'soft law', the rules provide a concise guide to states and their penal agencies (Peirce, 2018). International prison standards can enable states to adjust their prison system to internationally accepted norms.

1.1. Standard Minimum Rules for the Treatment of Prisoners (SMR)

The first international prison guidelines date back to the 1950s, with preparations having already started in the 1920s. In 1955, the Standard Minimum Rules for the Treatment of Prisoners (SMR) were adopted by the First UN Congress on the Prevention of Crime and the Treatment of Offenders and, two years later, in 1957, approved by the United Nations Economic and Social Council. The SMR formed a key international standard governing the treatment of prisoners. They were 'designed to spell out the conditions which are thought to be minimal to preserve human dignity, maintain contact with outside society, and encourage a form of classification that protects prisoners and reduces the risk of contamination for those younger and less addicted to crime' (Clifford, 1972, p. 233).

The original SMR consisted of a set of 94 rules, including minimum standards for accommodation, medical services, complaints, contact with the outside world, quality and training of prison personnel, and prison inspections (reference document). As non-binding rules, the SMR lacked the authority of a convention (Clifford, 1972). Despite this, the SMR were increasingly applied by UN member states. They were also used as a framework for monitoring and inspection bodies engaging in assessment activities. In many countries, the SMR served as a blueprint for developing national prison rules. In other countries, the SMR have remained the only document directly regulating the treatment of prisoners.

1.2. UN Standard Minimum Rules for the Treatment of Prisoners ('Mandela Rules')

In 2010, the United Nations Commission on Crime Prevention and Criminal Justice established an open-ended intergovernmental expert group to exchange information on the revision of the SMR so that they reflected advances in correctional sciences and best practices. Finally, after a five-year negotiation process, the revised UN Standard Minimum Rules for the Treatment of Prisoners were adopted by the United Nations General Assembly, on 17 December 2015 (Peirce, 2018). The rules were named the 'Mandela Rules' to honour the late South African President Nelson Mandela, who was known for his imprisonment and his long-standing struggle for human rights and against apartheid in South Africa (McCall-Smith, 2016).

The negotiation process that preceded the adoption of the Mandela Rules involved four International Expert Group Meetings (IEGMs), organ-

ised by the UNODC from 2012 to 2015, and preparatory meetings organised by NGOs and universities (Peirce, 2018). The Mandela Rules are an example of a new generation of soft law international norms. They are voluntary standards and oversight mechanisms built collaboratively by many countries within the UN structure, with the goal of solving a complex global problem (Peirce, 2018). Juan Mendez, the UN Special Rapporteur against Torture, was crucial for the negotiation process. Furthermore, the negotiation process greatly benefitted from the expert input of NGOs and think tanks, including the so-called 'Essex meetings' (Peirce, 2018). Evidence-based approaches played an important role during the revision process. Whereas the primary rationales were based on international laws and norms, social science evidence appeared in complementary ways, mainly on health and solitary confinement issues (Peirce, 2018).

The Mandela Rules expand the SMR and build upon the international human rights documents that have emerged since the first adoption of the minimum prison standards in 1955. The human rights documents that influenced the revision include the International Covenant on Civil and Political Rights (ICCPR); the Convention on the Elimination of all Forms of Discrimination against Women; the Convention on the Rights of the Child; the Convention against Torture and other Cruel, Inhuman or Degrading Treatment; and the Common Article 3 of the Geneva Conventions (McCall-Smith, 2016). As a result, the Mandela Rules synthesise a range of international laws that are relevant to ensuring the inherent dignity of all imprisoned individuals.

The inviolability of human dignity is a common thread in the Mandela Rules: 'All prisoners shall be treated with the respect due to their inherent dignity and value as human beings' (Rule 1). This is directly linked to the prohibition against torture or other cruel, inhuman, or degrading treatment of prisoners (McCall-Smith, 2016). The reinforcement of human dignity and the prohibition of torture lead to six broad considerations: holistic health and well-being; disciplinary procedures; in-custody complaints and investigations; legal representation; protection of vulnerable prisoners; and appropriate staff selection and training (McCall-Smith, 2016).

Firstly, the Mandela Rules emphasise the right of prisoners to health care, including medical attention regarding both physical and mental health concerns, as well as rehabilitation treatment. In particular, the rules state that 'the provision of health care for prisoners is a State responsibility' (Rule 24) and that 'prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status' (Rule 24). Secondly, the rules ensure that

human dignity is protected in all disciplinary procedures. The rules therefore expressly prohibit the use of restraint instruments, the prohibition of family contact, corporal punishment, food or water manipulation, and prolonged solitary confinement as disciplinary measures (McCall-Smith, 2016). Special attention is paid to the prohibition of indefinite and prolonged (fifteen days or more) solitary confinement, as this can have harmful physical and psychological effects on prisoners (Peirce, 2018).

The third set of considerations concern in-custody complaints and investigations. The Mandela Rules stipulate that prisoners have the right to raise complaints against those who are responsible for their treatment and that these complaints need to be considered promptly (McCall-Smith, 2016). Fourthly, the Mandela Rules emphasise the rights of prisoners to legal representation that does not only encompass formal legal proceedings but also investigation into prisoner or staff misconduct (McCall-Smith, 2016).

A fifth problem area concerns the protection of vulnerable individuals and groups in correctional institutions. The Mandela Rules stipulate that prison standards should follow the principle of non-discrimination, including a positive consideration of self-perceived gender (McCall-Smith, 2016). To protect human rights in the prison system, the Mandela Rules are intended to be read in conjunction with other guidance instruments, including international human rights treaties (McCall-Smith, 2016). Finally, the Mandela Rules emphasise the need for appropriate selection and training of prison professionals. This includes ensuring all staff members working with vulnerable individuals receive relevant training (McCall-Smith, 2016).

Overall, the Mandela Rules are remarkable, in that they aim to improve both human rights and prison safety (Peirce, 2018). Since their adoption in 2015, the discussion has focused on the international implementation of the rules. Before turning to this issue, we will present two other important international standards.

1.3. United Nations Standard Minimum Rules for Non-Custodial Measures (the 'Tokyo Rules')

The United Nations Standard Minimum Rules for Non-custodial Measures, known as the 'Tokyo Rules', are the key international standard on alternatives to imprisonment. The Tokyo Rules are a supplement to the more general Mandela Rules and focus on non-custodial measures that can be applied as alternatives to prison sentences. The Tokyo Rules were

adopted by the United Nations on 14 December 1990. They provide a 'set of basic principles to promote the use of non-custodial measures, as well as minimum safeguards for persons subject to alternatives to imprisonment' (Rule 1.1 General Principles).

The Tokyo Rules are based on the premise that there are effective alternatives to imprisonment (Penal Reform, n.d.). The United Nations therefore calls on member states 'to avoid unnecessary use of imprisonment' and 'provide a wide range of non-custodial measures, from pre-trial to post-sentencing dispositions' (Rule 2.3). In their decisions, judicial authorities should balance the 'rehabilitative needs of the offender, the protection of society and the interests of the victim' (Rule 8.1).

In particular, the Tokyo Rules stipulate that 'pre-trial detention shall be used as a means of last resort' (Rule 6.1). The document summarises a variety of non-custodial measures that can be applied as an alternative to imprisonment (Rule 8.2). The Tokyo Rules state that in their decisions, judicial authorities should take into account a number of factors, including the nature and gravity of the offence as well as the personal characteristics and background of the person who is charged with or convicted of a criminal offence (Penal Reform, n.d.). Furthermore, the rules emphasise the need for professionally and adequately remunerated staff that can supervise and implement non-custodial alternatives (Rules 15 and 16). Public participation should be strengthened, as an important factor for improving the ties between offenders and the community (Rule 17). The Tokyo Rules also call for scientific cooperation to expand the range of non-institutional options and facilitate their application across various countries (Rule 23).

According to the NGO Penal Reform International, the Tokyo Rules are an important international document for promoting alternatives to imprisonment (Penal Reform, n.d.). The rules result from two considerations. Firstly, many states are struggling with overcrowded prisons (Walmsley, 2005). Non-custodial measures can offer a more cost-effective alternative that takes into account both society's need for security and the offenders' rehabilitation needs. Secondly, there is a growing consensus among researchers that incarceration has harmful social and health consequences and does not reduce reoffending rates (Penal Reform, n.d.).

1.4. UN Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the 'Bangkok Rules')

The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders – or, in short, the 'Bangkok

Rules' – is a set of prison rules focusing on the treatment of female offenders and prisoners (Cerezo, 2017). The Bangkok Rules were adopted by the United Nations General Assembly on 22 December 2010. Similar to the Tokyo Rules, the Bangkok Rules can be viewed as a complement to the more general Mandela Rules: they address the specific needs of women in prison. The Bangkok Rules cover three overlapping issue areas: women's specific needs, the prevention of abuse, and the protection of children's rights (van Kempen and Krabbe, 2017).

The rules acknowledge that female prisoners have different needs and, consequently, require different treatment to male prisoners. Because women often have a crucial caretaking role in the family, non-custodial sentences are preferred to keep the family together and to ensure that children and elderly family members are taken care of (Rules 57–62). Because of the importance of family ties, frequent visits should be made available (Rule 4 and Rules 26–28). The Bangkok Rules also stipulate that prison authorities should take into account the special health needs of women, including their greater susceptibility to depression and self-harm (van Kempen and Krabbe, 2017).

A second central topic in the Bangkok Rules is the prevention of (sexual) abuse in the prison. Van Hout et al. (2021) show that women in prison are often subject to gender-based violence. As a rule, women are sentenced for less severe, non-violent crimes (Van Hout et al., 2021). Moreover, female imprisonment is often underpinned by poverty, for instance when women are breaking the law in order to secure their basic survival, so-called 'crimes of survival' (Van Hout et al., 2021). The Bangkok Rules therefore focus especially on the needs of women in prison. As measures to decrease the risk of (sexual) violence, they mention screening for prior (sexual) abuse, counselling, legal action, training of female staff members, special rules on searches and medical examinations, and a specific procedure in case of abuse in prison (van Kempen and Krabbe, 2017).

Furthermore, the Bangkok Rules aim to protect children's rights, sometimes through protecting the rights of their mothers (van Kempen and Krabbe, 2017). The rules stipulate that custodial sentences should be avoided for pregnant women and women with dependent children (Rule 64). If incarceration is necessary, prison administration should make it possible for children to stay with their mother (Rules 49–51). When children are not in prison with their mother, contact between mother and children should be facilitated by the prison administration (Rules 26–28). Because of the fact that women are sometimes accompanied by dependent children, the Bangkok Rules also focus on the specific needs of children in prison (Van Hout et al., 2022).

In addition to these three main issue areas, the Bangkok Rules also contain rules for specific groups of female prisoners, including juvenile females (Rules 36–39 and Rule 65), foreign nationals (Rules 53 and 66), and minorities and indigenous peoples (Rules 54 and 55).

The Bangkok Rules recognise the specific needs of female prisoners and provide guidance to meet these needs in the prison context and reduce the female prison population (Cerezo, 2018; Van Hout et al., 2021). As women form a minority among the prison population, their situation and needs have, for a long time, been invisible. The Bangkok Rules play an important role in creating international attention for female prisoners. The final sections of the Bangkok Rules therefore call for more research (Rules 67–70) with the aim of better understanding the situation and needs of women in prison (Van Kempen and Krabbe, 2017).

1.5. The Legal Status of International Prison Standards

As mentioned above, international prison standards are voluntary commitments that states make and they do not have any binding force. Their legal status is thus lower than that of conventions or agreements that carry obligations for the signatory parties. One can clearly see that prison conditions are seen as a state's internal affair.

Nevertheless, prison standards offer important guidelines for improving prison conditions worldwide. The standards are firmly embedded in the international human rights regime and make frequent references to international human rights laws. The prison standards, as we know them today, have been developed to provide a generally accepted basis for guaranteeing minimum human rights standards in the prison context. In the following section, the efforts of international actors to improve prison conditions will be discussed.

2. International Action on Improving Prison Conditions

International action on improving prison conditions has a long history. In 1777, the English philanthropist John Howard published the groundbreaking book *State of the Prisons in England and Wales*, in which he advocated for humanising prison conditions. Howard's publication can be considered the first comprehensive account of the prison system in England and Wales and a starting point for prison reform (Roberts, 1985).

In the 20th century this work became more concrete. The League of Nations provided the first space in which prison conditions were discussed internationally. The International Penal and Penitentiary Commission started to work on standard minimum rules for prisoners as early as 1926, resulting in a draft of 55 rules that were endorsed by the League of Nations in 1934 (Clifford, 1972). This work was taken up again two decades later by the United Nations and resulted in the adoption of the Standard Minimum Rules for the Treatment of Prisoners (SMR) in 1955 (Clifford, 1972). In the second part of this chapter, the development of international action on improving prison conditions will be presented. This includes an overview of the main actors, the most important issue areas, and the modes of implementation and cooperation with individual states.

2.1. The United Nations and the Promotion of Prison Standards

The United Nations plays a key role in the promotion of prisoners' rights and humane prison conditions (Bouloukos and Dammann, 2001). Within the UN framework, the United Nations Office on Drugs and Crime (UNODC) has the mandate to assist countries in building and reforming their prison systems, and in implementing non-custodial measures in compliance with human rights principles and UN standards and norms in crime prevention and criminal justice. UNODC offers assistance in improving legal safeguards for prisoners. In addition, UNODC helps states develop alternatives to pre-trial detention within domestic criminal codes. In order to promote the practical application of international prison standards, UNODC has produced a series of technical guidance tools and publications, which are made available on its website (UNODC, n.d.).

UNODC collaborates closely with UN Member States and has regional offices in all regions of the world. In Central Asia, UNODC started its operation in 1993 and focuses on providing technical assistance to law enforcement agencies, health care and criminal justice (UNODC, n.d.). In China, UNODC's work is organised through the Regional Office for Southeast Asia and the Pacific. The office is conducting a project strengthening law enforcement action to prevent the further spread of HIV/AIDS in China.

In addition to UNODC, the UN Office of the High Commissioner for Human Rights and the UN Department of Peacekeeping work on prison issues within the UN system. In 2021, the three agencies published the Common Position on Incarceration, which lays out a common approach across three thematic areas: shifting policies towards crime prevention

and alternatives to incarceration; strengthening prison management and improving prison conditions; and advancing the rehabilitation and social reintegration of offenders (Rope, 2021). The central objective of the common position is the reduction of global prison populations, which skyrocketed during the Covid-19 pandemic. Due to prison overcrowding and increased vulnerability, Covid-19 had a disproportionate impact in prison settings (UNODC, 2021).

The UN recognises prisoners as a particularly vulnerable and marginalised group that is subject to discrimination and exclusion (UNODC, 2021). UN agencies therefore strive to improve prison conditions. The United Nations System Common Position on Incarceration provides a common framework for these efforts (UNODC, 2021). The document is informed by research and emphasises the collaboration between the United Nations system, Member states, and societal actors, including social service providers and civil society organisations (UNODC, 2021).

2.2. Non-Governmental Actors

Non-governmental actors have played an important role in the promotion of prisoners' rights and humane prison conditions. Human rights protection in the prison system and prison reform is an active field of non-profit action. Altogether, there are more than 1,780 NGOs working on prisoners' issues. Important organisations include the British NGO Penal Reform International (PRI), the London-based Centre for Crime and Justice Studies, the US-American think tank Prison Policy Initiative (PPI), and the Canadian International Centre for Criminal Law Reform & Criminal Justice Policy.

The British NGO PRI has been especially influential. The NGO works on penal and criminal justice reform worldwide. It was established in 1989 by a group of criminal justice and human rights activists, including Ahmed Othmani, a former Tunisian political prisoner, and Vivien Stern, an academic and politician. PRI has worked in collaboration with the United Nations to improve norms and standards in order to better protect the rights of people in criminal justice systems. The NGO has a seat at the United Nations Economic and Social Council (ECOSOC); the African Commission on Human and Peoples' Rights; the African Committee of Experts on the Rights and Welfare of the Child; and the Council of Europe. Its work in Africa has been particularly influential, as the NGO managed to convince governments to improve prison conditions. In Uganda, for example, PRI developed a torture prevention programme that in-

cluded a police training course on international human rights standards. In Kenya, Tanzania, and Uganda, the NGO led a pilot project on the development of community service as an alternative to short-term prison sentences for petty offences (PRI, sub-Saharan Africa, n.d.).

The United Nations has acknowledged the important contribution that NGOs make towards improving prison conditions worldwide. The United Nations System Common Position on Incarceration, for example, mentions social service providers and civil society as key stakeholders in improving prison conditions and in developing alternatives to imprisonment (UNODC, 2021).

3. *Key Debates on Prison Conditions*

The international debate on humanising the prison system has revolved around a number of key human rights topics, including the prohibition of torture, the restriction of solitary confinement, the response to prison overcrowding, and the improvement of health conditions in the penal system. In the following sections, we will present these key areas of international debate.

3.1. *Prohibition of Torture*

The prohibition of torture in the prison system is a central human rights issue. Torture is an important concern in the prison system, as individuals are in an extremely vulnerable position in terms of potential maltreatment by law enforcement agencies or prison staff. In international law, the prohibition against torture and cruel, inhuman, and degrading treatment is described as absolute (Greer, 2015), which means that torture is not permitted under any circumstances. According to human rights lawyers, the prohibition of torture has been recognised as a *jus cogens* norm and as key to the protection of human dignity (McCall-Smith, 2016).

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is the key international human rights document for protection against torture. It was adopted by the United Nations General Assembly in December 1984 (resolution 39/46). The Convention entered into force on 26 June 1987, after it had been ratified by 20 States. The provisions of the Torture Convention deal with the obligations of the

States parties among which, mostly importantly, is the provision that 'each state party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture' (Article 2).

The majority of UN Member States, namely 173 states, are parties of the Convention against Torture and other Cruel, Inhuman or Degrading Treatment, which makes it a powerful human rights instrument. The Convention includes the decision to set up a Committee against Torture (Article 17) that is responsible for receiving periodic reports from the State parties and starting investigations. The Committee against Torture can also receive and examine applications from individuals claiming to be victims of a violation of the Convention by a State party (Article 22).

However, collaboration with the Committee against Torture is not compulsory. States may 'opt out' and declare that they do not recognise the Committee's competence to initiate investigations under Article 20 (Article 28). Similar to other human rights conventions, the implementation of the Torture Convention gave rise to extensive discussions at the international level (Danielus, 2008). Nevertheless, the convention is applied as a key reference for international prison action. Consequently, the Mandela Rules and other prison standards make frequent reference to the prohibition of torture (McCall-Smith, 2016).

The prohibition of torture is also protected at the regional level. A prime example is the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was adopted by the member states of the Council of Europe on 26 November 1987. Next to the European Convention on Human Rights, the Convention for the Prevention of Torture is commonly regarded as one of the most important human rights treaties in Europe. The convention has been ratified by all 47 of the Council of Europe's member states.

The convention is a flagship project for checking on human rights abuses in prisons. Part of the Convention is the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which controls prison conditions in Council of Europe (CoE) member states and may conduct unannounced visits to penitentiary institutions. The work of the CPT is closely linked to the European Court of Human Rights. Non-compliance with human rights standards in the prison system can lead to member states being convicted by the European Court of Human Rights and corresponding sanctions.

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment offers opportunities for legal action. People living in prisons can draw attention to grievances and maltreatment in the prison system and can thereby refer to the convention. If

human rights are violated in the prison system, these cases can be brought to the European Court of Human Rights. Within Europe, NGOs such as the European Prison Litigation Network (EPLN) work to strengthen the judicial protection of the rights and freedoms of prisoners in Europe. The EPLN uses advocacy and human rights litigation strategies to improve the conditions in European prisons (EPLN), n.d.). It is important to note that the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment applies only to the members of the Council of Europe.

3.2. Solitary Confinement

The restriction of solitary confinement is another important topic in the international debates on improving prison conditions. Solitary confinement describes forms of imprisonment in which the prisoner is kept in a single cell with little or no meaningful contact with other inmates. The issue has gained attention after reports from different country settings in which solitary confinement has been used as a punitive measure for (political) prisoners. Most importantly, solitary confinement has been criticised because of its adverse consequences on mental health. A well-known case is the imprisonment of the anti-apartheid activist and lawyer Nelson Mandela, who spent 27 years in prison and a significant proportion of that time in isolation. Mandela later described solitary confinement as 'the most forbidding aspect of prison life' (Mandela, 1994).

Because of the adverse effects of isolation, the prison standards named after him – the so-called Mandela Rules, adopted in 2015 – attach great importance to the prohibition of solitary confinement, characterising it as a practice that expressly violates human dignity (McCall-Smith, 2016). Rule 43 of the Mandela Rules prohibits 'indefinite solitary confinement' and 'prolonged solitary confinement'; Rule 45 states that 'solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review'. To be exact, the Mandela Rules specify that prisoners should not be subjected to solitary confinement for longer than 14 days.

The prohibition of solitary confinement is based on scientific research that has shown that solitary confinement has adverse psychological effects as human beings have a basic need to establish and maintain connections to others (Haney, 2018). Researchers particularly emphasise the negative effects of solitary confinement on prisoners' mental health (Grassian, 2006; Smith, 2006). Haney concluded that 'a robust scientific literature

has established the negative psychological effects of solitary confinement' (Haney, 2018: p. 285). According to Haney, scientific evidence has led to an emerging consensus to drastically limit the practice of solitary confinement (Haney, 2018).

However, despite this knowledge of its adverse consequences, solitary confinement is still widely applied in the prison system, for example in the United States, where an estimated 84,000 individuals endure extreme conditions of isolation (Cloud et al., 2015). In super-maximum security prisons, the so-called 'supermax', solitary confinement is a regular practice as prisoners are seen as a security risk. Human rights organisations such as the American Civil Liberties Union have therefore set up public campaigns to address the problematic use of long-term solitary confinement in the prisons (ACLU, 2022).

3.3. Prison Overcrowding

Prison overcrowding is one of the main contributing factors to poor prison conditions globally. According to the NGO 'Penal Reform International', prisons in over 118 countries exceed their maximum occupancy rate, with 11 national prison systems at more than double their capacity (Penal Reform, n.d.).

Overcrowding arises as more people are sentenced to imprisonment than the prison system has capacity for. Often, higher incarceration rates are not the result of growing criminal activity, but of underlying socio-economic and political factors, including growing inequality and societal marginalisation (UNODC, 2013). Prison overcrowding undermines the ability of prison systems to meet basic human needs, such as health care, food, and accommodation (Penal Reform, n.d.). In overcrowded prisons, detainees do not have the minimum space requirements and are, in some cases, spending up to 23 hours of the day, if not all day, in overcrowded cells (Penal Reform, n.d.). In some prisons, the level of overcrowding may be so acute that prisoners are forced to sleep in shifts or share beds (UNODC, 2013). Prison overcrowding has a particularly negative impact on health conditions. Lack of space and unsanitary conditions increase the risk of contracting infectious diseases, such as Hepatitis C, TB, and HIV/AIDS (UNODC, 2021).

Although it has widely been acknowledged that prison overcrowding has harmful social and health consequences, states have not been successful in addressing this issue (Guetzkow and Schoon, 2015). On the contrary, incarceration rates are on the rise globally (Penal Reform, n.d.). It has been

estimated that, as of today, almost 70% of prisons are overcrowded (Walmsley, 2005). The problem of prison overcrowding intensified during the Covid-19 pandemic and was one of the underlying reasons for issuing the United Nations Common Position on Incarceration, which aims to reduce global incarceration rates (UNODC, 2021). Researchers have shown that Covid-19 incidence and mortality have been higher among incarcerated persons than across the general US population (Leibowitz, et al. 2021). This effect was especially pronounced in those prisons where the population exceeded its originally specified capacity (Leibowitz, et al. 2021).

There is a growing awareness that prison overcrowding has detrimental consequences. UNODC has therefore developed strategies to assist governments in addressing the problem of overcrowding in prisons (UNODC, 2013). Among other things, the agency recommends that governments improve prisoners' access to legal assistance and legal aid, reduce pre-trial detention, and develop alternatives to imprisonment, such as non-custodial sanctions and measures (UNODC, 2013). UNODC tries to convince governments to reduce incarceration rates by arguing that imprisonment is a heavy financial burden (UNODC, 2013). By reducing incarceration rates, governments can cut costs and, at the same time, improve the conditions in their prison system.

3.4. Prison Health

Health is an important topic for humanising the conditions in the prison system. Rule 24 of the Mandela Rules stipulates the right to health care for people who live in prisons. According to the Mandela Rules, health-care services in penitentiary institutions should be organised in close connection with health administration for the general public and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis, and other infectious diseases, as well as for drug dependence. Within the Mandela Rules, an important principle is that of equivalence between the health care offered to people living in prisons and to the general population. People living in prisons should thus enjoy the same standards of health care that are available in the community (Rule 24).

The normative foundations for prison health are derived from general human right standards. The International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1967 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12). According to the 2006 European Prison Rules, "persons deprived of their liberty retain all rights that are not lawfully taken

away by the decision sentencing them or remanding them in custody" (Basic Principle 2) (Council of Europe, 2006). This means that detainees also retain the right to health care in prison. The WHO Moscow Declaration of 2003 therefore states that prison health is part of public health (WHO, 2003).

In practice, however, health care in penitentiary institutions is often low-quality and difficult to access. The reality of prison health is not the equivalence of health care, but rather a high level of inequality (Stöver et al., 2019). Overall, people living in prisons are among the most vulnerable populations and face greater health problems than the general population (Matejkowski et al., 2014). The poor health of people living in prisons is due both to structural determinants (institutional, environmental, political, economic, and social) and to the physical and mental constitutions of the prisoners themselves (De Viggiani, 2007). Most inmates already have a poor health status when they enter the penitentiary system. De Viggiani observed that prisoners 'come from the poorest or most socially excluded tiers of society and often have the greatest health needs' (De Viggiani, 2007: p. 115). Deprivation in prisons intensifies existing vulnerabilities among prison populations, as it denies individuals basic human rights and needs, and results in physical, mental, and social harm (De Viggiani, 2007). After prison, these adverse health effects make rehabilitation more difficult, as those released from prison find it harder to rebuild their lives if they face serious health restrictions (De Viggiani, 2007).

To address the manifold health issues in prison and reduce health inequalities, the World Health Organization (WHO) has established the Prison Health Framework (Alves da Costa et al., 2022). The objective of the framework is to achieve equivalence of care for people living in prison (WHO, 2022). The framework forms the basis for measuring and monitoring health-care delivery in the prison system and serves as a reference for policy design and implementation in different country settings (WHO, 2022). The framework consists of three main building blocks: the health system, health service delivery, and health outcomes. The first captures the system-level aspects of prison health care (or 'inputs'), whilst the second captures delivery aspects of prison health care (or 'outputs') (Alves da Costa et al., 2022). These building blocks are in turn modified by two influencing factors: the prison environment and health behaviour. Ultimately, all these elements impact the third building block: health outcomes. In addition, two cross-cutting principles are included in the framework: (1) adherence to international standards for human rights and good prison health and (2) reducing health inequalities and addressing the needs of special populations (Alves da Costa et al., 2022). The two

cross-cutting principles are especially important, as they relate to the objectives of improving prison health. The first objective refers to the adherence to international standards for human rights and good prison health; the second describes the goal of reducing health inequalities and addressing the needs of special populations (Alves da Costa et al., 2022).

A particular issue when it comes to prison health is the treatment of drug dependency and other health services for drug users in the prison system. Drug users form a significant part of the prison population. About 15 to 25% of European prison inmates are sentenced for drug-related offences. According to recent research, the prevalence of drug dependence among prisoners varies from 10 to 48% for male prisoners and 30 to 60% for female prisoners at the point of incarceration (Fazel et al. 2006; Stöver and Michels, 2010). Opioid use disorder is often associated with harmful health consequences, especially for people living in prison, including the risk of fatal overdose and infection with hepatitis B and C, and HIV, due to the use of contaminated syringes (Stöver et al., 2019). Although it is generally acknowledged that opiate substitution therapy (OST) is an effective drug dependence treatment, access to OST in prison is inadequate in most countries and falls short of the standards for people outside of prison (Stöver et al., 2019).

Another important topic is compulsory drug treatment, which is used in many parts of the world (UNODC, 2022). UNODC recommends that governments abstain from compulsory treatment as it is associated with low efficiency and a high risk of human rights violations. The agency instead advocates for the use of voluntary forms of treatment for people who use drugs. It advises governments to transform compulsory facilities towards voluntary community-based treatment and complementary health, harm reduction, and social support services (UNODC, 2022).

Prison health clearly shows that there is a discrepancy between the global objectives and the reality on the ground. The WHO Prison Health Framework was developed to support decision-making and implementation for prisons and other places of detention (Alves da Costa et al., 2022). However, the comprehensive framework cannot guarantee that prison conditions are, in fact, improved. This fully depends on the willingness of policy makers who often do not have an interest in spending public resources on improving prison conditions. Hence, De Viggiani (2007) concluded that the WHO's notion of a 'healthy prison' is a contradiction in itself, as prisons epitomise the antithesis of a healthy setting. There is thus still a long way to go before health care equivalence across prisons and the general population is achieved, as postulated in the Mandela Rules.

Conclusion: International Prison Action and Its Implications for the Region

This chapter presented an overview of the global framework for humanising prison conditions. In this concluding section, we turn to two evaluative questions: what has been achieved by international actors in terms of improving prison conditions and protecting human rights, and what are the implications of these efforts for the countries of Central Asia and China.

First of all, it is important to note that the prison system is generally seen as a state responsibility. International prison standards have been developed to provide national governments with guidelines for minimum standards. The standards, however, are voluntary and do not have any binding force. UN agencies, such as UNODC, can assist UN member states in their prison management and develop recommendations for humane prison conditions. However, it is up to states to decide the extent to which they are willing to implement international recommendations. In this sense, international prison standards are a *soft law* instrument. Many states – regardless of political system – see the prison system as their sovereign responsibility and are cautious about providing full information, especially in cases that are politically sensitive.

However, the character of soft law does not mean that international prison standards have no effect. Over the years, the efforts of international actors have achieved significant results in humanising prison conditions. The codified prison standards, such as the Mandela Rules and the Bangkok Rules, have been important milestones in this development. They describe globally agreed guidelines for guaranteeing basic human rights in the prison system. In the national context, international standards and guidelines can serve as palpable recommendations for prison administrations. Policy-makers and prison administrators can use these standards in their daily work. The standards help them to understand what to look out for to guarantee good conditions and avoid human rights violations. Moreover, the global framework provides an arena for debate, which enables the international dissemination of best practices. In all parts of the world, prison administrations are confronted with similar problems, such as the need to organise a daily structure, to avoid conflicts and violence, and to provide detainees with opportunities for social rehabilitations. The collaboration with international actors gives national administrations an opportunity to discuss these challenges and learn from other examples and recommendations. This, however, presupposes that prison administrations are willing to consider international advice.

Furthermore, international prison standards can serve as an important reference point for non-governmental organisations advocating for prisoners' rights. In many countries, prison reforms have not been an internal development but rather came about under pressure from external actors. By exposing human rights violations in the prison system, non-governmental organisations have asserted pressure on governments and achieved important improvements. These change processes often take a lot of time. International prison standards are important for the activities of advocacy groups as they describe the objectives towards which state policies should converge. By assisting governments in developing national legislation and policy implementation, UN agencies can work towards gradually improving prison conditions in different country settings. We can thus conclude that the existing global framework is still imperfect, but nevertheless offers important channels for humanising the prison system worldwide.

One should, however, not overlook the fact that the global framework also has several important limitations. International prison standards are formulated in a very general way and cannot account for the diverse realities in prisons, particularly not in developing countries where prison administrations are poorly funded and riddled with corruption. Despite the internationally agreed minimum standards, human rights violations in the penitentiary system remain widespread. This is due to the fact that prisons are closed institutions and are rarely controlled by the public. If human rights violations occur in the prison setting, they are rarely prosecuted. Failure to uphold international prison standards leads to impunity for potential offenders. Next to the arbitrariness of the prison administrations, general violence and the feeling of hopelessness and depression associated with imprisonment are among the predominant problems in the prison. At best, international prison standards can alleviate the situation for prisoners, but they cannot end the suffering.

In the regions of Central Asia and China, too, international norms and standards have been important in the process of prison reform. A comparison between the countries of the region reveals some interesting differences. While Central Asian countries have cautiously moved closer to international norms and have started to collaborate with international organisations, China has increasingly isolated itself from the international community in recent years.

Let us first take a look at the development in Central Asia. After the end of the Soviet Union, the five countries of Central Asia inherited an extensive and repressive prison system. After 1991, the repressive prison policy was initially continued in the newly independent states. Because of the authoritarian nature of the post-Soviet regimes in Central Asia, human

rights violations in the region's prison system have been widespread. For the past three decades, there have been regular reports of maltreatment and even torture in penal institutions. However, over the last couple of years, some tentative steps towards reforming the prison system could be observed. The governments of Central Asia have started to reduce the prison population and improve the conditions in the penal institutions. Kazakhstan and Kyrgyzstan, for example, have been successful in decreasing incarceration rates (ICPR, n.d.). The reforms in these two countries aim to lower the cost of prison management and improve the prospects of social rehabilitation for their prison populations. One key component has been offering rehabilitation and probation programmes as an alternative to imprisonment. UNODC has supported the governments of Kazakhstan and Kyrgyzstan in the prevention of evidence-based drug use treatment and the establishment of rehabilitation programmes in the prison (UNODC Central Asia, n.d.).

In Uzbekistan, the political system shows stronger authoritarian traits than in the neighbouring countries, and the prison system is a rather closed institution that is sealed off from international cooperation. However, since President Mirziyoyev came to power in 2016, the country has started some political reforms, which are controversially discussed. According to the Organization for Security and Co-operation in Europe (OSCE), political reforms in Uzbekistan 'have not yet resulted in a genuinely pluralistic environment' (OSCE, 2021). Furthermore, with regard to the prison system, Uzbekistan remains a largely closed country, with a high number of religious and political prisoners and a long legacy of state repression (USCIRF, 2021). However, Uzbekistan has joined international efforts to combat extremism and violence in Central Asia (United Nations Office of Counterterrorism (n.d.). Within the framework of this larger programme, some projects focus on the prevention of religious extremism in the prison system.

In contrast to the countries in Central Asia that have seen some tentative successes in prison reform, China is on a confrontational course with international organisations. Unlike in Kazakhstan and Kyrgyzstan, incarceration rates in China have been growing over the past two decades (ICPR, n.d.). In 2017, more than 1.7 million people were detained in Chinese prisons, which is an increase of 20% in comparison with the year 2000, when about 1.4 million people were imprisoned (ICPR, n.d.). This increase in the prison population is partly due to the fact that Chinese courts have become stricter in punishing drug-related crimes (ICPR, n.d.).

China's prison policies are particularly harsh in the Western province Xinjiang, where government agencies pursue a repressive policy towards

the Uyghur minority (Khalid, 2021). The oppression of the Uyghurs has been a concern for many years. In 2022, the conflict became apparent when the UN Human Rights Office (OHCHR) published a report on human rights violations in Xinjiang (OHCHR, 2022). In this report, the OHCHR accuses the Chinese government of using prisons and so-called 'vocational training centres' to persecute the Muslim minority under the pretext of anti-extremism policies. Researchers estimate that about a tenth of Xinjiang's Muslim population was incarcerated in 2021 and characterise Chinese policies as a 'cultural genocide' aimed at destroying the cultural identity of the Uyghurs in Xinjiang (Khalid, 2021: p 495).

The international controversy surrounding the secret detention camps shows that the topics of imprisonment and prisoners' rights are more relevant than ever before. In many parts of the world, governments use prisons to suppress political opposition and control the populace. International actors cannot prevent these practices of repression. However, they can raise awareness regarding the conditions of imprisonment and can keep up the pressure on governments to realise that human rights must also apply in prisons.

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3 Women in Prisons and the Bangkok Rules – A Practical Guide for Social Workers

Ulla-Britt Klankwarth, Simon Fleißner

Introduction

Human rights are a fundamental element of social work. Further, the global definition of social work names human rights as principles, a motivation, a justification, and a major focus that need to coexist alongside collective responsibility. Human rights can only be realised on a day-to-day basis if people take responsibility for each other and the environment (IFSW, 2014). '[…] it [is] imperative that those involved in the field of social work education and practice have a clear and unreserved commitment to the promotion and protection of human rights […]' (UN, 1994a, 3). Meyer and Siewert describe social work practice in various terms. They explain that social work mediates, practices, helps, advises, sanctions, evaluates, and accompanies. The field of social work practice is manifold (Meyer & Siewert, 2021, 9ff.).

This chapter shows how social work – as a human rights profession – can beneficially put human rights agreements into practice. The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) serve as a human rights instrument. This chapter demonstrates how the Bangkok Rules can be accessed step by step and become useful and applicable for everyday practice. For this purpose, we first give an overview of social work as a human rights profession, followed by an introduction to and history of the Bangkok Rules. Based on this theoretical background, Chapter 3 will put the Bangkok Rules into practice by using a simple and structured table. With this chapter, we want to encourage each social worker to claim human rights conventions as a useful tool for their daily practice.

1. Social Work as a Human Rights Profession

Silvia Staub-Bernasconi examines the historical development of social work as a human rights profession from 1902 until the present day (Staub-

Bernasconi, 2017). The International Federation of Social Work (IFSW) stated in 1988 that social work is a human rights profession (Prasad, 2017) and published a manual on social work and human rights, together with the United Nations (UN), in 1994 (UN, 1994b). The global definition of social work also names human rights as a fundamental element of social work (IFSW, 2014).

The Universal Declaration of Human Rights was adopted in 1948 due to the impact of the Second World War. Human rights are explicitly independent of national legislation, as Nazi Germany illustrated what could, seemingly legally, be done to people. An orientation on international human rights agreements also enables social work to criticise existing laws more convincingly. Especially the penal system, has an urgent need for change and action (Prasad, 2021, 562). Prasad also writes: 'Social work often finds it easy to denounce and address human rights violations by the state. However, there is a peculiar silence when it comes to reflecting on its failures to participate in violations of (human) rights' (Prasad, 2021, 563).

The first step in shaping practice accordingly - as a human rights profession - is knowledge of human rights (Prasad, 2021). However, knowledge of human rights alone will not be enough to improve the practice of social work in terms of human rights (Reichert, 2011, 194). It thus seems challenging at first to fully understand all the concepts and definitions of human rights (Reichert, 2011, 196). A successive appropriation of human rights, starting with the declaration particularly relevant to one's field of work, appears to be a practicable possibility. A social work practice orientated towards human rights enables one to recognise human rights violations, develop individual and structural solutions, and reflect on one's own practice (Prasad, 2021, 564).

2. *The Bangkok Rules*

'The adoption of the United Nations Rules for the Treatment of Women Prisoners and Noncustodial Measures for Women Offenders (the Bangkok Rules) in December 2010 represented an important step forward in recognizing the gender-specific needs of women in criminal justice systems' (PRI, 2021, 3).

Detention is a restriction, if not a violation, of basic human rights. In recent years, several international conventions set out important principles and human rights guarantees for prisoners. Since the mid-1950s, the United Nations has been developing standards and norms to encourage the promotion and development of criminal justice systems based on reinforcing fundamental human rights standards. The so-called 'soft laws'

represent the collective vision of the criminal justice system, create governmental frameworks, describe best practices, and support the development of sub-regional and regional strategies (UNODC, 2007, 10).

Since the adoption of the Standard Minimum Rules for the Treatment of Prisoners (SMRs) in 1955 (UN, 1955), a considerable amount of research has been conducted on, for example, the causes of crime or the impact of imprisonment. But only since the early 2000s has the research started to focus on the gender differences between women's and men's backgrounds and their social reintegration needs (PRI, 2021). In December 2015, the UN General Assembly adopted the revised UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) (UN General Assembly, 2015). The Nelson Mandela Rules are an updated version of the SMRs and set out the minimum standards for good prison management (PRI, 2016).To promote the basic principles of non-custodial measures, the UN adopted the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules) in 1990 (UN General Assembly, 1990) (see Chapter 2).

However, neither the Nelson Mandela Rules nor the Tokyo Rules take the unique needs of women who come into contact with the criminal justice system into sufficient account (UN General Assembly, 2011a, 5). In 2009, the Thai government submitted a resolution to the Commission on Crime Prevention and Criminal Justice expressing the particular vulnerability of incarcerated women in a system that is constructed principally for men. Based on that, the UN General Assembly adopted a set of rules in 2010 that represent a critical step towards recognising the needs of women in the criminal justice systems: the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules) (The Dui Hua Foundation, 2022; UN General Assembly, 2011b).

The Bangkok Rules complement and fill the gaps between the Nelson Mandela Rules and the Tokyo Rules. The Bangkok Rules address the ineffectiveness and harmful effects of prisons and suggest gender-sensitive detention alternatives. For example, the section on non-custodial measures (Bangkok Rules 57–66) supplement the Tokyo Rules and interpret them from a gender-specific perspective, by taking into account the rehabilitation needs of the person in view of women's backgrounds, such as their caring responsibilities (PRI, 2021, 8). The Bangkok Rules supplement the Nelson Mandela Rules with more detailed guidance on the particular support required by pregnant women in prison, breastfeeding mothers, and mothers with children (PRI, 2021, 114). The 70 Bangkok Rules can

be divided into the following 11 topics (Atabay and Penal Reform International, 2013):

Table 1: Bangkok Rules Topics (PRI, 2021)

Topic No.	Topic	Rules
1	Non-discrimination of women in prison	Rule 1
2	Admission, registration and allocation	Rules 2–4
3	Hygiene and healthcare	Rules 5–18
4	Safety and security	Rules 19–25
5	Contact with the outside world	Rules 26–28
6	Prison staff	Rules 29–35
7	Special categories	Rules 36–39 & 53–56
8	Rehabilitation	Rules 40–47
9	Pregnant women, breastfeeding mothers, and mothers with children in prison	Rules 48–52
10	Non-custodial measures	Rules 57–66
11	Research, planning, evaluation, and public awareness raising	Rules 67–70

Overall, the implementation of the Bangkok Rules around the world remains piecemeal (Van Hout et al., 2022, 2021). In December 2020 – 10 years after their adoption – representatives of the UN and more than 80 global organisations appealed to the international community to review their laws, policies, and practices regarding the full implementation of the Bangkok Rules. Particular attention should be paid to the low proportion of women involved in violent crimes, the background of the crime, and gender-sensitive alternatives to imprisonment (PRI, 2020).

The Bangkok Rules serve as a suitable instrument for improvement and reflection, and measures can be taken to redesign the practice in accordance with the Rules. Even if the Bangkok Rules are only recommendations and not legally binding, the impact they have on legislative processes should not be underestimated. The so-called 'soft laws' can serve as rules of conduct for international legal development; they can also result

in improvements that would not otherwise have been made (Cornel, 2020, 194; Prais, 2020).

For example, the influence of the "Principles for the Treatment of Women Sentenced to Imprisonment" can be seen in a guide to women's correctional practice in Sweden (Haverkamp, 2011, 37). Prais has extensively analysed the implementation of the Nelson Mandela rules in Canada (Prais, 2020). In a verdict, the Federal Constitutional Court in Germany pointed out that 'it may be an indication that fundamental rights requirements have not been adequately taken into account or that the interests of detainees have not been weighted in accordance with fundamental rights requirements if international law requirements or international standards relating to human rights, such as those contained in the relevant guidelines and recommendations adopted within the framework of the United Nations or by bodies of the Council of Europe, are not observed or are undercut'[1] (2 BvR 1673/04 Para. 63). Thus, the court ruled that falling short of human rights covenants indicates that insufficient attention is being paid to the needs of prisoners.

3. *Putting the Bangkok Rules into Practice*

Like other human rights regulations, the Bangkok Rules initially appear abstract and almost inaccessible in terms of daily implementation and application in practice. Due to the dense content and the many different regulations, it is challenging to get started. In the following section, we would like to show how a simple introduction can be achieved, and promote the use of the Bangkok Rules. It is not about implementing all the rules perfectly, which is, structurally, rarely even possible. It is much more about improving one's own practice bit by bit, in line with the human rights regulations. This piecemeal improvement happens when social work is seen as a human rights profession. It should be emphasised again that a flawless implementation cannot be (immediately) achieved, but a step-by-step approach is possible.

1 [Translation by the authors], original verdict: BVerfG, Urteil des Zweiten Senats vom 31. Mai 2006 - 2 BvR 1673/04 -, Rn. 63

3.1. Pick your Topic

As a first step, we suggest choosing one of the eleven topics that is relevant for your own practice and which you would like to see reflected in your own practice. This can be based on a concrete programme but also on a specific topic of interest. In the first instance, it is advisable to choose a smaller rather than a broader setting.

3.2. Pick your Rule

The rules that apply to the specific topics can already be clearly narrowed down using Table 1 above. From the relevant rules, one or two can be selected that are as suitable as possible for the selected topic. At this point, the need to be exhaustive can be set aside. Further rules can be used later on. Even simply reading these thematic rules can offer suggestions and broaden the perspective of one's own practice.

3.3. Reflect upon your Practice

Once the appropriate rules have been selected, the next step is to systematically relate them to the practice of social work. We propose using a table as a working aid for this purpose. First of all, an ad-hoc assessment should be made of the extent to which the requirements of the rule are already being met in practice. Is the rule being implemented *completely*, *partly*, or *not yet*? This first step is intended to encourage reflection on the contents of the rule and how to relate them to one's own practice. After this assessment, the next column can be used to write down what is missing for the requirements of the rule to be met. By writing down specific aspects, the difference between the current situation and the target situation becomes clear. The third step is to note what can be changed or done to meet the missing requirements. At the end of the process, there are practical options for action that can be taken to make the practice more human rights compliant. Again, implementation is a process and can only be realised step by step. Perhaps there are also small changes that can immediately and easily improve the practice.

Table 2: Worksheet for Reflecting on one's own Practice

Bangkok Rule	**State of implementation**			**What is missing?**	**How to improve the practice?**
	Com-plete	**Partly**	**Not yet**		
Chosen rule				*What is missing to ensure that the rule is fully complied with?*	*What can be done to address the shortcomings?*
	What is your initial evaluation of your practice according to the rule?				

The initial phase of this process should be associated with as few obstacles as possible. Therefore, we are convinced that simply reflecting on the practice in light of the rules already leads to a better practice. However, there is also reliable material on the Bangkok Rules that explains and comments on the rules and translates them into practice. Penal Reform International addresses a wide range of stakeholders with the Bangkok Rules (politicians, medical professionals, social workers). A concrete question that may be used to reflect on the implementation of Rule 48, for example, would be: 'Are the nutritional and other health-care requirements of these women met provided by the prison authorities?' (PRI & Thailand Institute of Justice, 2013, 144). The UN Guidance Document on the Bangkok Rules can be helpful in reflecting on the Bangkok Rules to better understand the scope of the individual rules.[2] In addition, this accompanying document can provide further suggestions for one's own practice and point out issues that may not be obvious from the rule itself. We therefore recommend referring to the accompanying document if a more in-depth study of a rule is possible and desired, or if filling in the table is difficult and no or hardly any ideas come to mind regarding the partially implemented rules. It remains important that the selected rule continues to be related to one's own practice.

2 Penal Reform International – PRI (2021): *Guidance Document on the Bangkok Rules: Implementing the United Nations Rules on the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*. London: PRI.

Table 3: Example for Reflecting on the Implementation of the Bangkok Rules (on the Topic of Health Care) within one's own Practice

Bangkok Rule	State of implementation			What is missing?	How to improve the practice?
	Complete	Partly	Not yet		
Rule 5 The accommodation of women prisoners shall have facilities and materials required to meet women's specific hygiene needs, including sanitary towels provided free of charge and a regular supply of water to be made available for the personal care of children and women, in particular women involved in cooking and those who are pregnant, breastfeeding or menstruating.		x		Women's specific hygiene products free of charge.	Provide free, women-specific hygiene products in the sanitary facilities (including soap, toothbrushes, toothpaste, and towels).
Rule 8 The right of women prisoners to medical confidentiality, including specifically the right not to share information and not to undergo screening in relation to their reproductive health history, shall be respected at all times.		x		Informing patients about the disclosure of personal information.	Patients should be made aware that their information will be shared within the medical team. Make sure that – with the exception of health-care staff – no other prison authority should have access to the patient's medical records (PRI, 2021).

Conclusion

The Bangkok Rules are, without doubt, appropriate and suitable guidelines and standards for the practical work of a human rights profession. If social work as a profession is committed to human rights, daily practice should be measured against these standards. The Bangkok Rules represent a framework for practice, provide appropriate guidelines, can be used as an orientation to improve the treatment of women in prison, and address the malpractice and low visibility of women offenders. This chapter intends to make the Bangkok Rules progressively applicable to everyday practice through a clearly structured table. The table therefore provides guidance

and serves as both an analytical tool for practice and as an assessment of the current state. It should be noted that the table represents a tool that can also be applied to other human rights standards, for example the Tokyo Rules or Nelson Mandela Rules (see Chapter 2), or beyond the prison setting (Mapp et al., 2019). There is also an emphasis beyond detention on the importance of human rights to social work (Gatenio Gabel and Mapp, 2020; Gruskin et al., 2010; Mapp et al., 2019). McPherson impressively describes how her understanding of her daily work has been profoundly changed through her personal discovery of human rights, both for herself and for the people she works with. She emphasises this with a quote from a women she worked with: 'I am still poor, but the problem is injustice, not simply personal failure' (McPherson, 2016).

As a human rights profession, social work not only contributes to the development of human rights (Healy, 2008) but can also contribute significantly to the implementation and enforcement of the Bangkok Rules. The soft laws reflect the circumstances of women who have committed crimes. What's problematic about the soft laws is the lack of binding and obligatory effect, accompanied by a lack of enforceability. However, their effect should not be underestimated (Prais, 2020). With an eye to the future, applying a gender perspective to the global criminal justice systems is long overdue. Finally, the adoption of the Bangkok Rules was a milestone in the field of human rights. But the true significance of these rules will only become clear when they are implemented in practice. We would like to encourage social workers to use human rights for your own practice. In particular, the Bangkok Rules are suitable for reflecting on one's own practice and can contribute to the further development of social work practice.

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4 China: Social Work and Health in the Penitentiary System

Hang Su

This chapter mainly introduces the development of social work services in the penitentiary system in China and is structured as follows: the structure of the prison system, the prison population, and social work in prison.

1. The Prison System in China

In a strict sense, the term 'prison' refers to a facility where inmates serving life sentences, fixed-term sentences, or death sentences with a two-year reprieve execute their sentences in accordance with the Criminal Law and the Criminal Procedure Law, which are the rules for China. Criminals are subjected to punishment, rehabilitation, education, and labour in an effort to make them law-abiding citizens. The Ministry of Justice is the primary administrative body, and the Prison Service is responsible for prisons.

2. Historical Development of the Prison System

Prisons have been around for thousands of years in China. There have been slave state prisons, feudal state prisons, capitalist state prisons, and socialist state prisons. When China was a slave society, punishment and its execution focused on vengeance and prisons had the task of housing criminals awaiting execution and conviction. Since the Qin dynasty (221 BC to 207 BC), China has been a centralised feudal society, and the methods, and purposes of prison sentences and their guiding ideology changed significantly compared to when the country was a slave society, further strengthening the dictatorial function as a tool to protect the ruling class's privileged interests. Life, liberty, and bodily punishment were the bulk of the feudal penal system, and the five old penalties of slavery were replaced by the five new, more humanitarian penalties of feudalism (flogging, caning, imprisonment, exile, and death). Modern China's prison system was improved by the Western prison system, which pioneered the use of educational sentences as a guiding ideology for prison sentences. China

proposed learning from the advanced experience of Western countries in terms of the training of prison officials and the education and rehabilitation of prisoners, but this was not implemented in practice. The first New China Prison Law was passed in 1994. Article states that prisons must combine punishment, reform, education, and work to convert criminals into law-abiding citizens. Chinese prisons practice resocialisation. Chinese jails utilise politics, labour reform, and prison administration to reform convicts (Qin XF, 2018).

Since the reform and opening-up of the country in 1978, the central government of China has reformed its prisons (Li YQ, 2019). The promulgation and implementation of the Prison Law improved China's criminal law system and was a major achievement in the reform of the prison legal system, a milestone in the history of the new China. In 2012, under the new era of the comprehensive rule of the law, prison work has been comprehensively reformed, strengthening the reform of internal prison management, improving the execution system, pushing forward the reform of the education and rehabilitation of offenders, continuously promoting the reform and development, improving the political and operational quality of the people's prison police, and gradually forming a new concept of solitary confinement. A Chinese-style communist prison labour resocialisation, management systems, working mechanisms, and working methods are being established.

3. Legal Framework

The People's Republic of China's Prison Law, passed at the eleventh meeting of the Standing Committee of the Eighth National People's Congress on 29 December 1994, is the nation's first prison code. It marks the establishment of China's prison legal system and is a major milestone in the country's history. The Constitution is the foundational law of the nation, and it has supreme legal authority. The Constitution's Article 28 declares clearly that 'the State shall punish and reform criminals'. The Constitution's clauses served as the foundation upon which China built its prison legal system, and these clauses also serve as the legal source of prison administration. The National People's Congress and its Standing Committee adopted the normative laws governing prison administration in accordance with prescribed processes. The Criminal Law, Criminal Procedure Law, Prison Law, People's Police Law, State Compensation Law, and Law on the Protection of Minors are among them. The Prison Law is the primary legal foundation for the prison legal system, while the Crim-

inal Law and the Criminal Procedure Law offer the fundamental legal framework for prison administration. These three laws combined make up the current Chinese legal framework for the imposition of penalties (Feng WG, 2019).

4. *Organisational Structure*

China's present prison system consists of three main organisational approaches, due to the historical legacy of circumstances and the imbalance of economic development in different regions. The first is functional organisation. A functional organisational structure is still used in most jails. With this organisational structure, the leadership supervises jail administration; each department performs its duty and oversees specific operations. The second is a project-based structure. The project team manages personnel and administrative matters within the prison's authority and responsibility. This organisational structure is utilised for multi-department, specialised, or lengthy tasks. The Prison Offender Rewards and Punishments Committee uses a project-based organisational structure. The third approach is section hierarchy. This model evolved in Chinese prison management and has a two-, three-, and four-level structure. Each aspect in this framework works as part of the whole, not independently, to develop a more effective management system.

5. *Types of Prisons*

Prisons are grouped and categorised based on what kind of prison they are in order to individualise punishments, prevent criminals from influencing each other, and conduct focused rehabilitative efforts. The basic prison types are as follows (Zou Y, 1991): male and female prisons, based on the sex of the offender; juvenile and adult prisons, based on the age of the offender; first-time and repeat offenders, based on whether the offender has previously received a prison sentence or not; negligence and intentional prisons, based on the form of guilt; political and ordinary criminal prisons, based on to the nature of the crime; and special prisons and ordinary prisons, based on their position in the criminal justice system. In addition, there are transitional jails (intermediate prisons), medical prisons, and other sorts of prisons.

6. Prison System Governance

China's prison management is central and provincial, and the provinces are mainly responsible. Article 10 of the Prison Law states that 'the judicial, administrative department of the State Council shall be responsible for prison activity across the country' and that the Ministry of Justice's Prison Administration Bureau is responsible for prison operations nationwide.

The Ministry of Justice is responsible for drafting, formulating, and issuing administrative regulations on prison work for the State Council, such as formulating development goals and implementation plans for prison work nationwide; coordinating the relationship between the prison system and other central state organs; approving the establishment, abolition, and relocation of prisons; and implementing State Council documents, resolutions, and instructions regarding prisons. The prison administration manages prisons and administers national laws, administrative regulations, and administrative rules on prison work; formulates budgetary, production, and investment plans for prison work; and inspects and directs prisons' work supervising and reforming offenders. The Provincial Department of Justice and the prison administration have similar tasks. Provincial prison administrations lead prisons as execution organs.

Internal prison operations are based on supervision, reform, labour, and administration. The Party Committee oversees a system of jail governors and political commissars. 'A division of labour between prison governors and political commissars under the leadership of the party committee' or 'prison governors under the leadership of the party committee' is how prisons are currently being run. The prison leadership team consists of Party Committee members: one prison director, two deputy prison directors, one political commissar, one deputy political commissar, one disciplinary committee secretary, and one political office director (or trade union chairman).

7. The Core Problems of the Current Prison System

The purpose of prisons is that perpetrators are treated, undergo training, and are prepared for life after imprisonment, so that they no longer commit crimes. However, there is little scrutiny of how successful prisons are in deterring people from committing further crimes. Those studies that do exist tend to suggest that imprisonment increases the likelihood of recidivism. While imprisoned, an inmate's social network often falls away.

Opportunities on the job market are slim. The conviction is permanently on their criminal record, which many employers want to see. In the worst case, those who are not fortunate enough to own property are left homeless after their imprisonment. Prisons are often drug swamps too. Many inmates are already addicted to drugs when they enter prison, and the problem can be exacerbated in prison. Everyday life in prison is characterised by violence. The proportion of people who commit or attempt suicide in prison is seven times higher than in the general population. More measures are needed to solve these problems.

8. The Prison Population

8.1. Incarceration Rates – Male/Female Ratio – Age Structure

As of 2018, there were 1.71 million inmates in China's prisons, a rate of 121 per 100,000 people. 8.4% of these inmates were female criminals and 0.8% were juvenile offenders (Zhou Y, 2021). Despite the lack of a national picture of crimes perpetrated by the elderly, several localities observed a rising tendency (Gao J,2018). If all convicted and indeterminate offenders were considered, China's jail rates would certainly be far higher.

8.2. Social and Health Issues

In recent years, the prison system built under the conventional planned economy has become incompatible with the changing situation, causing the following issues. First, liberal sentencing has increased the number of inmates and the state's financial burden. Second, prisons are closed institutions where behaviour is rigorously controlled and convicts are isolated from the world. The greater the gap between closed prisons and normal social life, the less effective prisons are at rehabilitating offenders. Third, the huge number of criminals in jail has led to the integration of criminal components, establishing prison subculture, which is in opposition to the institution's original aim. The offender absorbs the informal attitudes, habits, and conventions of the offender community and becomes immune to society's dominant ideals and prison restrictions, reducing their positive effects (Yang HN, et al, 1999).

According to previous studies, the health of some prisoners and the management of diseases in prisons are not optimal, especially in the fol-

lowing areas. Firstly, elderly prisoners and those with a history of drug addiction are currently the main groupings of unwell inmates. Illness primarily affects elderly prisoners and drug users (Zhang GR, 2021). Secondly, as the prison reform progresses, the inmates' work is getting more intensive and concentrated. The chance and frequency of accidents in chemical plants and hard labour workshops have increased, leading to an increase in inmate illnesses and the risk of infectious diseases (Li YF, 2021). Finally, jails lack suitable psychological counselling institutes, and existing centres are understaffed, making it difficult to immediately address inmates' psychological problems (Ye YH, et al, 2020).

8.3. Human Rights Issues

Before the reform and opening up, a turning point in China's protection of human rights, the country paid less attention to prisoners' human rights due to economic development limits. After the reform and opening up, the economy grew and China began to focus on prisoner rights. In 1991, China produced its first white paper on human rights, followed by others on protection and progress. In 1992, China's white paper on reforming criminals stated, 'People can be reformed, and most criminals can be reformed.' China follows humanitarian standards when rehabilitating offenders. It guarantees offenders' living conditions, respects human dignity, and bans humiliation. China's Constitution, Prison Law, Criminal Law, Criminal Procedure Law, People's Police Law, State Compensation Law, and other laws guarantee inmates' human rights. From these legal provisions, we can see that the human rights of prisoners are mainly guaranteed in three aspects in China: the purpose of human rights protection; combining education and rehabilitation, with education being the main focus; and the rights of prisoners (including prisoners' political and economic rights, prisoners' right to dignity and equality, prisoners' right to education, prisoners' right to physical and mental health, the right to sanitation, and the right to continue improving after release (Fan LCZ, 2020)).

8.4. Social Work in Prisons

Though social work has a history of more than 100 years, the formal development of social work really only began following the reform and

opening of China. The development of social work in China went through three main stages. Firstly, social work was introduced in China, from 1922 to 1952; secondly, social work education was abolished, from 1952 to 1988; and thirdly, social work was reconstructed and reintroduced from 1988 onwards (Xia X, et al, 2002). The continuity of social work in China was thus affected and, from 1988, the concept of social work was a blank slate. However, since 1988, social work has developed rapidly in China.

Correctional social work is carried out in prisons. Under the professional values of social work, professionals or volunteers apply social work theories, knowledge, methods, and techniques to provide offenders (or people at risk of committing crimes) and their families with psychological counselling, behavioural correction, information, employment training, life care, and social environment improvement services during trial, imprisonment, and community correction. A social service aims to reduce crime, alter behaviour, and adjust to social life (Zeng Y, 2020).

Social workers can provide the following services in prisons: (i) Helping inmates adjust to prison life, including familiarising them with the prison environment, helping them kick bad habits, helping them resolve life problems, and limiting cross-contamination of criminal ideas and conduct; (ii) Correctional social workers can provide therapeutic and corrective counselling for inmates in ideology, psychological personality, behavioural patterns, and lifestyle, including civic education, psychological and emotional counselling, vocational skills training, and interpersonal awareness and ability enhancement; (iii) Helping convicts grasp societal changes, establish family relationships, and build social networks.

8.5. Medical Services

Article 54 of the Prison Law of the People's Republic of China requires all jails to establish medical institutes specialising in health, epidemic prevention, and medical treatment for prisoners. These institutions provide prison medical and health services. 'Prisons must provide sanitary and living conditions for inmates to ensure their health and life. The prison's health strategy must include inmate health care.' The Prison Law must be observed when creating a prison hospital that provides sanitary and epidemic prevention and medical care to convicts. At this stage, every prison in every province has set up a three-tier health care guarantee system, consisting of a basic infirmary, a prison hospital, and a provincial hospital. This provides a strong guarantee for the life and health of the inmates and

enhances the supervision of those serving their sentences. Jail health care reflects the needs of the staff, the target group, and the facility.

8.6. Labour Integration Projects

In a growing society, prisons imprison, punish, and rehabilitate offenders so they can acknowledge their mistakes, reform, and reintegrate. Prison labour rehabilitation involves giving inmates productive jobs. Prison police assign jobs to inmates based on their expertise, such as electrician, turner, millwright, carpenter, tiler, etc. Supervision, education, and work help rehabilitate convicts. By law, the prison must supervise inmates, organise productive activities based on their rehabilitation needs, and provide ideological, cultural, and technical education.

8.7. Education

Educational rehabilitation refers to mandatory ideological, cultural, and technical instruction for Chinese prisoners. Educational reformation is an obligatory, basic sort of reformation meant to transform offenders into new individuals.

The education and reformation of offenders should adhere to the principles of individual education, classification education, and reasoning. The process should combine collective education with individual education while also combining education within the prison with social education and introducing social resources to the maximum extent possible, for example, to enable offenders to keep abreast of the social development situation and lay the foundation for life after prison. Through educational and reform activities, prisons help criminals realise their illegal behaviour and its dangers. They then utilise a variety of methods to remedy vices.

8.8. External Help through Families and Support Groups

Family support for offenders means the offender's family provides material, emotional, and informational support. These materials can help a prisoner cope with frustrations and emergencies. The Regulations on Offender Access to Communication state that family support providers are relatives and guardians. Parental, sibling, and spousal support are all im-

portant when it comes to family. Family meetings (including remote video meetings), phone calls, shared meals, mail, remittances, and affectionate support are important to offenders. Offenders outside prison only have family support. Positive and timely family assistance allows criminals to receive affection, boost their confidence and stress resistance, effectively cope with serving their sentence, and resocialise (Liao WH, 2021).

8.9. Participation of Non-Profit Organisations in Prison Social Work

The UK and the US have systems that allow social workers to intervene in court as professionals. Although social work's role has been recognised in China, social workers are not yet seen as professionals in court. Judicial, theoretical, and public awareness of social work is low. Social work is still considered a tool for judicial administrative oversight. Very few non-profit organisations in China are committed to rehabilitating convicts, and the pathways for them to intervene are still being explored. Non-profits can rehabilitate convicts through community rehabilitation, employment acceptance, social aid and education, and post-event supervision (Jiang T, 2007).

8.10. Reintegration/Rehabilitation/Reentry

Resocialisation occurs when a person's behaviour violates the social code of conduct and moral norms or deviates from the mainstream social model. In a narrower sense, resocialisation is represented by prisons and refers to coercive rehabilitation, where the perpetrator is forced to undergo social rehabilitation to reshape society, correct behavioural deviations, and restrict personal freedom. This is usually done with professional correctional and management staff, in a special place and with special mechanisms.

General and exceptional recidivism are types of reoffending. General recidivism is broader than recidivism and isn't limited by sentence or time served. Socially detrimental recidivism can be punished harshly. Some national laws add culpability for recidivism. China has no general recidivism provisions, but it does have some provisions for special cases, such as those convicted of a specific offense who commit it again, known as 'special recidivists'. Article 356 of the Criminal Code states that if a convicted drug smuggler, trafficker, transporter, manufacturer, or illegal possessor

performs the same offense again, the penalty is increased. Statutory aggravating circumstances include reoffending.

8.11. What are the Barriers for Social Work in the Prisons?

Social rehabilitation law is incomplete. The legal framework of social correctional work for criminals lacks essential rules and regulations. There is no written special law; only the Prison Law, Section 5, Articles 36, 37, and 38 of 'release and resettlement' establish general, non-specific requirements.

Social support or rehabilitation is lacking. Social rehabilitation requires coordination and communication between several departments, including public safety, courts, prisons, resettlement, community, labour, and personnel.

Social rehabilitation efforts lack depth. There are three main forms of social help and education in China. Firstly, social help and education personnel come to the prison to give reports, speeches, policy propaganda, etc. Secondly, the relatives of criminals, colleagues, and friends from the criminals' original unit come to the prison to do persuasion and probation work, and they sign a help and education agreement, which confirms mutual cooperation and joint responsibility for the education and reform of criminals. Thirdly, the prison forms an arrangement with the offender's government, which sends correctional workers to the prison.

Social rehabilitation is harder. The courts, prisons, public security guards, resettlement and rehabilitation, and community work are not coordinated enough, so relevant information cannot be shared. As a result, foreign criminals in other provinces are difficult to catch, and released prisoners are difficult to cross-check.

8.12. How Can These Challenges be Addressed?

The focus needs to be on solving the key challenges of social help in our jails, doing a good job, and enhancing the efficacy of help and education work. Education should be supported, as well as legal and moral education for mental health. Employment should also be promoted. Criminals should be included in local vocational skills training and provided with employment support, vocational coaching, and other services. Social insurance should be implemented. The prison system and community correc-

tion departments should communicate and coordinate with social security departments. Prison and community offenders can adopt basic medical insurance and other medical security policies and enjoy unemployment insurance treatment. Enough living aid should be provided. The prison system and community correction departments should contact and work with civil affairs departments to help prisoners and community offenders with basic living needs.

8.13. Improving Prison Social Work

Social support and education are the most effective ways for social forces to help convicts. Full-time law enforcement teams within the workforce are required, but it is also important to widely mobilise social workers and volunteers, as well as social organisations, schools, family members, and other social forces, to do a good job in terms of prison education and rehabilitation, and community correction work. Within the work method, it is necessary to fully recognise the role of professional organisations and professionals and encourage the comprehensive use of sociology, psychology, pedagogy, law, social work, and other disciplines. In terms of system and mechanism, it's important to rely on villages, grassroots groups, all relevant departments, appropriate rules and measures, and the smooth return of offenders to society (Li YQ, 2015).

In conclusion, social work in China's penitentiary system is still at a relatively preliminary stage, and many aspects of work need to be improved, especially in medical care, education, vocational training, psychological counselling, social support, etc.

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5 Kazakhstan: Social Work and Health in the Penitentiary System

Dinara Yessimova, Mariya Prilutskaya, Dalida Mukasheva, Medet Kudabekov, Sandugash Ismagulova, Zhanar Shaidullina

This chapter deals with the development of social work and health services in Kazakhstan's penitentiary system in the light of the systemic reforms. The steady reduction of the prison population reflects the changes in Kazakhstan's law enforcement system. The introduction of alternative means of punishment and the development of the probation service are key measures in addressing a number of issues: overcrowding, stigmatisation, criminal recidivism, and recourse limitations. Although a wide range of legal amendments have been launched over the past decade and fundamental international standards have been ratified, Kazakhstan still faces an urgent need for suitable policies regarding the well-being and health of the prison population.

Considering these issues, the main objectives of the chapter are to provide insights into social work and health services in Kazakhstan's penitentiary system, to understand their structural barriers, and to identify the potential for future developments. The chapter describes the legal basis of social work in Kazakhstan's prisons and provides information on the policy reforms in the field. The last section of the chapter sheds light on the current integration of prison health into public health services. The first positive results and the pitfalls of this reform are discussed in the context of evidence-based recommendations and international research data.

1. Social Work in Kazakhstan: Context, Reforms, and Institutionalisation

In order to understand social work and health services in prisons in Kazakhstan, it is necessary to provide information about the context of social work. Considering Kazakhstan as a case study, it is impossible not to focus on the enormous institutional changes in the field of human rights and political movements towards achieving greater social justice for citizens. With regard to the protection of human rights, this resulted in the adop-

tion of the Constitutional Law on the Human Rights Commissioner, who is today endowed with greater powers than before (Constitutional Law of the Republic of Kazakhstan, 2022). According to the new constitutional law, not only legal experts but also representatives from civil society with a background in social work can apply for the position of the Human Rights Commissioner.

Currently, Kazakhstan implements the 'Human Rights Commissioner PLUS' model, in which human rights protection is accompanied by a national preventive mechanism against torture (NPM) that conducts independent monitoring through both scheduled and special visits to prison institutions (Penal Reform International, 2013). Since 2014, the NPM has been introduced in all regions and its members have visited prison institutions to independently monitor and develop proposals for improving the maintenance of prisoners and ensuring their basic social rights. In each region, the branch office of the NPM includes one head of the representative office and two to three employees who, at any time, can visit penitentiary institutions in the region at the request of relatives or based on the appeals of the prisoners themselves.

People in prison can issue an electronic application or petition through the terminals installed in each prison facility in Kazakhstan. From 2014 to 2019, there were no social work experts among the members of the NPM. Since 2019, two academically trained social workers have been participating in the NPM's monitoring visits in the largest cities, Astana and Almaty. Due to the fact that the involvement of social work specialists and their visits to prisons and detention institutions proved to be a useful, effective and practical instrument for developing recommendations, in December 2022, three social work graduates were additionally selected to join the NPM. This is also a key driver for strengthening the role of professional social work in the field of human rights protection in Kazakhstan.

Professional social work is also in demand at the expert level. Social workers at the macrosocial level have successfully performed as decision makers and policymakers. The head of the National Alliance of Professional Social Workers of Kazakhstan is a member of the Human Rights Expert Council under the Commissioner for Human Rights in the Republic of Kazakhstan. This fact may contribute to the active utilisation of social work tools and advocacy of the social work mission and mandate, which embrace movements towards social justice and the empowerment of each individual.

Human rights violations stem from a violation of basic social human rights. This is why the human rights approach in social work is one of the most relevant issues on the country's agenda. In Kazakhstan, significant

policy reforms have been introduced in various areas of social, economic, and political life. The majority of these reforms are stipulated by the fundamental strategic programme 'New Kazakhstan, Fair Kazakhstan', which plays a conceptual role in the strengthening of social work at the highest level of public administration. Despite its youth as a profession in Kazakhstan, professional social work already has the prerequisites to be integrated into the penitentiary system framework. Kazakhstan plans to introduce social work into the system of penitentiary institutions in 2023, starting with a team of social workers for detained persons with disabilities who will organise their intra-prison support. This is a progressive move which is in line with the Mandela Rules, the UN Sustainable Development Goals, and the Constitution of the Republic of Kazakhstan.

In connection with changes in the socio-economic situation, as well as the institutionalisation and strengthening of power in the country, social policy approaches are being reviewed, with an emphasis on a client-oriented approach. The development of the Social Code is on the agenda. The president of the country noted that the Social Code should be a key element of the new 'social contract' (Vlast, 2021). It should be noted that in recent years, the initiatives to develop social work as a professional activity have also been supported by the Ministry of Labour and Social Protection, which is responsible for developing the social protection system and supports the idea of introducing a social worker position in penitentiary institutions in the near future.

2. *Legal Regulations for Social Work in Kazakhstan Prisons*

The basis of the legislation of the Republic of Kazakhstan in the penitentiary system is the Penal Code, adopted on 5 July 2014, No. 234-V. This Code is based on the Constitution of the Republic of Kazakhstan and the generally recognised principles and norms of international laws and other regulatory legal acts that establish the procedure and conditions for sentence serving and other measures of criminal law punishment.

International treaties ratified by the Republic of Kazakhstan have priority over national legislation and are applied directly, except when the application of the international treaty requires the issuance of a law.

The goals of the penal legislation of the Republic of Kazakhstan (2014) are the restoration of social justice, the correction of convicts, and the prevention of new criminal offenses by both convicts and other persons.

The tasks of the penal legislation encompass regulating the procedures and conditions for the execution and serving of sentences and other mea-

sures of criminal law influence. The legislation obliges the prison system to guarantee the rights and freedoms of the convicted and to assist them in the process of social adaptation.

The execution of punishments and other measures of criminal law influence is not intended to cause physical suffering or the violation of human dignity. The principles of penal legislation underline the importance of rights, freedoms and legitimate interests, and humanism while striving to impose differentiated, individualised, and rationalised measures of punishment with corrective actions. Correction is provided through a regime of serving a sentence, educational impact, positive social ties, socially useful work, education (primary, basic secondary, general secondary, technical, and vocational), and social impact.

Guardianship and public supervisory boards, committees of the parents of convicts, trade unions, labour collectives, public associations registered in accordance with the legislation of the Republic of Kazakhstan, religious associations, public and charitable foundations, political parties, other organisations, and citizens can all participate in the correction of convicts by getting involved in sociological and other kinds of monitoring, public discussion surrounding the development of legal acts, humanitarian and charitable campaigns, and NGO programmes.

Convicts in penitentiary institutions have the right to be informed about the procedures and conditions for sentence serving, to file a petition for pardon addressed to the President of the Republic of Kazakhstan, to send oral and written proposal, statements, and complaints to the administration of the penal institutions, courts, prosecutors, and public associations, to give explanations, conduct correspondence, and submit proposals, applications, and complaints in their native language or in any other language that they know, or to receive the services of an interpreter or translator. The Penal Code ensures convicts' right to qualified legal assistance, health protection and qualified medical care, psychological assistance from the psychological service of the penal institution, social and pension provision in accordance with public legislation, safe working conditions, rest, vacation, and wages in accordance with the labour legislation of the Republic of Kazakhstan.

Convicts who have a speech, hearing, or vision impairment have the right to use the services of specialists who know the Dactyl sign language or Braille. Convicts cannot be subjected to clinical trials. Persons sentenced to punishments not related to deprivation of liberty who have mental or behavioural disorders, including those associated with the use of psychoactive substances that do not cause psychosis, are subject to com-

pulsory medical measures in accordance with the Criminal Code of the Republic of Kazakhstan.

In the case of sentenced persons who need treatment for mental or behavioural disorders associated with the use of psychoactive substances, compulsory medical measures are carried out in penitentiary institutions. Sentenced persons suffering from tuberculosis or other infectious diseases who have not completed a full course of treatment also receive compulsory treatment.

With regard to persons sentenced to imprisonment for committing a crime against the sexual inviolability of minors, the administration of the institution – not later than six months before the expiration of the prison sentence – sends materials to the court to request a forensic psychiatric examination to establish whether the individual has any mental deviations or tendencies towards sexual violence. The provisions outlined here do not apply to convicts who, following a court decision, receive compulsory medical treatment in connection with a mental disorder. Convicts engaged in labour are subject to compulsory social insurance in accordance with the legislation of the Republic of Kazakhstan. Convicted women are provided with social benefits in case of loss of income due to pregnancy and childbirth in accordance with the legislation of the Republic of Kazakhstan on compulsory social insurance. Convicts have the right to social and pension provision in accordance with the legislation of the Republic of Kazakhstan. With regard to convicts serving deprivation of liberty sentences in institutions, the operation of voluntary medical insurance is suspended until the end of their sentence.

According to Article 125 of the Penal Code, the administration of penitentiary institutions provides social adaptation and psychological support for convicts on an individual basis and in accordance with their needs. Social adaptation is carried out in various forms, including the development of individual social programmes and the provision of legal assistance. The Code states the key role of state bodies, local executive bodies, and communities in strengthening positive social ties and resocialisation processes.

In order to correct convicts, the administration of the institution contributes to the restoration of their social status as a full member of society and their return to an independent life in society on the basis of the rule of law and generally accepted norms of behaviour (resocialisation).

Involved in the educational work with convicts is a psychologist who diagnoses the individual psychological characteristics of each convict's personality and provides psychological assistance to convicts in adapting to conditions of isolation, the social environment, and the regime of detention; optimising interpersonal relationships; and preparing for release.

According to Article 125 of the Penal Code, organisations of convicts are created on a voluntary basis, working under the control of the administration of the institution in order to facilitate the correction of convicts in penitentiary institutions.

The voluntary organisations aim to facilitate a positive moral and psychological climate in the institution, develop positive social connections between convicts, support the socially useful initiatives of convicts, assist in mental, professional, and physical development, and organise work, life, and leisure in penal institutions.

In institutions, it is guaranteed that convicts under thirty years of age must receive primary, basic secondary, or general secondary education (Article 127 of the Penal Code of the Republic of Kazakhstan), while prisoners over thirty years old and convicts with disabilities receive primary, basic secondary, or general secondary education at their request.

3. *Socially Oriented Reforms of the Penal System in Kazakhstan*

The Constitution of the Republic of Kazakhstan affirms the social nature of the state, the highest value of which is the individual, his rights, and his freedoms (Article 1). The Constitution declares that human rights and liberties determine the content and application of laws and other legal acts (Article 12), excludes the possibility of discrimination on any grounds (Article 14), and emphasises the inviolability of human dignity (Article 17).

The process of the formation and development of prisons in Kazakhstan can be divided into two stages: Stage I: from October 1917 to the late 1920s, characterised by the development and adoption of normative acts regulating the activity of prisons on the basis of the experiences of the penitentiary systems of Western Europe and the USA, and the practical implementation of these acts, as prisons were not transformed into educational institutions. Stage II: from the mid- 1930s to 1991.

The main goals of prison reform is to stop the growth of the prison population since Kazakhstan once ranked 33rd in the world in terms of the number of people held in colonies and prisons. There were 316 convicts per 100,000 population. This was twice as high as the international average.

In 2013, the country held its first Prison Reform Forum. This forum became a platform for discussing a strategy for Kazakhstan to move out of the top 50 countries with the largest prison populations. An important

argument in favour of prison reform is economic, since in 2012 the maintenance of one prisoner cost the Kazakh treasury 580 thousand tenge.

The Penal Code of the Republic of Kazakhstan was adopted on 16 July 1997 and came into force on 1 January 1998. It culminated in developing and applying the 1959 Penal Code of the Kazakh SSR, which had been amended and added to over thirty-five years.

Since 1997, Kazakhstan has significantly increased the length of the prison sentences it issues for the most common offenses. From 1997 to 2007, the cost of maintaining Kazakhstan's prison system grew steadily, while the number of convicts did not change, and the level of post-penitentiary recidivism remained very high (Turetskiy, 2022).

As a result of this situation, in 2009, the Legal Policy Concept set the objective of bringing the penal enforcement system closer to generally accepted international standards. In 2010, the President signed a decree on measures to improve the effectiveness of law enforcement and the judicial system in the Republic of Kazakhstan (Decree of the President of the Republic of Kazakhstan, 2022).

In 2012, Kazakhstan adopted the 'Programme for the Development of the Penal and Correctional System for 2012–2015'. The need to revise domestic prison policy included a wide range of measures: support for alternative sentences and preventive measures, revision of legislation and reduction of sentences, full-scale introduction of probation, changes in sentence terms, and provision of jobs for prisoners. In 2012, the probation service was established in Kazakhstan, in pilot mode and only for those who had been conditionally convicted.

To significantly reduce the number of prisoners, some offenses were decriminalised, the scope of non-custodial sentences was expanded, and maximum prison sentences were reduced for certain crimes. The new Penal Code, the Criminal Procedure Code, and the Penal Enforcement Code entered into force in 2015 (D.Kanafin, 2022).

In recent years, Kazakhstan has moved towards changing its penal and correctional practices. The new Penal Code is based on the Constitution of the Republic of Kazakhstan and the social values and universally recognised principles and norms of international law enshrined therein. It contains several fundamental provisions that distinguish it from the old Penal Code and are primarily aimed at protecting the individual, society, and the state.

The government recognises the importance of the development of the penal and correctional system. The reforms carried out in the penal and correctional system are, first and foremost, purposeful improvements of

legislation and a systematic transition from an outdated mechanism to a modern model.

The organization International Prison Reform played an important role in the reform of Kazakhstan's prison system and in the introduction of alternative non-custodial measures. In addition to the issues of humanisation, resocialisation, and support of external relations with relatives, the deputies are concerned about the employment of former prisoners. In order to transfer production to the management of the prison institution, the deputies are developing appropriate bills to amend the legislative framework.

In order to change the public perception of prisoners as people lost to society, it is necessary to involve non-governmental organisations, according to the Government of the Republic of Kazakhstan. Taking international experiences into account, the deputies believe that NGOs can play a central role here. However, among the factors hindering the implementation of activities in this area within the framework of the state social order are insufficient material and technical basis; the short-term implementation of projects; lack of effective interaction between NGOs, the state, and business structures; and a mismatch between the real problems of the population and the lack of methodological support from the state. In terms of prison reform, a special role was played by Penal Reform International, a global non-governmental organisation working on criminal justice reform around the world.

Since 2013, 14 penal colonies have been closed in the Republic of Kazakhstan. There are now 80 institutions (64 colonies and 16 pre-trial detention centres), in which 33,000 convicts and remand prisoners are held.

Under Article 89 of the Penal Enforcement Code, the modern prison system consists of the following types of institutions: minimum security institutions, medium security institutions, medium security institutions for the detention of juveniles, maximum security institutions, extreme security institutions, total security institutions, and mixed security institutions.

In 2015, the state programme '100 Concrete Steps to Implement the Five Institutional Reforms' was adopted. In 2016, six public-private partnership (PPP) projects were developed for the construction of specialised correctional facilities. After evaluating these projects, it was decided to abandon the plans to build new penitentiary as PPPs. In addition, the government decided to change the legal form of the existing correctional facilities (Davydova, 2017).

However, due to a lack of investors, this proposed reconstruction was never carried out. Similarly, the attempt to shift responsibility for the work of the probation service and resocialisation of convicts from the penitentiary system to *akimats* and health care, justice, labour, and social welfare authorities led to a sharp increase in post-penitentiary recidivism. Thus, the Committee of the Penal and Correctional System was not ready for the reforms that were planned in 2015.

The implementation of the Mandela Rules into the national legislation started in 2015. This introduced four forms of probation (pre-trial, sentencing, penitentiary, and post-penitentiary). Since then, the quality of social, legal, and psychological assistance to people in prison has improved. Digitalisation is actively being introduced in the penal system and services as an additional tool to ensure the rights of convicts are observed.

Efforts are being made to improve the legal situation of convicted persons. From January 2020, for example, amendments were made to criminal and criminal procedural legislation that simplified the procedure for transferring prisoners to their place of residence. The process for sharing an inmate to a penal colony at their place of residence was also simplified; restrictions on the transfer of medicines were lifted; deadlines for the consideration of applications for release on the grounds of illness were reduced; and the right to submit applications electronically was granted. Following the Presidential Decree on Further Measures in the Field of Human Rights, a relevant Priority Action Plan is being implemented.

The *Majilis*, the lower house of the Parliament of Kazakhstan, introduced amendments to the legislation of Kazakhstan regarding the possibility for convicted women to stay with their children for an additional year after the child reaches the age of three. This is aimed at preserving the social ties between convicted mothers and their children and the possibility of organising the educational process and development of the children in a children's home.

It has been proposed to provide in Article 75 of the Criminal Code a norm allowing the court to apply deferment of punishment to convicted persons who have a serious illness when sentencing them to imprisonment. If this proposed amendment is adopted, when sentencing a person, the court will have the opportunity to apply deferment of serving the sentence if the defendant has a serious illness. This will give the condemned person an opportunity to receive timely, qualified treatment in civil medical institutions.

In order to provide more effective education to convicts, it has been proposed to make amendments to the Criminal Code to detain those serving their first prison sentence separately from those who have already

completed a prison sentence (Consultative document, 2022). To facilitate constant monitoring in real time and prevent possible offenses being committed by inmates and staff, the idea of providing full video surveillance of penitentiary institutions (with no blind spots) is being considered, on the instructions of the President of the Republic of Kazakhstan.

Criminal justice reform has reduced the number of convicted prisoners and detainees from around 63,600 (2010) to around 35,200 (2018).

Table 1: Prison Population Trends (World Prison Brief data, 2021)

Year	Prison population total	Prison population rate
2010	63,643	393
2012	52,338	314
2014	49,821	289
2016	39,179	221
2018	35,219	192

However, according to the RK Prosecutor General's Office, the number of repeat offences by convicts on probation has quadrupled, from 248 cases in 2016 to 938 cases in 2017, while the overall reduction in criminal offenses compared to 2016 was 12%. Inspections carried out in 2018 at the request of the Prosecutor General revealed the lack of the coordinating role of local executive bodies in the resocialisation of convicts and insufficient cooperation between health, justice, labour, and social welfare agencies (Stativkina, 2018).

In 2018, the Strategic Development Plan of the Republic of Kazakhstan 2025 was approved, which includes seven reforms that are global in nature for Kazakhstan. (Legal acts, 2022).

The following provisions of the Strategic Plan 2025 are relevant for the development of the penitentiary reform programme. The 'Strategic Plan – 2025' is a working document of the government created to implement the tasks of the third modernisation, which includes seven reforms that have a global nature for Kazakhstan, directly affecting millions of Kazakhstani people. Prison reform is one of the components of the global reforms and is conducted in accordance with its principles and objectives. State, business and civil society participate in prison reform.

Initiative 4.3, 'Further Humanisation of the Criminal and Administrative and Social Legislation' – possibilities will be identified for further humanising criminal policies, primarily in the area of economic crime,

taking into account risks to the rule of law. Further work on the decriminalisation and humanisation of economic criminal offences with a low degree of public danger, including tax, customs, and others, is planned.

Initiative 4.4, 'Modernisation of Criminal Proceedings' – envisages the gradual introduction of a pre-trial process model based on the principles of developed countries, which implies strengthening the guarantees of human rights protection against unjustified involvement in criminal proceedings, reducing prosecutorial bias, and increasing objectivity in making procedural decisions in criminal cases. The adversarial principle will be introduced more broadly, giving the defence more significant opportunities to gather evidence and present it to the court.

Initiative 4.5, 'Development of the Law Enforcement System' – the development of law enforcement agencies and the improvement of their forms and methods of operation will continue.

Initiative 4.14, 'Improvement of Penal Measures' – the scope of application of non-custodial criminal sanctions will be expanded. The system of executing criminal sanctions will be brought closer to international standards. Personal security and respect for the rights and legitimate interests of persons serving this type of punishment will be ensured in places of deprivation of liberty (On approval of the Strategic Plan, 2022).

In order to further improve the penal and correctional legislation and the penal system and to enhance the efficiency of penal and correctional activities in the Republic of Kazakhstan, it is necessary to continue the implementation of international legal acts in the treatment of prisoners and their harmonisation with the norms and institutions of the national penal and correctional legislation. It is necessary to enhance its role and significance in the system of legislative regulation of interaction between the state and civil society in crime prevention.

Kazakhstan has ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, thus committing itself to establishing a National Preventive Mechanism (NPM) in the country (Law on Ratification of the Optional Protocol, 2008). On 2 July 2013, the Law of the Republic of Kazakhstan 'On Amendments and Additions to Certain Legislative Acts of the Republic of Kazakhstan on the Creation of a National Preventive Mechanism for the Prevention of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment' was adopted (Law on the Establishment of the NPM, 2013).

In April 2014, the NPM in Kazakhstan began work on the prevention of torture and other cruel, inhuman, or degrading treatment or punishment.

The NPM was established as part of the implementation of the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. Its main purpose is to prevent and combat torture and ill treatment and to eliminate the causes and conditions contributing to them in places of detention and restriction of freedom. All prisons are subject to preventive visits by NPM participants.

The aims and objectives of NPM, its conditions, the rights and obligations of its participants, and the requirements for applicants are set out in the Penal Enforcement Code of the Republic of Kazakhstan, the Code on Public Health and the Health Care System, and the laws on the rights of children in the Republic of Kazakhstan, on special social services, on preventing juvenile delinquency, child neglect, and homelessness, and on compulsory treatment for alcohol, drug, and toxic addiction (Information of the Commissioner for Human Rights [Ombudsman] in the Republic of Kazakhstan Concerning the National Preventive Mechanism Under the Optional Protocol to the Convention against Torture, 2022).

Elected NPM participants might be members of public monitoring commissions, public associations, or social NGOS; lawyers; social workers; or doctors. NPM participants are divided into regional groups, a purely practical solution for a ninth largest country in the world.

In the few years of the NPM's existence, its participants have managed to identify a number of serious violations in the work of law enforcement bodies and prison administration related to the detention conditions, torture, ill treatment, and punishment of persons deprived of their liberty, which triggered the modernisation of law enforcement agencies and the implementation of institutional reforms in the rule of law. Thus, in order to implement international commitments and domestic policy objectives, the Office of the Prosecutor General of Kazakhstan initiated the project 'Towards a society without torture'.

The project is aimed at developing a comprehensive system of measures to prevent, investigate, and rehabilitate cases of torture and ill treatment in Kazakhstan.

The NPM has managed to improve detention conditions in the country's closed institutions; modernise medical rooms; recruit staff, taking gender considerations into account, and ensure the presence of male and female staff in temporary detention facilities (East Kazakhstan and South Kazakhstan regions), special reception centres (East Kazakhstan region), and juvenile adaptation centres (South Kazakhstan region).

Recommendations made by NPM participants for closed institutions in the South Kazakhstan and Pavlodar regions helped in the development of special infrastructure for persons with disabilities.

At the same time, the penal and correctional legislation of the Republic of Kazakhstan provides for public control over the observance of prisoners' rights in penitentiary facilities. The lawmakers name public monitoring commissions (PMCs) among the parties that can exert such control. PMCs enjoy the right to visit penal facilities of the Ministry of Internal Affairs, meet with inmates, check the conditions of their detention, and assess the status of the protection of the rights and legitimate interests of inmates in specific institutions.

However, despite the significant progress that has been made, the NPM in Kazakhstan must continue to improve. In particular, the creation of a separate law on NPM in Kazakhstan remains an open question. At the same time, maintaining a fragmented reference to NPM in various laws and codes is also important in terms of the mechanism's visibility. Other challenges facing the NPM in Kazakhstan include increasing its independence through the transfer of NPM budgeting functions to the NPM Coordinating Council, establishing a separate law on the NPM Ombudsman's activities, and creating a separate NPM Law. The question of creating a separate law on the activities of the Ombudsman for Human Rights in the RK would involve enshrining in that law its functions in coordinating NPM activities and expanding its staff, as well as the aim of creating a separate unit to support NPM activities.

Thus, NPM and PMC activities combine and complement each other, which contributes to better differentiation of public control measures. Undoubtedly, this is a positive development related to the implementation of the 2010 Concept.

4. Prisoner Health and Medical Services

A vast array of research and social projects highlight the unprecedented degree of distress and vulnerability of various kinds that imprisoned people face as part of their criminal punishment. Incarceration based on the principle of specific and general deterrence entails a myriad of moral and material disturbances that increase the economic, social, and health risks for individuals and communities. Objectively, intensity of stress is associated with numerous mental diseases registered in prison populations all around the world. A recent international meta-analysis by Facer-Irwin et al. (2019) confirmed that the prevalence of PTSD in prison populations is, like other mental disorders, significantly higher than in community populations, with a pooled point prevalence of 6% in male prisoners and 21% in female prisoners.

This dramatic difference between the prison and community populations stems from the fact that prison populations have inappropriate access to the qualified and advanced health services available to the general population. With overcrowding and poor hygienic conditions, incarceration all around the world is associated with the higher likelihood of contracting infectious diseases that could undermine anti-epidemic and anti-pandemic policies of whole states and geographical regions, including those in place for general population (Wali et al., 2019).

In the Central Asian region, Kazakhstan – alongside Turkmenistan – has taken a leading position in the ranking of prisoner numbers for more than three decades, despite the downward trend in the country's prison population rate (per 100,000), with a reduction from 520 in 2000 to 177 in 2017. According to the International Centre for Prison Studies (ICPS), Kazakhstan ranks 55th in terms of the total number of prisoners (World Prison Brief, 2022). According to the Consolidated Report of the National Preventive Mechanism in 2019, there were 17 departments, 82 institutions (66 corrective colonies and 16 pre-trial detention centres), and 246 probation service departments in the national penitentiary system structure (Human Rights Commissioner in the Republic of Kazakhstan, 2022). Figure 1 illustrates the dynamics of the prison population across a 17-year period (absolute value) (Bureau of National Statistics of the Agency for Strategic Planning and Reforms of the Republic of Kazakhstan, 2022). As can be seen from the figure, during the Covid-19 pandemic, the number of imprisoned people has increased, which contradicts the worldwide trend and should be considered as an additional challenge for the system of social and health services in prisons.

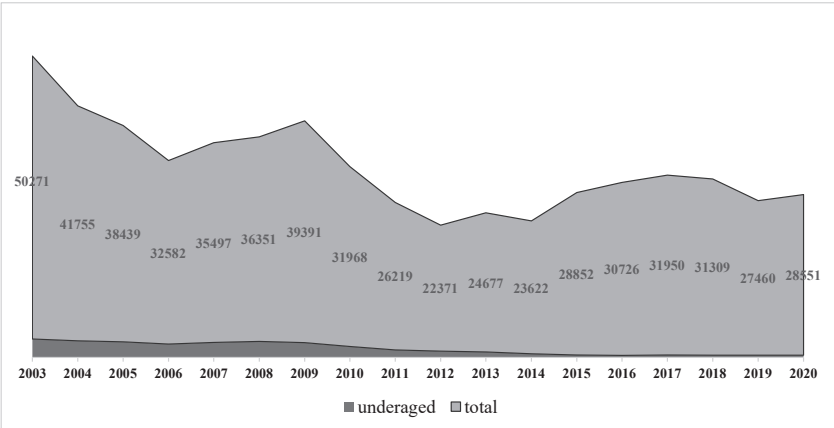

Figure 1: Size of the Prison Population in Kazakhstan, 2003–2020

As of May 2022, the number of penitentiary institutions has decreased to 80, with 16 pre-trial detention centres, three correctional facilities for women, and one mother-child prison (for children up to the age of three). Penitentiary institutions differ in form and exercise various levels of social restrictions. As described above, all the regulations and organisational standards of penitentiary processes are provided in accordance with the Penal Code, established 5 July 2014.

Among other basic rights and human guarantees for convicted persons, the Code also includes the right to protection of health and to receive adequate medical treatment in accordance with the legislation of the Republic of Kazakhstan in the field of health care services. Furthermore, psychological aid and social security with pension benefits are stated as well-being guarantees in Kazakhstan's prisons. Additionally, the issues of medical and sanitary provision are regulated by Article 117 of the Penal Code. It is stated that '… medical assistance to convicts is provided in accordance with the legislation of the Republic of Kazakhstan in the field of healthcare', which in turn is regulated by the Code 'On Public Health and Healthcare Systems', established in 2020.

The Penal Code establishes the structural framework of prison medical settings, which encompasses somatic, psychiatric, and tuberculosis hospitals, medical units, and medical stations. As of May 2022, penitentiary medical facilities in Kazakhstan were comprised of 48 medical departments in prisons, 16 medical units in residential corrective colonies, and 16 medical chambers in pre-trial detention centres. All the medical divi-

sions provide primary and secondary medical care. Currently, in-patient medical-care centres include one hospital for somatic diseases, one hospital for mental diseases, and two for tuberculosis.

Compared to previous years, in 2022, there was a reduction in the number of prison medical centres. This was due to the steady decrease in the prison population as well as the growing role of primary and secondary public health services that are also available to prisoners.

The process of transferring the medical service from the Ministry of Internal Affairs to the Ministry of Healthcare started in 2020 and included the adaptation of legal acts and Article 143 of the Code, 'On Public Health and Healthcare Systems.' As a result, convicted people are now able to receive medical support for free, as stipulated in the Guaranteed Basic Package of Free Medical Services. It is claimed that the coverage of the Package is equal for all Kazakhstani residents and includes emergency and primary health services and treatment of HIV, tuberculosis, and other infectious diseases as well as chronic diseases and mental disorders (including substance abuse). The medical services that go beyond the Basic Package (e.g. tertiary treatment, planned surgical operations) are provided by the Mandatory Medical Insurance Programme and are fully subsidised for convicted people by the state (with the exception of prisoners placed in minimal security penitentiary settings, who are required to pay insurance fees themselves).

In addition to the Codes, the practical aspects of medical support in prisons are regulated by several orders launched by the Ministries of Internal Affairs and Public Health. For instance, the most overarching legal order in the field, 'Rules of Medical Help Provisions for People Sentenced to Prison Punishment and Those in Pre-Detention Centres', embraces a diverse array of organisational procedures for HIV and tuberculosis prevention, drug addiction treatment in prisons, sanitary and hygienic control, maternity and child support, and pharmaceutical provision. According to the Rules (Ministry of Internal Affairs, 2020), people in prison settings receive medical support from both penitentiary and public health specialists. In practice, all of Kazakhstan's prisoners can receive basic medical services from primary public health facilities, according to the principle of catchment area jurisdictions. For the last several years, general practitioners have provided prisoners with screening tests for oncopathology and free vaccinations (including Covid-19 vaccinations).

Furthermore, general practitioners, in collaboration with prison medical specialists, have undertaken annual medical check-ups for prisoners with referrals to community medical specialists, if necessary. The active referral of prison patients to public HIV and anti-tuberculosis services,

with regular consultations and therapy provision, has been practiced in Kazakhstan for the last decade. Namely, as of August 2022, according to the official information of the governmental bodies, 1,350 HIV-positive incarcerated people had received antiretroviral treatment (ART), with a 67% effectiveness of viral suppression. Meanwhile, the issue of HIV in Kazakhstan's prisons remains.

In 2019, the HIV prevalence in penitentiary settings was as high as 3.6%. The majority of HIV cases stem from injection transmission due to drug addictions. According to the national epidemiological sentinel data, the estimated number of drug-dependent prisoners with HIV was 1,539 in 2019 (Kazakh Scientific Center of Dermatology and Infectious Diseases, 2020). In terms of tuberculosis measures, the reduction of the prison population, active implementation of fluorographic screenings, and higher utilisation of standardised treatment protocols led to a 14.3% reduction in the number of tuberculosis cases between 2014 and 2018 (Dadu et al., 2021). Strengthening tuberculosis diagnostic capacities as well as increasing the awareness and competencies in this field are highlighted as key milestones in the National Comprehensive Plan for the development of the Anti-Tuberculosis Service in the Republic of Kazakhstan for 2021–2025 (Government Decree, 2021).

In contrast to the aforementioned diagnoses, substance abuse is treated only within the penitentiary setting, by staff psychiatrists/narcologists. Treatment for addiction in Kazakhstan's prisons is substantially limited and inadequate in comparison with the services available in the country's public health sector. According to the official information of the Head of the Medical Chamber of the Penal System Committee, there were 1,126 registered prisoners with drug addictions as of April 2022, with an upward trend having been seen over the last three years. Likewise, the number of prisoners with alcohol addiction rose from 1,218 in 2019 to 1,434 in 2021. Only patients registered as having a drug dependency are entitled to receive the limited, basic treatment services available within the penitentiary system, but even they have neither access to systematic, evidence-based medical and rehabilitation interventions nor to tertiary consultations with public psychiatrists or narcologists.

To the best of our knowledge, the services of psychologists who are employed in prisons do not include addiction screenings or assessments focusing exclusively on suicide prevention and whether prisoners are prone to aggression, self-injury, or extremism. In most cases, support for addicted prisoners includes sporadic courses of medication following the cessation of acute withdrawal symptoms (rapid immunoassay testing every three months). Information on the prevalence of opioid poisoning in Kaza-

khstan's prisons is, to the best of our knowledge, not available. To date, it has not been possible to provide naloxone in the country's penitentiary facilities, as the drug is not registered within the country's pharmacovigilance system (Dietze et al., 2022; Sajwani & Williams, 2022).

The majority of substance-abusing prisoners with an officially registered diagnosis receive compulsory treatment by court order. Meanwhile, evidence-based interventions (such as harm reduction through syringe exchange programmes, opiate substitution therapy (OST), peer interventions, psychotherapy, psychological consultations, and motivational interviews) are not available in Kazakhstan prisons (Eurasian Harm Reduction Association, 2021). According to legal standards, following the termination of compulsory treatment within penitentiary medical facilities, convicts have to be under medical observation for five years. If this five-year medical observation period has not been completed upon release from prison, individuals can continue to be observed by mental health centres within the public health sector. To the best of our knowledge, there are no special medical standards on the services and treatment/ interventions provided during the observational period. In practice, compulsory monitoring stipulates a series of clinical interviews, whereby any interventions other than sobriety controlling are beyond the scope of anti-relapse approaches (UNODC, Regional Office for Central Asia; Canadian HIV/AIDS Legal Network, 2010).

NGOs and public HIV centres are responsible for the distribution of harm reduction services, condoms, and informational material in prisons. These activities meet the standards for key groups in the general population, without any adaptation to the context of the prison population (Kazakh Scientific Center of Dermatology and Infectious Diseases, 2020). Systemic monitoring and statistical data on the harm reduction coverage in Kazakhstan prisons are not available, although trace information can be found sporadically in short reports and conference materials provided by the national HIV service provider. In 2017, 710,119 condoms were distributed in places of detention, 2.7 times as many as were distributed in 2016 (258,467). The number of informational documents distributed also increased between 2016 and 2017 (from 55,597 to 110,439) (Shailoobek et al., 2020).

To generalise, legal acts regarding medical services for prisoners have been actively established and amended over the last decade, which is an indicator of overarching reforms within the framework of the national Conception of Legal Policy, which claims to follow the principles of the 'human-centred' model of public administration and humanisation of the penitentiary sector (Decree of the President of the Republic of Kazakhstan,

2021). On the other hand, these reforms have faced a range of challenges and can hardly address the practical issues. For example, Dochshanov & Kravchenko (2015) pointed to inconsistencies in the medical services, which depend on the availability of healthcare resources in the region. The authors pointed out the financial inadequacy of the insurance packages allocated to prison population health, which contributes to pronounced medical and social disadvantages in comparison with the general population. This is exacerbated by the low level of clinical expertise among penitentiary medics, which has been indicated not only by academic experts but also by human rights organisations and international bodies (Human Rights Commissioner in the Republic of Kazakhstan, 2022; Todts et al., 2021).

This can be seen in the fact that the quantitative data on the work of the health and medical services obtained from Kazakhstan's committee of the penitentiary system reveal a downward trend in the staff and equipment capacities of prison medical divisions, alongside a significant increase in the prison population from 2019 to 2021. Table 2 shows a steady decrease in the number of inpatient beds for the treatment of mental diseases, tuberculosis, and other somatic pathologies, while the number of prisoners with infectious diseases (HIV/AIDS, hepatitis B and C, and tuberculosis) has been on the rise since 2019 (+19%). Poor staffing coverage for the prison population (4.11 staff members per 100 prisoners in 2021) is also a cause for concern, considering the key role that trained medical specialists play in delivering prompt and qualified help within the confinement circumstances and for patients with multiple health problems.

Table 2: Health Care Provision for the Prison Population in Kazakhstan

Characteristics	2017	2018	2019	2020	2021
Number of prisoners (males/females)	33,244 30,343/ 2,901	29,875 27,638/ 2,237	28,137 26,153/ 1,984	29,976 27,992/ 1,984	33,599 31,257/ 2,342
Number of prisoners with infectious diseases (HIV/AIDS, hepatitis B and C, tuberculosis) (males/females)	2,816 2,655/ 161	2,534 2,367/ 167	2,133 1,981/152	2,520 2,300/220	2,545 2,363/182
Number of patients registered for socially significant diseases*	4,174	4,158	3,768	4,121	4,318

Number of prisoners undergoing compulsory drug treatment	1,371	1,124	980	869	719
Number of medical staff positions (doctors, nurses)	1472.5	1471.5	1425	1429	1382.25
Number of narcologists, psychiatrists, phthisiatricians, psychologists	196.25	194	179.25	171.5	163.25
Number of inpatient beds in somatic, psychiatric, and tuberculosis hospitals	1,330	1,330	1,220	1,120	1,010
Number of dental offices	71	69	67	67	64
Number of preventive activities in cooperation with AIDS centres (number of distributed condoms and informational and educational documents)	16,109 58,877/ 20,392	17,074 94,830/ 18,234	26,254 100,928/ 19,874	4,805 107,640/ 12,619	4,962 51,403/ 10,960

* Socially significant diseases are diseases predominantly caused by socio-economic conditions, that are detrimental to society, and that require social protection for the individual (HIV, tuberculosis, acute myocardial infarction, rheumatism, systemic connective tissue diseases, degenerative diseases of the nervous system, demyelinating diseases of the central nervous system, orphan diseases, mental and behavioural disorders, diabetes mellitus, malignant neoplasms, chronic viral hepatitis and cirrhosis, cerebral palsy).

To fully understand the context of medical support as a key part of the multifaceted work with prisoners, it is necessary to analyse the barriers that compromise the claimed principles and impede the tasks of current legal acts in the field. Available publications on the pitfalls in the utilisation of prison services have stated inappropriate collaboration between the Ministries of Internal Affairs and Public Health in various fields: data exchange, transparency, accountability mechanisms, and evidence-based policymaking (International Drug Policy Consortium, 2012; Vagenas et al., 2013; McLeod et al., 2020).

To the best of our knowledge, the most recent systemic analytical report to have investigated the practical problems of Kazakhstan's penitentiary medical system was published in 2019 (Todts et al., 2021). The project on the topic of 'Analysis of the state of the medical care system in the penitentiary system of the Ministry of Internal Affairs of the Republic of Kazakhstan' was prepared by the Representative Office of Penal Reform International in Central Asia with the support of the Development Pro-

gramme of the United Nations in the Republic of Kazakhstan and the Commissioner for Human Rights in the Republic of Kazakhstan.

The mixed-method study included surveys of 462 prisoners, 46 penal officers, and 77 independent experts in the field, as well as content analysis, comparisons of legal systems, and pilot implementation of the medical services moved to the jurisdiction of the Ministry of Health in two regions: Almaty and Karaganda. Among the problems revealed at the prisoner level were the following: limited access to or delay of medical care, deficit of secondary and tertiary consultations and treatment, and low awareness of basic rights and social guarantees in the field. The surveyed respondents highlighted poor sanitary and hygienic conditions in prisons. In terms of medical staff, the project registered low proficiency, staff shortages, overworked staff, and high staff turnover.

Mental health disorders (including drug addictions) were indicated as being some of the most pertinent challenges for prison medicine by three respondent groups (inmates, penal specialists, and experts). One striking association was discovered during the study: the more severe the incarceration regime was, the more prevalent mental health issues were. This observation warrants the compelling need for capacity building and systemic reforms as regards access to psychological interventions, training, and the equal availability of psychopharmacological treatment and evidence-based programmes for prisoners with drug addictions. In this regard, local initiatives and pilot projects can be valuable starting points for the implementation and assessment of evidence-based approaches for health care provision in Kazakhstan's prisons.

One example of effective collaboration between governmental bodies and international organisations is the 'Atlantis' project. Supported by the Border Management Programme in Central Asia and the Central Asia Drug Action Programme, the project, which centred on the rehabilitation and resocialisation of drug-addicted prisoners, has been implemented in Central Asia over the past decade. In Kazakhstan, the active phase of the project was from 2007 to 2012. The cutting-edge regional initiative stipulated the pilot introduction of psychosocial rehabilitation according to the Atlantis approach in three of Kazakhstan's prisons: Astana, Semey, and Pavlodar. According to this approach, first introduced in Minnesota prison, detained people with drug-use disorders are allowed to enter the 12-step programme that provides social support in a special clean-zone setting. The principles of therapeutic community and peer-support groups are used to confront the criminal culture and enable the start of the resocialisation process.

In the Pavlodar prison, the programme took place at both a prison-based rehabilitation facility and a halfway house in the community in order to provide a step-by-step approach to resocialisation for those who had been released from the penitentiary treatment centre. A body of media reports described the success of the Atlantis activities, which resulted in a cascade of training and workshops for prison personnel and journalists all around the country (Chistyakova, 2008; Central Asia Drug Action Programme, 2012). Despite showing promising results, the Atlantis project was not expanded nationwide, which could be explained by the lack of support from the high-ranking policymakers responsible for the penal system governance. During that time (2010–2012), the lack of legal procedures for coordination between the Ministry of Internal Affairs and Public Health was also a substantial barrier to the expansion of the project.

5. Discussion and Conclusion

This chapter has presented insights into the development of the role of social work in the penitentiary system in Kazakhstan. The development of professional social work as an academic discipline, profession, and practice has been able to influence the provision of social services for people in prison. Despite the classic conclusion that full responsibility for both the content of services and strategic development in this direction is solely the responsibility of the state, it should be noted that the proactive initiatives and actions of NGOs at the national level are quite positively accepted by the responsible Correctional Committee and the Ministry of Internal Affairs as a whole. The forum 'Social work with convicts', organised within the framework of the SOLID project in May 2022, and the forum organised by UNODC and USAID together with the Correctional Committee of the Republic of Kazakhstan in 2022 were both successful events. A number of sociological studies in 2021 and 2022 demonstrated that in the field of deradicalisation of convicts, it is impossible to do without social workers and that just theological and psychological rehabilitation is not enough (United Nations, 2019; Penal Reform International, 2021; UNODC, 2020).

As part of the implementation of the UNODC project and the Ministry of Internal Affairs, theologian positions were introduced in prisons, which makes it possible to prepare for the response of the system to challenges in certain areas of the penitentiary system. Following the implementation of this project by the UNODC and the Ministry of Internal Affairs, the Kostanay Academy of the Ministry of Internal Affairs allowed it to be piloted in two of Kazakhstan's regions (Karaganda and Pavlodar) and also

permitted the implementation of a needs assessment system and the use of elements of case management with evidence-based interventions (e.g. an individual development plan).

In here, it will be much more preferable to introduce a social worker into the penitentiary institutions of Kazakhstan instead of a theologian. The implementation of this project made it possible to test the components of case management in penitentiary institutions, which is an undoubted step forward in the institutionalisation of social work as a profession in the penitentiary system of Kazakhstan. Even though there were no professional specialists or social work experts from Kazakhstan in the teams of the penitentiary institutions that took part in this project, there was significant expert support from internationally acknowledged social work experts. A progressive moment within the project was the implementation of supervision as a social work approach and quality control of the provision of social services in the project.

These developments suggest that, within the coming five years, social work positions in the penitentiary system will be established and assigned to social work graduates. It is worth noting that after a three-year break of studying for their bachelor's degree in Social Work, their training will be resumed at the initiative of the Correctional Committee at the Department of Social Work of the Kostanay Academy of the Ministry of Internal Affairs.

The state governments are not solely responsible for the development of and reforms in the penitentiary system. UN agencies (e.g. UNODC) that have the appropriate mandate, since becoming a key stakeholder, have introduced a wide range of initiatives supported by the Institute of the Commissioner for Human Rights, professional associations of social workers, and NGOs at the national level, as well as by a number of local NGOs. In addition, NGOs put forward initiatives at their own, as they strive to strengthen the protection of human rights in the prison system by implementing international prison standards.

Recently, the initiatives for the development of social work as a professional activity have been also supported by the Ministry of Labour and Social Protection, which is responsible for developing the social protection system and supports the idea of introducing a social worker unit in penitentiary institutions in the near future. The Ministry of Labour and Social Protection also supported the initiatives of the National Alliance of Professional Social Workers to join the ranks of the International Federation of Social Workers in 2022 and approved the amendments of this organisation to the national ethical rules of workers in the social protection system.

To date, the vast majority of social workers in Kazakhstan, no less than 79%, are employees of the social security and social protection system of Kazakhstan. In the future: in the field of education, through the introduction of a social work specialist position in secondary schools, and in the system of drug treatment and psychiatric services, where the positions are mainly occupied by specialists with a medical background, which indirectly contributes to a greater number of offences being committed and drug users entering places of detention for social reasons. The most important thing is that these percentages change following the introduction of a social work specialist position in penitentiary institutions, when 30,000 convicts will be able to have social support and the system will be able to see the effects of a possible reduction in recidivism.

This can be facilitated by the work of the national-level working group 'Strengthening and raising the status of the social worker', which is led by the head of the National Alliance of Professional Social Workers. The responsibilities of this working group included the revision of the professional standard 'Psychological and Social Work', developed and adopted in 2019. As a result, a draft for the profession of 'specialist in social work in the penitentiary system' with the qualification of Bachelor of Social Work has been proposed in the new edition of the standard. This allow the implementation of the Nelson Mandela standards on a systematic basis and contribute to a greater efficiency of employees of closed institutions, who are also objects of social protection in accordance with the Nelson Mandela international standards.

A wide range of internationally acknowledged and locally ratified legal acts state the priority of health and well-being of vulnerable groups of populations. Detained people limited in their rights and freedoms by punishment sentences and subjected to various sanctions of penal settings are the most vivid example of social vulnerability and exposure to numerous social and health risks. That is why the system of social support and health care in prisons and for prisoners continues to be a central focal point for all humanitarian organisations. Kazakhstan is recognised as a country with an ongoing penal system reform process, where the prison population is reducing and the health system has been transferred to the jurisdiction of the Ministry of Health.

On the other hand, the system of social support programmes and their institutionalisation remain beyond the scope of basic penitentiary policies. In the health context, the main issue of concern lies in the poor and untransparent system for monitoring medical services. The officially available estimates of prison population health relating to drug addictions, mental problems, and infectious diseases yield a range of challenges to

be addressed through multifaceted policies. In terms of prison health, the implementation of systemic measures has to establish internationally acknowledged and reliable services in correctional settings in accordance with the principles of equivalence, continuity, diversion of services, prompt transitional care, and cultural/ethical sensitivity (World Health Organization. Regional Office for Europe, 2019). That warrants activities in four directions: health care, health protection, health promotion, and health resilience (World Health Organization Regional Office for Europe, 2016). The analysis of legal and organisational standards of prison medical services indicated just the initial step in the process of integrating prison health care into the public sector, whereby the legal transition should be followed by capacity building, new budget allocation, and quality standardisation with transparent data processing (Webster, 2013). The principle of equivalence in the delivery of health services necessitates new personnel positions and the upgrading of treatment and diagnostic standards, taking into account social instability, environmental risks, and stigmatisation in prisons. According to Winkelman et al. (2022), services delivered upon release, over a transitional period, play as important a role in prison health care as clinical services do within correctional facilities. According to the authors, rapid movement between community and prison and a lack of transitional support entail high rates of morbidity and mortality, and raise service costs due to emergency visits, infections, and prolonged hospital stays.

In the UK, the process of transferring prison health divisions to the jurisdiction of the public health bodies took five years and went far beyond the legal regulation, which required extensive efforts in commissioning procedures, considering the higher demands of this population group. In the UK, the integration process resulted in the diversification of the services provided on-site in the country's prisons, including primary care, mental health, dentistry, ophthalmology, public health functions, sexual health, and substance misuse (Edge et al., 2022). To date, Kazakhstan's policymakers have not yet introduced any special standards or additional budgets for particular clinical services, increasing only medical personnel salaries.

According to Winkelman et al. (2022), coverage with community-based insurance programmes for the penitentiary population, with transparent processes and quality control, should be a basic imperative for the whole prison health care system at its various levels. In Kazakhstan, the unified state insurance programme stipulates subsidised health care for correctional and pre-trial facilities but does not cover just-released ex-prisoners. Moreover, insurance payment exemptions do not relate to those sentenced

people who serve their punishments in colony settlements (facilities with minimal security), and they have to pay their insurance while working during their sentence.

Previously published research data underline the principal role of the scaling-up of insurance coverage for vulnerable social groups. There is not an available estimate on insurance coverage among Kazakhstan's ex-prisoners, but worldwide the uninsured rates ranged from 40% to 90% in this population group (Winkelman et al., 2017). Although the experiences of high-income countries in implementing special insurance plans for ex-prisoners have resulted in various positive outcomes for vulnerable populations, a range of studies have still indicated a growing need for additional policies addressing the structural barriers both at the insurance company level (competition in the insurance service markets, economic incentives) and at the ex-prisoner level (social and vocational support for ex-prisoners) (Alan et al., 2011; Kinner et al, 2012; Espinosa & Regenstein, 2014; Winkelman et al., 2017). These challenges are also pertinent to Kazakhstan and require fundamental reforms in the national insurance and social support legislation.

Our analysis has revealed that the gaps between public and prison health care systems are even more critical in services for vulnerable social groups. The laws concerning health care provision mostly focus on communicable disease prevention and enforce basic standards of prompt professional reactions to potentially infectious cases. Meanwhile, instructions regarding non-communicable diseases and chronic disorders are fragmental and arbitrarily refer to operational public health standards and treatment interventions. Meanwhile, current international guidelines and publications state that incarceration, psychiatric and substance-use disorders, and infectious diseases form a syndemic and should be addressed with increased funding and special systemic approaches (Fazel et. al, 2022; Massoglia, 2008). While, in Kazakhstan correctional practice, the prevention of infections in prisons is postulated as a main component of health care provision, mental health services have remained underrepresented for three decades.

In a systematic literature review, Simpson et al. (2022) underscored the relevance of the quality of prison mental health services for a wide range of correctional outcomes: reintegration, incarceration and criminalisation recidivism, and community security. Analysing various publications on mental health services in prisons, the authors concluded that the ideal penitentiary mental health system did not exist anywhere in the world. No country has established a system with an exhaustive combination of screening, triage, assessment, intervention, and re-integration (STAIR).

In Kazakhstan, mental health screening procedures are patchy and provided in the form of short clinical interviews with a physician at the moment when a detainee enters a prison or a pre-trial setting. However, some prisoners should be assessed by psychiatrists with clinical interviews and diagnostic psychometric tests on demand. In Kazakhstan's prisons, the most fragmentary items from the STAIR continuum are mental health interventions and reintegration. Our analysis revealed the absence of evidence-based psychosocial care for prisoners alongside harm reduction interventions. We found out that only condoms and informational material are distributed through campaigns founded by the state. Contract treatment units and drug-free units, internationally acknowledged as an effective stimulus for treatment involvement (for patients) and well-being capacity building (for prison administration and personnel), are to date beyond the scope of the national penitentiary policy, regardless of the substantial effects of the past pilot project at the Semey and Pavlodar prisons (Atlantis).

According to Latypov et al. (2014), the experience of all the projects and NGOs initiatives could not compensate for the lack of a multifaceted policy for prison services and necessitates the active implementation of structural, evidence-based approaches and cutting-edge interventions (harm reduction, access to specialised medical care) in Kazakhstan and the whole Central-Asian region.

The main challenges regarding the well-being and health of prisoners encompass the following factors and shortages. The inequality in the provision of medical services for the prison population is accompanied by fragmentary and substandard mental health services in the penitentiary sector. Drug treatment and harm reduction interventions are beyond the evidence-based scope. The low transparency of treatment procedures and social interventions for the prison population is encompassed by the lack of monitoring of statistical data in health and social wellbeing.

One of the most critical issues is the low quality of social and medical services in transitional periods ('community-prison-community'). In social work, there is inadequate funding of community and NGO initiatives for ex-prisoner resocialisation. Case management is not implemented widely in prisons, with low competencies of prison staff in crisis management and planning. Correction is provided mostly through limitations, controls, punishment, and deterrents, while probation is limited to control and formally informing on the possible interventions for ex-prisoners with referrals to other governmental bodies.

The global definition of 'social work' has not been legally approved, and the status of a social worker is not fixed by law. There is a shortage of high-

ly qualified personnel in the field of penitentiary social work. The system for training them is still being formed, as is penitentiary social work itself. There is no system of post-penitentiary resocialisation and reintegration of former convicts into the social environment; it is thus necessary to form a system of interdepartmental interaction.

Another problem is that of providing equal opportunities for people with disabilities, including the creation of an accessible environment in the penitentiary system.

There is also no list of positions for specialists performing the functions of a social worker in the penitentiary system, requiring the global competencies of social work, as well as a lack of approach to help mothers and children in prisons through an early intervention programme.

In this regard, the solution addressing the aforementioned challenges should include systemic measures. It is necessary to establish isolated rehabilitation centres for drug addiction treatment with interventions based on the positive Atlantis experience, and to develop clinical protocols for the treatment of mental disorders based on international, evidence-based recommendations. The mental health and well-being of prisoners should be promoted during the entire sentence term.

Most problems can be solved by improving the existing experience, developing new technologies for social work with convicts, and forming a scientific and methodological base and professional training system.

It is necessary to discuss the issues of including a social worker to the staff of the penitentiary system with government agencies, to establish systematic procedures to ensure equal opportunities for people with disabilities, including the creation of an accessible environment in the penitentiary system. Increasing the state social orders for projects for the reintegration and resocialisation of released prisoners is to be recommended.

Finally, some historical milestones in the process of reforming the penitentiary system of Kazakhstan should be noted. One of them was the transfer of the prison health care system from the system of the Ministry of Internal Affairs to the department of the Ministry of Health. Another was the creation of the Constitutional Court, which replaced the Constitutional Council and gave citizens and organisations the opportunity to seek help in case of a violation of the constitutional rights, which is an important step towards social justice. A further prominent step in the social reforms was raising the status of the Human Rights Institute to the constitutional level and opening official branches in each region of Kazakhstan, which has significantly sped up, among other things, the mechanism for filing appeals and complaints about violations of the rights of prisoners, signs

of torture and ill treatment, and the reception of prisoners by regional representatives of the Commissioner for Human Rights.

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6 Kyrgyzstan: Social Work and Health in the Penitentiary System

Jarkyn Shadymanova, Nurgul Musaeva, Eric Orosaliev, Cholpon Omurakunova

Introduction

The penitentiary system actually represents an inherited Soviet model, the remnants of which have been affected by a number of negative factors that are socio-economic, political, and criminal in nature.

Currently, the penitentiary system of the Kyrgyz Republic, which holds about 10,000 convicts, is facing many difficulties, including an insufficient material and infrastructural basis for keeping prisoners, limited opportunities for training penitentiary staff, and the widespread prevalence of infectious diseases, particularly tuberculosis. The State Penitentiary Service operates in conditions of severe underfunding. Low wages and hard working conditions make it difficult to attract qualified personnel. Increasing crime, distribution and use of drugs, as well as violence among prisoners are serious concerns. There are also no opportunities to detain prisoners in separate parts of the prison, depending on the conditions of their sentence. In addition, there are low levels of control and supervision of the activities of organised criminal groups in the prison, which leads to serious violations and the division of prisoners into hierarchical groups.

After the collapse of the Soviet Union, the penitentiary system of Kyrgyzstan remained largely unchanged since the prison system is not a priority for the government. Another important aspect thing is the reduction in the number of prisoners. For example, for minors, women, and other groups, more lenient punishments are provided (Shambilov, 2017). This saves public funds and protects non-violent people from imprisonment. For them alternative punishments are provided. For example, they often live with their families and continue to work but, at the same time, probation and alternative penalties are introduced.

The aim of this chapter is to describe the penitentiary system in the Kyrgyz Republic. It starts with the history of prisons during the Soviet time and how they changed after the collapse of the Soviet Union, before moving on to examining the structure, legislation, and current demographic situation of the prisoners. The chapter also analyses the way in which –

and when – social worker services introduced into the penitentiary system and what the regulations of their areas and responsibilities, as well as the challenges of the system, are.

1. *The History and Legal Framework of the Prison System in Kyrgyzstan*

In Central Asia, and in the post-Soviet space as a whole, prisons are considered a legacy of the Soviet Union. The prison regime was built based on camp systems – Gulags such as Karlag (a corrective labour camp in Karaganda, 1930–1959) and 'Alzhir' (the Akmola camp for the wives of traitors to the motherland, 1938–1953). The main purpose of such institutions was to isolate people from society whilst they serve their sentences.

Since 1960, the administrative and functional purpose of the penitentiary system has changed. For example, on 13 May 1960, the Prison Department was reorganised into the Department of Places of Confinement of the Ministry of Public Order of the Kirghiz SSR (Shagivaliev, Smanalieva and Shagivaliev, 2017). On 30 May 1969, the Department of Places of Confinement of the Ministry of Public Order of the Kirghiz SSR was reorganised into the Department of Executive Labour Institutions of the Ministry of Internal Affairs of the Kirghiz SSR.

After the collapse of the Soviet Union, the entire structure of governmental institutions was reorganised. This process also affected the penitentiary system in Kyrgyzstan. On 28 May 1991, the Department of Executive Labour Institutions of the Ministry of Internal Affairs of the Kyrgyz SSR was reorganised into the Department for Correctional Affairs of the Republic of Kyrgyzstan. On 4 June 1993, the Department for Correctional Affairs of the Republic of Kyrgyzstan was reorganised into the Department for Criminal Executive Affairs of the Kyrgyz Republic. On 14 April 1995, the Department for Criminal Executive Affairs of the Kyrgyz Republic was reorganised into the Main Department for the Execution of Punishments of the Ministry of Internal Affairs of the Kyrgyz Republic.

On 20 June 2002, the Main Department for the Execution of Punishments was transferred from the jurisdiction of the Ministry of Internal Affairs of the Kyrgyz Republic to the Ministry of Justice of the Kyrgyz Republic by the Decree of the Government of the Kyrgyz Republic dated 20 June 2002, Decree 391. Since 2002, the penitentiary system of the Kyrgyz Republic has been administered by the Ministry of Justice. Its withdrawal from the subordination and structure of the Ministry of Internal Affairs corresponds to generally accepted practice and helps to reduce abuses

caused by the implementation of criminal, procedural, and operational search activities.

The change in the structure of subordination was carried out as part of measures to implement the Decree of the President of the Kyrgyz Republic 'On Measures to Further Improve the Penitentiary System of the Kyrgyz Republic', dated 24 October 2001, and the Decrees of the Government of the Kyrgyz Republic 'On the Procedure and Conditions for the Implementation of the Protection of Correctional Institutions and Escort of Convicts and Persons Taken into Custody', dated 17 May 2002, and 'On the Transfer of the Penitentiary System of the Ministry of Internal Affairs of the Kyrgyz Republic to the Jurisdiction of the Ministry of Justice of the Kyrgyz Republic', dated 20 June 2002 (Shagivaliev, Smanalieva and Shagivaliev, 2017).

With the implementation of Law of the Kyrgyz Republic 'On Approval of the Structure of the Government of the Kyrgyz Republic', dated 22 October 2009, Decree No. 283, and the Decree of the President of the Kyrgyz Republic 'On Measures to Ensure the Implementation of the Law of the Kyrgyz Republic' and 'On the Structure of the Government of the Kyrgyz Republic', dated 26 October 2009, No. 425, the State Service for the Execution of Punishments under the Government of the Kyrgyz Republic (hereinafter referred to as the State Penitentiary Service) was formed. The State Penitentiary Service included the Department for the Execution of Sentences and the Department for the Protection and Escort of Convicts and Persons in Custody.

Laws adopted in the 1990s in Kyrgyzstan are still in place. The old laws still applied until 2019, when the new norms came into force, which includes humanisation and new institutions. From 2000 to 2008, work was carried out to decriminalise criminal punishment. That is, for petty criminals, norms were introduced that provide for administrative punishment or fines in place of imprisonment. The conceptual foundations for the further development of the Main Directorate for the Execution of Sentences were laid down in the National Programme for Reforming the Penitentiary System of the Kyrgyz Republic, known as 'Umut', by 2010; Umut was adopted by the Government of the Kyrgyz Republic on 10 March 2006 (OSCE Centre in Bishkek and Prison Amnesty International, 2006).

2. Organisational Structure of the Penitentiary System of the Kyrgyz Republic

During the Soviet era and after the country gained independence, the penitentiary system of Kyrgyzstan was under the jurisdiction of the Ministry of Internal Affairs of the Kyrgyz Republic, initially as the Department of Correctional Affairs of the Kyrgyz Republic. In 1995, as part of the initial stage of reforms in the penitentiary system, the Department of Correctional Affairs of the Kyrgyz Republic was transformed into the Main Department for the Execution of Punishments of the Ministry of Internal Affairs of the Kyrgyz Republic. The prison system functioned as part of the Ministry of Internal Affairs of the Kyrgyz Republic until 2002. Then, in order to carry out a systematic and comprehensive reform of the judicial system and law enforcement agencies, as well as to implement the concept of reforming the penitentiary system approved by the Decree of the Government of the Kyrgyz Republic 'On the Concept of Reforming the Penitentiary System of the Kyrgyz Republic for the Period up to 2010', dated 9 December 2002, No. 833, and for the purposes of humanisation and demilitarisation, the penitentiary system was transferred from the Ministry of Internal Affairs of the Kyrgyz Republic to the Ministry of Justice of the Kyrgyz Republic. The next important stage in the activities of the penitentiary system was its transformation in 2009 into a separate State Service for the Execution of Sentences under the government of the Kyrgyz Republic (hereinafter referred to as the SSEP).

At present, the functions of the State Penitentiary Service include the following main components: the detention of persons under investigation (SIZO); the execution of sentences in the form of deprivation of liberty without isolation from society (colonies, penal settlements, penitentiary inspections); the security of correctional institutions and the escorting of convicts and persons taken into custody ('Department for the Protection and Escort of Convicts and Persons in Custody').

The total number of employees and military personnel of the State Penitentiary Service is about 3,700. As regards the gender ratio of employees, 27.1% are women and 72.8% are men. The majority of SSEP employees are young and middle-aged people. The staff in higher ranks is mainly made up of employees with higher and secondary specialised education. The level of education among employees is as follows: 56.6% of employees have higher education, 14.2% have secondary specialised education, and 29.2% have secondary education. More than half of the employees have one to five years of work experience, which cannot but affect the level of professionalism of the institutions (Omurkanova, 2014).

The term 'correctional institutions' refers to settlement colonies, correctional colonies, educational colonies, and prisons. There are twelve correctional institutions which can be broken down according to their classification as follows: four correctional colonies for men with a general regime, in which convicts are kept according to the closed-camp principle with accommodation in barrack-style premises; four correctional colonies with a strict regime, provided by law for men, in which convicts are kept according to the closed-camp principle in barrack-type premises; one correctional colony for men with a special regime, where convicts sentenced to life imprisonment are serving their sentences, as well as persons for whom life imprisonment has been replaced by a pardon for twenty years, in which convicts are kept in cell-style; one educational colony for male minors; and one correctional facility for females. Finally, there is one prison where the convicts serving their sentences – malicious violators of the established order of serving sentences – have been transferred from correctional colonies in the manner prescribed by the Criminal Executive Code of the Kyrgyz Republic, where convicts are kept in cell-style. At two correctional colonies there are medical and correctional institutions: a medical correctional institution (special hospital) with a mixed regime at correctional institution No. 31 for persons with tuberculosis and a medical correctional institution (hospital) with mixed types of regime at correctional institution No. 47.

There are also 19 settlement colonies, which are open-type institutions in which prisoners live, as a rule, in specially designed dormitories in which, under supervision, those sentenced to imprisonment for less than five years for crimes committed through negligence, as well as those convicted and transferred from correctional colonies after serving a main sentence in correctional colony.

Furthermore, there are five SIZOs designed for the cell-by-cell detention of persons subjected to pre-trial detention as a measure of restraint, i.e., those under investigation and registered with the courts until their sentence enters into force (including the stages of appeal).

The regime category of correctional colony No. 19 is even more conditional, since the colony is used for the detention of former law enforcement officers and of some other groups (those sentenced to a term of up to five years, convicted of so-called 'economic' crimes, convicted over the age of 50) (The Service of Execution of Punishments under the Ministry of Justice of the Kyrgyz Republic, 2022).

Legislation also provides for colonies with general and enhanced regimes for juveniles. For female convicts, the legislation provides for cor-

rectional colonies with general and strict regimes, as well as an educational colony with a general regime for minors.

3. Demography and Types of Prisons and Colonies

As of 1 July 2006, 15,249 persons were being held in the institutions of the GUIN. Of these, 8,402 – or 55% – were kept in correctional institutions and 4,194 – or 27.5% – were registered in settlement colonies. In recent years, there has been a clear decrease in the total number of persons held in the penitentiary system (for example, as of 1 July 2005, this number was 16,364 persons). The prison population index in Kyrgyzstan is 300–350 persons per 100,000 people in the general population, which, although average, is quite high, including for the Central Asian region.

We have to admit that the positive trend in reducing the prison population is the result not of a system of measures to humanise criminal legislation and law enforcement practice, but of multiple acts of amnesty, leading to the effect of 'inflation of justice'.

This is confirmed by the stable and even slightly increased number of persons held in pre-trial detention centres compared to 2005 (the number increased from 2,613 to 2,653 people). Moreover, due to the non-acceptance by the Jogorku Kenesh (Parliament) of the Kyrgyz Republic of a package on the humanisation of criminal legislation submitted for consideration by the government in 2006, over a period of six months in 2006, 1,932 people arrived in correctional institutions, which is 22% more than the number of those who left (1,574).

The occupancy limit of the institutions of the penitentiary system is set at 20,263 prisoners, which is more than the number of people detained. However, in the presence of legislatively fixed norms of living space, according to which (Article 71 of the Penal Code of the Kyrgyz Republic) there cannot be less than two square metres of space per convict in correctional colonies, two and a half square meters in prisons, three square metres in colonies intended for keeping women, three and a half square metres in educational colonies, and five square metres in medical institutions of the penitentiary system.

As of 1 January 2013, about seven thousand people were kept in the correctional institutions of the Republic and over five thousand people were registered with the penitentiary inspection, totalling about twelve thousand people.

The correctional institutions are also used to hold those sentenced to the prison regime and the death penalty under a moratorium on its execu-

tion, even though, according to the law, pre-trial detention centres are places of detention and perform the task of ensuring measures of criminal procedural coercion. In particular, in connection with the introduction of a moratorium on the death penalty in the country, SIZO No. 1 in Bishkek and SIZO No. 5 in Osh held persons sentenced to an exceptional measure of punishment (Criminal Code of KR, 2002).

According to recent data presented in the report 'Monitoring the observance of the right to health protection of the prison population in the Kyrgyz Republic in the context of COVID-19', 8,724 prisoners were kept in the institutions of the State Penitentiary Service in 2020 (Ombudsman of the Kyrgyz Republic, 2020). The number of persons in places of detention in 2020 is 9.6% less than in 2019 (9,654 prisoners) and 22.2% less than in 2018 (11,214 prisoners).

Of the 8,724 prisoners, 324 (3.7%) were women, 11 (0.12%) were minors,139 (1.6%) were pensioners over 60 years old and 58 people (0.7%) were persons with disabilities, of which 26 people fall into groups 1 and 2, and 32 people into group 3.

In terms of the structure of morbidity among prisoners, there were 183 people (2%) with an HIV infection, 83 persons (0.95%) with drug dependence, 22 persons (0.3%) with alcohol dependence, and 59 persons (0.7%) with tuberculosis. In 2020, according to reports, a total of 962 patients (11%) received medical treatment, of which 51 (5.3%) received inpatient treatment in civil healthcare institutions.

There are 9,600 prisoners in the penitentiary institutions of the country, according to the head of the Department for the Execution of Sentences and Special Records, Termechikov Bakyt. According to him, there are 5,300 prisoners in correctional colonies, 1,700 in pre-trial detention centres, and 2,500 in settlement colonies. 'The number of life-sentenced prisoners is more than 340 people. More than 400 people are serving sentences for extremism, and six of them are women. In total, there are 286 women in prisons,' said Termechikov (Kamchybekova, 2009).

4. Human Rights Issues

This paragraph is based on the report 'Universal periodicals overview. Overview of the working group of the Kyrgyz Republic', presented by the public association Human Rights Council Bir Duino Kyrgyzstan and the Centre for Studying Public Opinion and Forecasting

In 2020, the number of those sentenced to life imprisonment (PLS) was 340. To date, no specialised institution has been allocated for persons

sentenced to PLS, and as a result they are kept in the basements of pre-trial detention centres and local areas on the territories of correctional institutions. Mortality among PLS, most common diseases among PLS are chronic diseases of the digestive system and respiratory organs. There are not sufficient paramedics and medical units to work with PLS. In this regard, there is not sufficient analysis of medical problems to track the increase or decrease in diseases for further prevention. The estimate approved by the Ministry of Finance of the Kyrgyz Republic for 2013 for the State Penitentiary Service under Article No. 3112 'Machinery, equipment' provides for 1,200,000 Soms, which is only 1.5% of the annual requirement. As a result of this situation, the provision of medicines to convicts is solved mainly with the help of international organisations and the relatives of convicts.

In the penitentiary system, the issues of keeping convicts remain unresolved, the level of budget allocations for the functioning of the penitentiary system remains insufficient, there are no qualified medical personnel and psychologists, and social security for employees of penitentiary institutions is insufficient. The detention conditions of those sentenced to life imprisonment do not comply with the UN Standard Minimum Rules for the Treatment of Prisoners, the Basic Principles for the Treatment of Prisoners, or other international obligations of the Kyrgyz Republic. Convicts do not have proper access to basic resources (decent living conditions, the necessary nutrition, medical care, living space, sanitary conditions, social rehabilitation programmes, etc.), equal rights qualified legal and advocate assistance, information, and communication with the outside world. In places of detention, there are no security conditions for either prison staff or convicts, or for persons visiting these institutions (Public Association 'Human Rights Council Bir Duino Kyrgyzstan and Centre for Studying Public Opinion and Forecasting 'El-Pikir', 2020).[1]

As a result of many years of advocacy work by civil society and human rights lawyers, the probation law came into force on 1 January 2019. The law provides for measures that allow ex-prisoners to quickly undergo social rehabilitation, including obtaining the necessary documents and continuing medical treatment, such as ART, OST, or tuberculosis treatment. The Department of Justice Inter-Agency Parole Working Group, which includes civil society groups, is working to ensure that pre- and post-release

1 Human Rights Council. Universal Periodic Review. The Working group on review of the Kyrgyz Republic is presented from: NGO "Human Rights Movement: Bir Duino Kyrgyzstan", "Center for Public Opinion Research and Forecasting "El-Pikir".

rehabilitation programmes help ex-prisoners access community-based HIV and TB services.

5. Social Work in the Prisons of the Kyrgyz Republic

Penitentiary social work is one of the specific areas of social work with the population, carried out in line with the requirements of the penitentiary system. There is a clear need for social work with convicts since it creates conditions for the exercising of the rights of a group of people who find themselves in places of deprivation of liberty.

Social work is an important part of the penitentiary system because it improves conditions for people who find themselves in places of deprivation of liberty. The goal of social work is to help prisoners to maintain and create important and positive social contacts outside of the prison, and to increase the prisoner's ability to live independently and develop law-abiding behaviour. Following the requirements of the Universal Declaration of Human Rights, social workers must resist cruel or degrading treatment of prisoners, improve the sanitary and hygienic conditions of their prison stay, take measures to protect their health, etc. As stated in the Constitution of the Kyrgyz Republic, 'Everyone deprived of liberty has the right to humane treatment and respect for human dignity' (Article 22 of the Constitution of the KR) and social workers are responsible for providing for the needs of people in prison. The adopted Criminal Code of the Kyrgyz Republic provides for the principle of humanism, according to which, punishment and other measures of criminal law should not cause physical suffering or degrade human dignity (Ministry of Justice KR, 2021).

The goal of executing punishments and coercive measures of criminal law is not to violate human dignity, cause physical and moral suffering, or use torture and ill-treatment. The treatment of convicts is based on the recognition, respect, and protection of their right to the inviolability of human dignity. Kyrgyzstan is consistently taking steps to improve criminal legislation mechanisms ensuring the human rights of prisoners. The main focus of reforming the penitentiary system of the Kyrgyz Republic is the development of humanitarian values and adherence to international standards for the treatment of prisoners, according to the Ombudsman of the Kyrgyz Republic and the Coalition against Torture (Ministry of Justice of KR, 2019).

For a long time, correctional institutions did not include the position of 'social worker' in their structure. Social workers' responsibilities were

put onto the shoulders of other staff within the system, such as medical staff and military personnel. It was expected that the penitentiary system would improve the conditions for prisoners. This situation was changed in 2006, when the social worker position was officially introduced into the structure of the prison system.

The National Programme for Reforming the Penitentiary System of the Kyrgyz Republic, 'Umut', raised issues related to social work with prisoners, such as:

- humanisation of the penitentiary system,
- observance of guarantees to ensure the rights and legitimate interests of prisoners serving their sentences,
- creation of medical, social, psychological, labour, and rehabilitation centres and organisation of effective methods for working with prisoners;
- provision of conditions for the social rehabilitation and adaptation of prisoners to life in society after their release from places of deprivation of liberty (Government House, 2006).

Today, the purpose of social work with convicts in a correctional institution is to create prerequisites for the correction and resocialisation of convicts, as well as for their successful adaptation after their release from prison.

In the penitentiary system of the Kyrgyz Republic, there are eleven senior inspectors for social work in closed correctional facilities (Ministry of Justice 2019). Their responsibilities are:

- implementing social diagnostics of convicts, identifying persons in need of priority social assistance, and developing individual programmes for working with them,
- carrying out a comprehensive study of the personality of convicts in need of social assistance, in collaboration with employees of the psychological team and other services of the correctional institution,
- providing people in need with qualified social assistance and encouraging convicts to independently solve their social problems,
- providing assistance in strengthening convicts' positive social ties with the external social environment: with family, relatives, labour collectives and educational institutions, and public and religious organisations (associations),
- organising continuous work to prepare convicts for release,
- rendering assistance in matters of employment and accommodation arrangements for convicts released from a correctional institution,

- restoring identity documents, pensions, and disability statements to enable former convicts to purchase property.

The objects of the activity of social work specialists in a correctional institution are persons sentenced to imprisonment for committing crimes who need outside help and find themselves in a difficult life situation from which they cannot get out on their own. These include:

- the disabled, the elderly, and pensioners,
- oppressed drug and alcohol addicts,
- pregnant women and women with young children,
- patients with incurable diseases,
- juvenile convicts,
- convicts who do not have a permanent place of residence,
- convicts with mental disorders,
- those released from serving sentences on various grounds, who have social problems relating to their employment, living arrangements, medical issues, or social situation.

The activities of those carrying out social and psychological work in penitentiary institutions are guided by the Criminal Executive Code of the Kyrgyz Republic. Moreover, social workers should adhere to the internal regulations of correctional institutions of the penitentiary system of the Kyrgyz Republic, which determine the purpose and content of social work,, its main goals, tasks, and functions, and the rights and obligations of employees.

These internal regulations also include a list of documentation compiled and maintained by the social work inspectors of penitentiary institutions. This document regulates the procedures for the interaction of state bodies in documenting convicts serving sentences in correctional institutions and persons held in pre-trial detention centres as suspects and defendants (Ministry of Justice KR, 2017 a.).

According to the Internal Regulations of Correctional Institutions of the Penitentiary System of the Kyrgyz Republic, an authorised employee of the institution is responsible for:

- determining the list of persons serving sentences or persons held as suspects or accused, subject to documentation using the 2017 model of passport,
- checking for the presence of a passport,
- in the absence of a passport, finding out the location of the passport or the circumstances of its loss,

- sending a notification to the relatives of a person serving a sentence or a person held as a suspect or accused, or to the relevant state bodies on the provision/sending of a passport to the appropriate institution, if it is impossible to establish the location of the passport or if there is information about the absence of a passport, clarifying the necessary information and completing the relevant paperwork/questionnaire on behalf of the applicant,
- preparing an appropriate application for documentation following the format outlined in the Regulations;
- sending an application for documentation along with the applicant's attached questionnaire by post or courier to the appropriate territorial department (Ministry of Justice of KR. 2019 b.).

In their daily practice, the senior inspector for social work conducts individual meetings with convicts to discuss their personal issues, analyses the data received and if necessary, prepares and sends letters to law enforcement and judicial authorities on the issue of restoring lost documents proving the identity of convicts, carries out work to restore lost family links with relatives of convicts, and, if the convict is illiterate – and also to provide social assistance and help with the resocialisation of the convict – sends clients to general educational and vocational educational institutions of correctional institutions of the penitentiary system.

Various issues are currently being discussed, such as increasing the number of social workers and psychologists working in the penitentiary system, activating the activities of social and psychological assistance services, creating counselling rooms for prisoners and staff, improving work on career guidance, employment, general education, and vocational training for convicts, providing opportunities for obtaining primary, secondary, higher, and vocational education for prisoners, and improving the process of preparing convicts for release.[2]

In general, in social work in the penitentiary system of the Kyrgyz Republic, importance is attached to complex measures of a social and preventive nature, ensuring the social, legal, and socio-psychological protection of convicts, creating conditions for independent socialisation, adaptation, and integration after release from punishment, conducting individual psycho-correctional work with convicts, studying the personality of convicts, promoting the formation of positive value orientations, maintaining socially useful contacts with the outside world, and maintaining contact with

2 According to an informal interview with the senior inspector, the psychologist of the INS institution (20.10.2022).

the family, with the community, and with public, religious, and other organisations.

Social work with convicts in correctional institutions is based on the legal framework of the Kyrgyz Republic, including the Constitution of the Kyrgyz Republic, the Penitentiary Code of the Kyrgyz Republic, the Criminal Code of the Kyrgyz Republic, and the Strategy for the Development of the Penitentiary System of the Kyrgyz Republic for 2018–2023, as well as on the orders of the Ministry of Justice of the Kyrgyz Republic.

Thus, the Criminal Executive Code of the Kyrgyz Republic provides for the rights of convicts to social and pension security, social protection, legal assistance, personal security, decent treatment, etc.

The main forms of work on the social adaptation of convicts and psychological work include:

- Social diagnostics of convicts, aimed at identifying persons in need of social assistance,
- Development of individual programmes for social and psychological work with convicts,
- Provision of advisory, legal, and psychological assistance,
- Psychological assessments of the personality of the convict, individual and group therapy, including psycho-correctional therapy aimed at changing convicts' moral and value orientations,
- Development, organisation, and implementation of rehabilitation, adaptation, and other programmes intended to provide social assistance to convicts,
- Involvement of convicts in rehabilitation and special medical programmes,
- Organisation of classes (training, seminars) aimed at the resocialisation of convicts,
- Development of convicts' desire to independently solve their social problems,
- Involvement of state bodies in the fields of social protection of the population, pensions, employment, state registration, healthcare, education, and law enforcement, as well as local state administrations and local governments, in resolving the social problems of convicts,
- Involvement public, non-governmental, and international organisations in social work with convicts,
- Assistance in strengthening convicts' positive social ties with the external social environment: with family, relatives, labour collectives, educational institutions, and religious organisations (associations),

- Organisation of continuous work to prepare convicts for release and help them adapt to the conditions of life at large, including the provision of assistance regarding employment and accommodation arrangements for convicts released from a correctional institution,
- Help for convicts released from correctional institutions.

It also provides for the organisation of social assistance for persons released from correctional facilities.

No later than six months before the expiration of the term of punishment in the form of deprivation of liberty, the institution executing the punishment shall notify the local self-government bodies and the employment service at the convicted person's chosen place of residence about his forthcoming release, availability of housing, working capacity, and potential specialities.

Upon their written application and the proposal of the institution executing the punishment, convicted invalids in Groups 1 and 2, as well as convicts who have reached retirement age, are sent by social protection bodies to homes for the disabled and the elderly.

Other persons in need of social assistance, upon their written application and presentation by the institution executing the punishment, are sent to social adaptation centres.

After being released from imprisonment, persons suffering from alcohol and drug addiction, substance abuse, tuberculosis, and venereal disease, all of whom need to continue compulsory treatment, as well as persons living with HIV/AIDS, are – according to the legislation on the protection of health – subject to referral to special health institutions.

To assist persons released from prison, they are provided with free travel to their place of residence, as well as food or money for the journey within the territory of the Kyrgyz Republic. In the absence of clothing and footwear appropriate for the season, persons released from correctional institutions are provided with clothing and footwear at the expense of the state.

6. Socio-Psychological Work in Prisons

The work of the entire psychological service is regulated by the instruction on organising the activities of the psychological service of the penitentiary system, approved by order of the State Penitentiary Service No. 107 of 5 March 2016.

The psychological service of the penitentiary system carries out its activities based on the principles of humanism, the priority of universal values, and professional competence. Based on the main tasks related to psychological work within the penitentiary system, psychologists in institutions should provide services for:

- Psychological diagnostics of persons in prison,
- Psychological counselling, especially in crises,
- Conducting group socio-psychological trainings,
- Psychological correction of behaviour and psychotherapy,
- Psychological prevention and education.

Diagnostic: consists of making a psychological diagnosis and writing a psychological portrait based on an in-depth, objective, and comprehensive study of the individual's personality to identify and describe psychological characteristics and conditions of formation; identifying persons belonging to the 'group of increased attention' and requiring preventive treatment by a psychologist; and studying social communities (groups of convicts, etc.) and the dynamics of socio-psychological phenomena and conditions.

Psychological diagnostics are implemented through the use of special psycho-diagnostic methods (testing, studying documents, conversation, observation, etc.) for studying a person and/or a group and psychological algorithms for processing and interpreting the information received.

Diagnostic measures are carried out by following an approximate list of psychological techniques recommended for use in the activities of psychologists.

Advisory: aimed at providing psychological assistance to the individual in solving personal psychological problems, developing the internal resilience of the individual to overcome crisis and problem situations, and providing assistance with career guidance and self-development, as well as solving official tasks, taking into account psychological factors.

Psycho-corrective: consists of a purposeful change in the socio-psychological attitudes and value orientations of the individual, teaching them techniques and methods of self-regulation and self-control, the formation of the necessary skills and abilities in the field of communication, and increasing resistance to adverse psychological influences and factors (stress, and critical and conflict situations). The State Penitentiary Service pays special attention to the reintegration of convicts into society. One of its areas of focus is the implementation of activities that contribute to the psychological readiness of released convicts for the realities of life post release. One effective method here is the use of art and music therapy. In

this regard, probation officers study and practice art therapy models and methods of rehabilitation.

As part of their role, the psychologist conducts psycho-corrective measures using individual and group forms of work (auto-training, socio-psychological training, etc.)

Within the penitentiary service under the Ministry of Justice of the Kyrgyz Republic, there are 17 staff positions for senior inspectors of psychologists in correctional institutions (Kudryavtseva, 2018).

7. *Difficulties and Shortcomings in the Implementation of Socio-Psychological Work*

Some of the barriers and difficulties faced by psychologists and social workers should be noted. The results of the study carried out in nine institutions show that, in these institutions, there are no services for psychological correction, psychotherapy, or psychological diagnostics (there are no scientifically tested and recognised methods for assessing the personality of convicts and persons under investigation). There are also no programmes for psychological prevention, nor is there any education or systematic socio-psychological training for the staff.

The results of interviews with convicts show that only a third of them received the services of a psychologist at the institution, and only every seventh convict received the services of a social worker. The convicts' level of dissatisfaction with the services provided is quite high.

The results of observation in nine correctional institutions showed that in five institutions, it is hard for convicts to physically access a psychologist or social worker. No information or educational materials are provided about psychological and social services.

The infrastructure of psychological and social services in institutions is rigid. For example, the consultation room is located in the administrative building, and there are separate procedures for admission to psychological counselling. According to the study, this significantly limits the availability of psychological services and reduces the number of requests from prisoners for these services.

Currently, 18 psychologists work in the penitentiary system of the Kyrgyz Republic, of which only one specialist has a basic psychological education. Ten specialists have a higher legal education and six specialists are educated in another field (economics, engineering, transport logistics, customs, informatics, and communications). Only two specialists have

pedagogical education and one is qualified as a social worker. None of these specialists work under the supervision of a qualified psychologist/psychotherapist (Public Council of the State Penitentiary Service under the Government of the Kyrgyz Republic, 2019).The situation is similar when it comes to social services. Each of the eleven correctional facilities has a social worker, but none of them has a basic education in social work.

There is a quantitative criterion for the ratio of the number of convicts to one psychologist. Professional standards for the work of a psychologist in the prison system suggest that in order to perform quality work, a psychologist should be working in line with the following ratios (Yoon, Slade & Fazel, 2017): one psychologist per 150–160 adults deprived of their liberty; one psychologist per 50–75 prisoners of special categories deprived of their liberty (drug addicts, persons with mental disorders, those with life sentences, or those convicted of terrorist and extremist crimes); one psychologist for 60–75 minors, and for 20–25 in institutions for minors. Throughout the prison system of the Kyrgyz Republic, this figure is 1:470 for psychological services and 1:594 for social services.[3]

This means that the penitentiary system of the Kyrgyz Republic urgently needs to recruit qualified psychologists and social workers and to increase the efficiency of their staff.

Thus, according to the results of the study, psychological and social services are poorly staffed (in terms of the 'number of full-time employees for the existing number of persons deprived of liberty') and employees of the psychological and social services of correctional institutions do not meet the expectations of their positions in terms of educational and professional requirements. In addition, there is no system for supervising the work of these specialists (Public Council of the State Penitentiary Service under the Government of the Kyrgyz Republic, 2019).

As noted in the strategy for the development of the penitentiary system of the Kyrgyz Republic for 2018–2023, despite the measures taken by the Government of the Kyrgyz Republic and other state bodies, the situation remains unresolved in terms of providing citizens who have served and are serving a prison sentence with passports, which, in turn, entails a series of violations and infringements of these citizens' constitutional rights and freedoms.

3 The indicators were calculated as of October 2017, based on the data of the State Penitentiary Service of the Russian Federation on the number of convicts in correctional colonies: 6,534 people (for social services) and the total number of convicts in correctional colonies and pre-trial detention centeres: 8,450 people (for psychological services).

The issue of establishing the degree of disability of persons in places of deprivation of liberty remains unresolved, meaning that it is also not possible to assign them a disability pension.

There are practically no specialised rehabilitation centres or other organisations in the country to provide the necessary support to persons, including minors, released from places of deprivation of liberty, or to provide them with shelter or temporary residence.

Today there is still a need for the systematic improvement and deepening of the initiated modernisation reforms regarding the mechanism for the execution of sentences and resocialisation of convicts, including minors, which should be carried out based on ongoing judicial and legal reforms.

7.1. Participation of Non-Profit Organisations in Social Work in Prisons

The role of civil society in the development of the penitentiary system is very important. Today, thousands of non-governmental organisations are registered in Kyrgyzstan, which work in dozens of different spheres. According to the Ministry of Justice, in April 2018, 17,117 registered NGOs were registered in Kyrgyzstan (Ministry of Justice of the Kyrgyz Republic, 2018). On the basis of the interaction between the prison and civil society, the implementation of effective and innovative technologies is also taking place. Employees of the penitentiary system are trained in methods of social work with convicts through seminars and trainings organised by the Ministry of Labour and Social Development of the Kyrgyz Republic, international organisations, and NGOs.

As a result of constructive interaction with NGOs, public attention is now being paid to the problems of the penitentiary system, the protection of the rights of prisoners, the openness of the penitentiary system, the provision of legal assistance to prisoners, assistance in improving the conditions of their detention, and the medical and socio-psychological rehabilitation of prisoners.

As a possible way to solve this problem, our penitentiary system turned in the 1990s to 'Atlantis' – a model of therapy, psychological training, etc. that was brought to Kyrgyzstan by the Polish expert Pawel Moczydłowski. He is a sociologist, criminologist, journalist, and state official who had been responsible for reconstructing the prison system in Poland through reform projects, following the breakdown of the communist regime. He criticised the use of the Soviet-style system of colonies instead of a prison

system based on respect for the human rights of prisoners in line with international standards and UN conventions (Moczydłowski, 2015).

Moczydłowski introduced so-called 'Atlantis centres' and, later, a 'Clean Zone' in the colonies. Before introducing the "Clean Zone," a 12-step rehabilitation program based on the Atlantis Model was introduced and is now available in eight Kyrgyz prisons. These Atlantis programs differ in each facility by virtue of whether participants are housed privately from other prisoners. Entry is voluntary, but participation requires extensive participation in group therapy sessions and workshops with trained social workers for up to 18 months. Participants must sign a pledge to reject all psychoactive substances including medications to treat psychiatric or substance use disorders prescribed by physicians.

Graduates of the Atlantis program may opt to return to their prison units or transfer to the Clean Zone (Azbel et al., 2017, 2). The Atlantis programme for the treatment of drug addicts in correctional institutions has been operating since 2005 (Akipress, 2005). The Atlantis programme is a complex course of addiction therapy, used in combination with psychotherapeutic and psycho-corrective methods in small groups. Atlantis is based on the Minnesota model for the treatment of chemically dependent persons. The key components of this programme are the philosophy of the 12-step programme and participation in it. Rehabilitation programmes for drug-addicted prisoners are essential for preventing the spread of criminal activity within prisons. Atlantis rehabilitation centres exist in seven colonies of the Kyrgyz Republic (For.kg, 2014). Today, this type of treatment, rehabilitation, and resocialisation is available to persons addicted to psychoactive substances in every correctional colony. It works as follows. A separate room is created in the colony, which, is repaired and furnished with the necessary equipment with funding from donors.

Thus, conditions are created that stimulate the desire to 'clean up', undergo treatment and rehabilitation, and return to a normal, sober life ('sober' in the sense of both drugs and alcohol). They come to Atlantis voluntarily, having passed certain tests. Next, specialists begin to work with patients using special methods. Many note that people who have been treated at Atlantis are different. Their views differ from normal social attitudes; for example, they view the use of psychoactive substances, and sometimes even tobacco, negatively.

Realising that the result of the programme could be much more successful,, we – on the advice of a well-known Polish expert in the Republic, Moczydłowski – decided to create a mini-colony, where convicts from the whole Republic – those who had undergone a course of treatment and rehabilitation, demonstrated steadfast commitment during this process,

completely refused psychoactive substances, and wish to deepen the process of resocialisation – would be treated.

This is how the Clean Zone was born, which was implemented with the help of the Programme for the Prevention of the Spread of Narcotics in Central Asia. The project 'Clean Zone' was presented and then, a separate, dilapidated building was allocated in colony No. 31 in the village of Moldovanovka, near Bishkek. From 2006 to 2007, it was renovated and equipped, and staff members trained at the expense of CADAP, the EU Central Asia Drug Action Programme (CADAP, 2016). The director, Irina Lapuzina, is a professional and a volunteer who was trained in Poland and has also completed numerous international and local trainings. Today, there are more than 40 clients in the Clean Zone and there are 100 seats, which will be filled as new patients appear. After successful treatment at an Atlantis rehabilitation centre, the best patients are sent to the Clean Zone Centre for Rehabilitation and Social Adaptation, where they continue their treatment according to the 12-step programme, which includes elements of social adaptation (professional training, occupational therapy), psycho-correction, and psychotherapy (LEAHN Law Enforcement and HIV Network, 2014).

The work of these programmes is aimed at carrying out the rehabilitation of convicts addicted to alcohol and drugs, and providing assistance in adapting to new life situations. These programmes are also educational in nature, which is of great importance in conditions of imprisonment. According to international researchers, the low subscription rate of the Clean Zone and high staff-to-client ratio suggest that, if the Clean Zone were to be continued, it would benefit from integration of stabilized methadone patients combined with a post-release aftercare program. However, extraordinarily hostile and negative attitudes persist among patients in the Atlantis program and the Clean Zone toward methadone treatment. This perception may, in part, have evolved from methadone being originally introduced as a harm reduction program alongside PNSPs. As such, methadone was viewed as a means to prevent HIV transmission, but not as an effective treatment for opioid addiction.

The Clean Zone, based on within-prison therapeutic communities, harbours profoundly negative attitudes toward OAT, incorrectly stating that individuals with addiction problems cannot be in recovery from their addiction as long as they take any form of psychoactive substance, including medications prescribed by a physician (Azbel, 2017).

7.2. Reintegration/Rehabilitation/Returning Home

Having been released from prison, a person faces difficulties in adapting to society, experiences stigma and social discrimination, and suffers from unemployment, lack of documents, and lack of education. It is difficult for them to get access to public services and health care. Problems of a social and legal nature constantly arise among convicts after their release.

The work of preparing convicts for release is an integral and top priority for social workers within the framework of a correctional institution. Social workers need to know all the clients problems during the period when they served their sentence and at the stage of preparing for release.

Also, social workers provide social services relating to employment and accommodation arrangements for convicts who find themselves in a difficult life situation, upon release and during their integration into society (Decree of the Government of the Kyrgyz Republic, 2014). In line with this Decree to provide social and other assistance to convicts preparing for release, correctional institutions, penitentiary inspectors, and social development bodies draw up a social ID of the individual requiring social assistance, which includes their basic social, medical, and legal needs and a social assistance plan.

To prepare the convict for release, a social worker prepares notices for the district employment departments and self-government bodies (all okmotu) regarding the convict's employment and accommodation arrangements. Senior inspectors for social work interact with state bodies and carry out visits to the territorial divisions of the Ministry of Labour and Social Development, the State Registration Service, boarding schools, nursing homes, municipal hostels, and non-governmental organisations.

Upon release from prison, the convicted person, in respect of whom the issue of employment has been previously resolved, is issued a corresponding letter for the district department of the employment service. When a minor is released, the social worker sends notifications to the guardianship authorities, divisions for juvenile affairs, internal affairs bodies, and the Commission for Minors and the Protection of Their Rights. The social worker also applies to local governments with a request to resolve the issue of finding the convicted person a job or study place and providing him with a living space.

The social worker is also mediator with non-governmental, international, religious, and public organisations on the provision of social support to convicts. The main task of a social worker is also to conduct social counselling – explaining to released convicts the need to comply with the

requirements of the current legislation of the Kyrgyz Republic, as well as the inadmissibility of committing new crimes.

Convicts are provided with relevant information related to their preparation for release, which contributes to both successful rehabilitation within the walls of the correctional institution and successful adaptation outside the institution. It also informs those released of the need to register with the internal affairs and probation authorities no later than five days after release.

The process of preparing convicts for release is defined by paragraphs 4–8 of the Procedure for the Interaction of State Bodies and Local Self-Government Bodies with the Administrations of Correctional Institutions in Matters of Providing Social Assistance to Convicts. According to this document, preparation for the release of convicts serving sentences in correctional institutions begins one year before the end of their term of imprisonment and includes the following activities (Decree of the Government of the Kyrgyz Republic, 2014): within 10 working days after determining that the convict is to be released within a year, the administration of the correctional institution sends information about the convict to the probation authority for their registration within the framework of penitentiary probation. A social worker from the institution conducts a conversation with the convict to determine his place of residence, work, or study after release; his needs for social, legal, and psychological assistance; his education, profession, necessary documents, medical and social services, and pensions; whether he has relatives and his relationship with them.

The administration of the institution organises for him, with his consent, paid work within the institution, to ensure his material independence when preparing for release. Also, the administration of the institution sends requests to state bodies (social development and employment, healthcare, education) and local governments regarding the possibility of providing social assistance to a convict preparing for release, relating to issues of material and domestic arrangements and other social needs, and sends notices to the guardian or the guardianship authorities if it is established that the minor is an orphan or left without parental care, to resolve issues of his social and accommodation arrangements.

Upon release, the convict shall be issued with his belongings, valuables, money stored in a personal account, identity documents, and other documents stored in their personal file, as well as a certificate in the established format indicating the grounds for release. If the convict does not have valid, in-date identity documents, a workbook, and a pension certificate in their personal file, the administration of the institution or body execut-

ing the punishment or other criminal law measure – together with the relevant state bodies – takes measures to formalise them (AFEW, 2018).

The social worker is obliged to maintain contact with released convicts by telephone for six months. Based on the statistical data, about half of the prisoners continue to commit crimes after being released from places of deprivation of liberty, and their number significantly exceeds the number of those convicted for the first time. This situation is related to the stigma surrounding convicts in Kyrgyz society, unemployment, low living standards, a lack of the necessary education, work skills, and legal knowledge, and poor social adaptation after release.

One of the stages of preparing a convict for release is finding employment. The main legislative document regulating labour and related legal relations is the Labour Code of the Kyrgyz Republic. It does not contain any restrictions on the employment of persons released from places of deprivation of liberty. But in practice, those released from places of deprivation of liberty experience great difficulties in finding work and employment (Criminal Executive Code of the Kyrgyz Republic, 2017).

One of the ways to overcome this situation is to organise job fairs together with specialists from the Ministry of Labour and Social Development of the Kyrgyz Republic in the institutions of the Penitentiary System INS. Within the framework of the fairs, representatives of the business community share information about the possibility of finding a job for citizens who are not serving their sentences in closed institutions. Representatives of the Ministry of Labour and Social Protection of the Population offer persons preparing for release a list of services provided by the state. Among them are short-term training courses, employment, and microcredit. Employment, both in colonies and after release, is one of the significant factors that contribute to preventing the recurrence of the crime, which will save the public funds allocated for the maintenance of the convict.

Preparation for the release of persons serving a sentence in a correctional institution begins six months before the end of their term of imprisonment. A record of the convicts whose term of imprisonment expires in six months is kept in a special journal. In turn, the preparation of convicts for release from a correctional facility includes such areas as the restoration and development of socially useful ties between convicts and relatives, intensive preparation for employment and accommodation arrangements after release, and assistance in restoring lost documents.

Conclusion

Kyrgyzstan is consistently taking steps to improve criminal law mechanisms aimed at ensuring the observance of human rights. The main focus of the reforms to the penitentiary system of the Kyrgyz Republic is the development of humanitarian values and adherence to international standards for the treatment of prisoners. Over the past five years, great steps have been taken to humanise the Criminal Code and the Code of Criminal Procedure. There have been reforms to both criminal legislation and the penitentiary system. Various schemes for the development of the penitentiary system were considered.

Work is underway to introduce the institution of probation – a form of probation. In February 2022, the president signed the Probation Law. The new law defines the new responsibilities facing the prison system.

There is now an alternative form of punishment available, in which a person is not isolated from society but rather remains at home under the probation control of special institutions. Kyrgyzstan, in comparison with other countries of Central Asia, has made progress in terms of the legislative framework. There is another side to the effectiveness of the legislative framework: the implementation of laws.

Currently, in the penitentiary institutions of Kyrgyzstan, the processes of social adaptation and resocialisation have not been fully implemented, due to the peculiarities of prison conditions, and the lack of financial resources and professional skills among the staff. Many of the prisoners do not have a specific address, means of transportation, or documents. The social adaptation of prisoners is not well developed, and therefore, preventive measures against further criminalisation have a very weak impact. To minimise the destructive impact of the prison and the criminal environment, the convict must be persuaded to reconsider his criminal behaviour and helped to use the offered opportunities for assuming social responsibility when entering normal life after release.

The problem of access to quality medical care for prisoners remains relevant. The reason for this is not only the lack of medical personnel but often untimely medical care. The temporary detention of patients with severe, drug-resistant tuberculosis in institutions that do not specialise in the care of prisoners with tuberculosis, meaning that they are detained together with other prisoners before transportation, may also affect the regime environment of the institution as a whole, since it increases the risk of other prisoners and staff becoming infected. A particular subculture of prisoners is a problem in any prison. It is well known that a group of prisoners has their own values and norms of behaviour, which differ

from the norms accepted in society. However, the rules adopted in society also apply in the penitentiary. Thus, violence and drug abuse should not be tolerated in a penitentiary. It sounds quite simple, but it will work only if each employee complies with these rules and, on the whole, the penitentiary institution functions successfully and has a clearly defined structure of activities.

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7 Uzbekistan: Social Work and Health in the Penitentiary System

Sergey Soshnikov, Heino Stöver

Introduction

This chapter presents an overview of the development of social work and health services in the prison system in Uzbekistan. It addresses the question of prison reform: to what extent has Uzbekistan made progress in humanising the conditions for its prison population and address this issue through social and medical services.

The chapter is structured as follows: first, the legal framework and organisational structure of Uzbekistan's prison system is presented. Second, the main social and health issues of the prison population are explained. While Uzbekistan has made progress in improving the social and health situation of the prison population, continuous monitoring is still needed. Third, the chapter discusses the development of social work and health care services in Uzbekistan's prison system. The chapter concludes with a short summary and outlook for prison reform in the future.

1. The Penitentiary System in Uzbekistan

The Constitution of the Republic of Uzbekistan establishes the legal framework for the penitentiary system in Uzbekistan. The Constitution guarantees the rights and freedoms of citizens, including the right to a fair trial and the prohibition of arbitrary detention. It also establishes the framework for the organisation and operation of the penitentiary system, including the powers and responsibilities of the Ministry of Internal Affairs and other authorities.

In addition to the Constitution, several laws and regulations provide more detailed guidance on the operation of the penitentiary system. These include the Law on Execution of Sentences, which sets out the legal framework for the detention and rehabilitation of individuals who have been deprived of their liberty, and the Law on Execution of Sentences,

which guides the organisation, management, and oversight of penitentiary institutions (Tadjibayeva, 2019; Salaev, 2018).

Overall, the legal framework for the penitentiary system in Uzbekistan is designed to protect the rights and interests of inmates while enabling the effective management and rehabilitation of individuals deprived of their liberty.According to Article 19 of the Constitution of the Republic of Uzbekistan, citizens and the state are bound by mutual rights and responsibilities. As outlined in the Constitution and laws, the rights and freedoms of citizens are inviolable and cannot be deprived or restricted without a trial. In 2017, a decree was issued by the President of the Republic of Uzbekistan to improve the activities of internal affairs bodies in relation to the execution of sentences involving deprivation of liberty (Uzbekistan-Geneva, 2021). This was intended to increase the efficiency of protecting the rights and interests of individuals serving sentences in detention centres and to align the penitentiary system with international standards (Uzbekistan AT, 2021). In 2020, the Cabinet of Ministers of the Republic of Uzbekistan adopted a resolution on additional measures to ensure transparency and openness in the penitentiary system concerning deprivation of liberty (Tadjibayeva, 2019).

The penitentiary system of Uzbekistan has a hierarchical structure, with different levels of authority and responsibility. At the top of the hierarchy is the Ministry of Internal Affairs, responsible for overseeing the entire penitentiary system. Below the Ministry of Internal Affairs, there are several regional departments, each of which is responsible for overseeing the penitentiary institutions within its geographic area. These provincial departments are responsible for implementing national policies and regulations within their jurisdictions and providing support and guidance to individual penitentiary institutions.

Individual penitentiary institutions, such as prisons and detention centres, are responsible for carrying out the day-to-day operations, including the management and rehabilitation of inmates. These institutions are typically organised into various departments, such as security, administration, education, and health, each of which has specific responsibilities.

Overall, the organisational structure of the penitentiary system of Uzbekistan is designed to provide a transparent chain of command and to ensure that inmates' rights and interests are protected, while also enabling the effective management and rehabilitation of individuals who have been deprived of their liberty.

The organisational structure of the penitentiary system of Uzbekistan has changed since the Republic became independent in 1992. According to the Department for the Execution of Sentences under the Ministry of

Internal Affairs, today, there are 54 correctional colonies in the Republic, of which 18 are with strong regime, 25 are colony settlements, and 11 are pre-trial detention centres (Podrobno, 2022).

The penitentiary system of Uzbekistan includes several different types of prisons, each of which serves a specific purpose. The main types of prisons within the system are:

- General regime prisons: This is the most common type of prison in Uzbekistan, and they are designed to accommodate a wide range of inmates, including both male and female offenders. General regime prisons typically have a range of facilities and services, including education and vocational training programmes, health care services, and recreational activities.
- High-security prisons: These prisons are designed to hold offenders who have been convicted of particularly serious crimes or who pose a significant risk of escape or violence. High-security prisons have a higher level of security than general regime prisons, and they may also have additional facilities, such as specialised workshops or medical units.
- Juvenile prisons: These prisons are specifically designed to hold offenders who are under the age of 18. Juvenile prisons typically have a more rehabilitative focus than adult prisons, and they may offer a range of educational, vocational, and therapeutic programmes.
- Women's prisons: These are designed to hold female offenders and typically have facilities and services tailored to women's needs. Women's prisons may offer programmes and services related to childcare, health care, and education, as well as providing support for women who have experienced trauma or abuse.

Overall, the different types of prisons within the penitentiary system of Uzbekistan are designed to meet the specific needs of groups of offenders and to provide a range of rehabilitative services and programmes. According to the second part of Article 45 as amended by the Law of the Republic of Uzbekistan, dated 28 August 2019 (No ZRU-558 – National Legislation Database, 08/29/2019, No 03/19/558/3662), institutions for the execution of punishment include colonies for the execution of punishment, educational colonies, prisons, and specialised hospitals for convicts.

Colonies for the execution of punishment are divided into colony settlements – colonies of general, strict, and special regimes – and are intended for the detention of convicts who have reached the age of majority. Educational colonies are intended for the detention of juvenile convicts. Prisons are designed to hold adult convicts.

The prison system in Uzbekistan is organised as follows:

- The Ministry of Internal Affairs is the primary government agency responsible for the prison system in Uzbekistan. The Ministry is responsible for the overall management and oversight of the prison system, including developing and implementing policies and regulations, allocating resources, and coordinating activities with other agencies.
- The General Directorate for the Execution of Punishment is the agency within the Ministry of Internal Affairs responsible for the prison system's day-to-day operation. The General Directorate is responsible for the management of individual prisons and other institutions, as well as for the provision of services and programmes to inmates.
- The Penitentiary Service is the agency within the General Directorate for the Execution of Punishment responsible for the security and management of individual prisons and other institutions. The Penitentiary Service is responsible for supervising inmates, maintaining order and safety, and enforcing rules and regulations within the prison system.

The prison system in Uzbekistan plays an essential role in the country's criminal and legal policy. After gaining national independence, the government began to reform its penal system, recognising the need to update its regulatory framework and develop a long-term strategy (UzbekistanAT, 2021).

According to national legislation, the tasks of the criminal-executive system in Uzbekistan include executing criminal penalties such as fines, imprisonment, and compulsory public works, as well as supervising the behaviour of conditionally convicted persons and ensuring law enforcement and safety in prisons. The system also focuses on providing education and vocational training to convicts, ensuring their health. These goals aim to strengthen and protect the rule of law in Uzbekistan (Salaev, 2018).

The development of the prison system has evolved with time the first known prisons appearing in ancient civilisations. Over time, the purpose of prisons began to shift, and they began to be used not only as places of punishment but also as places of rehabilitation. This trend continued throughout history, with the development of various forms of punishment and rehabilitation, such as the use of solitary confinement and the introduction of parole and probation. The prison system has evolved in modern times, now emphasising rehabilitation and reintegration into society. However, the specific developments and practices within the prison system can vary significantly from country to country. Modern Uzbekistan has a post-Soviet prison system and ideology and a legal system.

Over the past four years, long-term, purposeful, and large-scale work has been carried out in this area, based on a profoundly analytical and systematic approach. In particular, three laws, five Resolutions of the President, eight Resolutions and Orders of the Government, and 14 other legal acts aimed at further expanding convicts' rights and legitimate interests and improving their living conditions were adopted. In particular, the 'Standard Minimum Rules for the Treatment of Prisoners', adopted by the resolution of the UN General Assembly on 17 December 17 2015, were implemented in the national legislation. For the first time, the right to vote was granted to persons serving sentences for small- and medium-gravity crimes and less severe crimes (Uzbekistan-Geneva, 2021).

2. *The Population of the Penitentiary System*

Over 29,000 convicts are kept in penitentiary institutions in Uzbekistan (Salaev, 2018; Podrobno, 2022). It is reported that more than 7,000 people are in correctional colonies, and 22,000 are in other penal settlements (Widespread, 2016). In 2018, there were, on average, 140 prisoners for every 100,000 residents of Uzbekistan (Clark, 2020).

In the first half of 2022, criminal courts considered 29,783 criminal cases against 38,077 persons in Uzbekistan. As a result, 8,929 people went to jail, 19,070 were given other types of punishment, and 737 were given suspended sentences, according to the Supreme Court (Sputnik Uzbekistan, 2019); Sputnik Uzbekistan (2022).

Of every 30 people currently serving sentences in places of deprivation of liberty, 29 are men and one is a woman (Clark, 2020).

Among the prisoners in Uzbekistan in the first half of 2022, 25,564 were men, 5,945 were women, 11,695 were young people (including 971 minors), and 854 were over 60 years old (Sputnik Uzbekistan, 2019; Sputnik Uzbekistan, 2022).

According to the legislation of the Republic of Uzbekistan, all prisoners have the right to medical care. This is a fundamental human right protected under international law and should be respected and upheld by all governments. However, in practice, this right is not consistently implemented in Uzbekistan, and access to medical care for prisoners may not be consistently provided.

In addition, there have been improvements concerning torture and other forms of abuse in the country's penitentiary system (Uzbekistan AT, 2021). While this is a positive development, it is essential to continue monitoring and addressing these issues to ensure that prisoners' rights

are fully protected. It is also crucial to continue to work towards fully implementing the right to medical care for all prisoners and address any other gaps in the protection of human rights in the criminal justice system.

On 29 December 2020, the President of Uzbekistan addressed the *Oliy Majlis*, the country's parliament, and announced plans to introduce a more humane approach to the penal system. As part of this effort, 25 settlement colonies will be phased out and replaced with probationary supervision for individuals sentenced to imprisonment for the first time. This will allow around 6,000 people serving sentences to live at home with their families under the control of the *mahalla*, a traditional community-based organisation.

The President's announcement marks a significant shift in the approach to punishment in Uzbekistan (Diplomatis, 2021). It is a positive step towards the wider introduction of the principle of humanism into the country's penal system. By providing individuals with the opportunity to serve their sentences in a more humane and rehabilitative manner, the government hopes to reduce recidivism and improve the overall effectiveness of the criminal justice system.

Furthermore, moving away from settlement colonies and towards probationary supervision is expected to positively impact families and communities. Allowing individuals to live at home and be supervised by the *mahalla* (community centre) will help them maintain connections with loved ones and support their reintegration into society. This, in turn, will help reduce imprisonment's social and economic costs and promote a more sustainable and inclusive approach to punishment.

Overall, the President's announcement represents a significant step forward in the ongoing effort to reform the penal system in Uzbekistan and align it with international standards (Diplomatis, 2021; Uzbekistan AT 2021). By prioritising the principles of humanism and rehabilitation, the government hopes to improve the effectiveness of punishment and promote a more inclusive and humane society.

Many social and health issues in Uzbekistan's prison system affect prisoners and incarcerated individuals. Uzbekistan is building a culture of human rights, but concerns about political prisoners, torture, forced labour, and corruption remain, experts of the Human Rights Committee say (United Nations, 2020).

Prisoners may not have access to adequate health care, which can lead to the spread of infectious diseases and other health problems. Lack of education and vocational training can also be a significant issue in prisons, making it difficult for individuals to reintegrate into society after they

are successfully released. This can lead to high rates of recidivism, where individuals return to prison after being released.

Overall, the social and health issues in prisons are complex and multifaceted. Addressing them requires a comprehensive approach that addresses the underlying causes and seeks to promote rehabilitation and successful reintegration into society.

3. *Human Rights Situation in the Penitentiary System*

Incarcerated individuals are often subject to a range of human rights violations, including inadequate access to health care, lack of education and vocational training, and physical and sexual abuse.

Many prisoners also face restrictions on their freedom of movement and association and may not have access to adequate legal representation or other forms of support. This can make it difficult for them to assert their rights and seek justice when violated.

Additionally, prisoners may be subject to overcrowding and poor sanitary conditions, which can have a negative impact on their physical and mental health. These conditions can also lead to an increased risk of violence and other forms of abuse.

Overall, the human rights situation in prisons is often a cause for concern. Addressing these issues requires a comprehensive approach that prioritises the rights and well-being of incarcerated individuals.

There are reports on torture in prisons (USCIRF, 2003). Torture and other forms of abuse are reported to be widespread in the prisons of Uzbekistan. According to a report by the United States Commission on International Religious Freedom (USCIRF), many prisoners in Uzbekistan are subjected to torture and other forms of abuse to extract confessions and information. This abuse is often carried out by law enforcement officials in order to achieve their goals, and it is done with impunity.

The USCIRF report states that methods of torture used in Uzbekistan's prisons included beatings, suffocation, electric shocks, and other forms of physical abuse (USCIRF, 2003). In addition, prisoners has been subjected to psychological abuse, including threats and intimidation. Many prisoners are also held in inhumane conditions, with little access to medical care and poor sanitation. This abuse is particularly prevalent in the case of prisoners who have been arrested on religious or political grounds. Many of these prisoners are subjected to torture and other forms of abuse to force them to renounce their beliefs or to provide information about other individuals.

In conclusion, torture and other forms of abuse are widespread in Uzbekistan's prisons. These abuses are often carried out by law enforcement officials to extract confessions and information, and this is done with impunity.

4. Informal Governance Structures in Prisons

Informal governance structures in Uzbekistan prisons can exist to regulate decisions outside the formal rules and regulations the prison administration sets and how prisoners and correctional officers interact with each other (Moczydłowski, 2015).These structures can take many forms and can vary from one prison to another.

The division of penal facilities into "red" and "black" is a legacy of the Soviet system, and although it is an informal, unofficial classification it is respected by prison authorities and inmates alike (IWPR, 2015). Prisoners may form informal hierarchies based on factors such as race, gang affiliation, or other criteria, and these hierarchies can significantly influence the daily lives of prisoners. Informal governance structures can also arise in relationships between prisoners and correctional officers, with prisoners using various means to gain favours or special treatment from officers. Overall, these informal governance structures can significantly impact the functioning of prisons and sometimes create challenges for the administration in maintaining order and control within the facility.

5. Social Work in the Penitentiary System

Social work services in the penitentiary system include social and medical services. For instance, there is a state social service that helps people in prison to follow professional training and acquire a new professional specialization as a form of resocialisation. In addition, medical services are provided in the penitentiary system. However, medical care in the prisons leaves much to be desired.

For example, Uzbekistan has faced criticism for its handling of torture in its prisons (CABAR.asia, 2020). To address this issue, the ombudsman for human rights in the country has proposed transferring medical services in prisons from the Ministry of the Interior to the Ministry of Public Health. This proposal continues to be ignored by the authorities. A deputy in the country's parliament has called for action on the proposal, arguing

that the current arrangement contributes to the prevalence of torture in the country's prisons. Human rights activists have also criticised the lack of transparency and accountability in handling allegations of torture.

Despite promises to improve legislation and prevent torture, little progress has been made in addressing the issue, and doctors in Uzbekistan can earn money from sick prisoners (Acca Media, 2022).

Sick female prisoners in Uzbekistan reportedly experience serious difficulties with accessing medical care. Human rights activist Tatyana Dovlatova has claimed that there is a high level of corruption in the hospital of Zangiata district in Tashkent region, where patients from nearby penitentiary institutions are treated. Dovlatova has reported that patients are forced to pay for their own medication, which is often overpriced and of poor quality. She has also described medical staff showing contempt for prisoners and denying them the necessary treatment. These reports highlight the need for improved access to medical care for prisoners in Uzbekistan.

Prone of the examples of the medical service work is Fazilkhoja Arifkhojayev, a prisoner of conscience in Uzbekistan, who is forced to do physical labour in a brick factory despite being in poor health and constant pain. He has a deformed spine and has been repeatedly tortured, yet the regime has denied him the necessary medical care. Arifkhojayev's family has made repeated requests for medical treatment, as required by the UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules). Yet officials have denied any knowledge of these rules and continue to refuse Arifkhojayev the care he needs. In addition to this mistreatment, Arifkhojayev has also been attacked by other prisoners with offensive insults, at the instigation of a senior regime official.

These actions violate Uzbekistan's legally binding international human rights obligations established under the UN Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. No officials suspected of involvement in Arifkhojayev's torture have been arrested and imprisoned.

6. *International Organisations and the Penitentiary System*

UNODC also provided technical assistance and support to national partners in developing gender-sensitive legislation, policies, and procedures in the criminal justice sector (Nelson Mandela Rules, 2008).

In addition, UNODC closely collaborates with civil society organisations to increase awareness of gender-based violence and promote victims'

rights (Women and Imprisonment – United Nations Office on Drugs and Crime, 2008). This included providing training and support to crisis centres and shelters for women and children and collaborating with national partners on developing comprehensive services for victims of gender-based violence.

UNODC also supported the implementation of the regional strategy on HIV and AIDS in Central Asia, focusing on reducing the stigma and discrimination faced by people living with HIV. This included providing training to law enforcement and justice sector officials on HIV-related issues and collaborating with national partners to develop and implement policies and programmes that support the rights of people living with HIV (United Nations, 2011).

Overall, UNODC's work in Central Asia in 2021 demonstrated a strong commitment to promoting gender equality and women's empowerment and ensuring the protection of the human rights of all individuals, particularly vulnerable populations.

7. *Participation of NGOs in Prison Social Work*

The situation for NGOs in Uzbekistan is challenging, with various obstacles and hurdles hindering their ability to operate and make a meaningful contribution to society. These include unnecessary bureaucratic hurdles, a lengthy registration process, language barriers, low legal literacy, and a lack of legal support. In addition, unwritten rules about 'expertise' complicate the formation of a genuine civil society in the country. Despite efforts to improve the situation through the adoption of legal acts, the third sector in Uzbekistan still needs to be developed.

Self-initiative NGOs, unlike state-organised NGOs, need more resources and organisational potential to significantly contribute to the country's development. The main reasons for this situation are the lack of financial assistance and support from the government and the dominating of control functions over developing partnerships and dialogs with civil society institutions. Authorities in Uzbekistan need to support and encourage self-initiative NGO activities to foster the growth of a vibrant and active civil society.

The Organisation "Barqaror Hayot" is one of the few well-established, successful NGOs in Uzbekistan. The NGO assists victims of human trafficking and former prisoners with rehabilitation and reintegration into normal life, supports anti-human trafficking efforts, and prepares labour migrants to adapt to working abroad. Barqaror Hayot's director Oliya Il-

muradova is enthusiastic about the new law: 'The new law will expand our opportunities to work with the population, the youth, and the vulnerable people.'

The simplified requirements will create a truly enabling environment both for the existing and newly initiated NGOs, which will impact the overall development of civil society in Uzbekistan. DVV International is the Institute for International Cooperation of the Deutscher Volkshochschul-Verband e.V. (DVV), the German adult education association. DVV represents the interests of the approximately 900 adult education centres (*Volkshochschulen*) and their state associations, Germany's largest further education providers.

On 1 January 2019, probation services and their territorial divisions were established to assist in the social adaptation and employment of former convicts and minors released from penitentiary institutions, which includes organising professional trainings. To improve the legal mechanism aimed at guaranteeing the protection of the rights, freedoms, and legitimate interests of convicts when they are corrected in the system of execution of punishment and social adaptation in society, as well as to strengthen the protection of the rights, freedoms, and legitimate interests of convicts, the prohibition of the unreasonable use of physical force and special means during searches – the law 'On Introducing Amendments and Additions to the Penitentiary Code of the Republic of Uzbekistan, Aimed at Ensuring Reliable Protection of the Rights and Legitimate Interests of Convicts' – was adopted.

The DVV branch in Uzbekistan is implements the project 'Interaction between State Bodies and Civil Society Institutions in the Resocialisation of Convicts and Those Released from Places of Deprivation of Liberty'. The project is implemented with the support of the European Union and the German Federal Ministry for Economic Cooperation and Development (BMZ), in partnership with the Republican Information and Educational Center 'INTILISH' and the NGO 'Institute for Democracy and Human Rights'. The institute was founded in March 2015. The director of the institute is Sayora Khodjaeva. The organisation is engaged in improving the legal culture of the population, advocating for the protection and culture of human rights. Legally, the institute is a non-governmental, non-profit organisation with four branches across the regions of the Republic. One of the institute's research projects is dedicated to developing the national parliamentary system. The goal is to analyse the Uzbek experience and foreign practice in parliamentary democracy. According to Khodjaeva, the institute will contribute to the implementation of the tasks set in the concept, initiated by the President of Uzbekistan. 'For this, we brought

together highly qualified lawyers, undergraduates from law schools, and human rights experts,' she emphasised (DVV International, 2022).

The goal of the project is to strengthen the capacity of civil society organisations to protect the social, economic, and cultural rights of vulnerable groups of the population – convicted and released from places of execution of punishment through the establishment of social partnership and cooperation with government agencies and the provision of adapted services to target groups.

Sayora Khodjaeva turned to the head of the NGO for help (the head of the NGO asked that they neither mention their name nor the name of the NGO). According to the head of the NGO, there is an unspoken rule throughout the country not to allow them to carry out social work or provide it to convicts in prisons. Permission can only be obtained in a colony with minors and when joining an international program, as is the case with DVV International, which, in cooperation with several NGOs, ensures their participation in social work with convicts

8. Reintegration, Rehabilitation, and Re-entry

Reintegration, rehabilitation, and re-entry refer to the process of helping individuals who have been incarcerated to transition back into society successfully. In Uzbekistan, this process should involve providing individuals with the tools and support they need to rebuild their lives, find employment, and avoid returning to criminal behaviour.

Reintegration should focus on helping individuals reconnect with their communities and rebuild relationships with friends and family. This can involve providing access to housing, education and vocational training, and other support services. Rehabilitation, on the other hand, focuses on addressing the underlying causes of criminal behaviour and helping individuals to develop the skills and coping mechanisms they need to avoid returning to crime. This can involve providing access to mental health and addiction treatment, as well as education and vocational training. Re-entry refers to the actual process of returning to society after being incarcerated. This can be a challenging process, and many individuals face barriers to finding employment and housing, as well as discrimination and stigma. To support successful re-entry, it is often necessary to provide individuals with access to support services, such as job training and placement, housing assistance, and mental health care.

Overall, reintegration, rehabilitation, and re-entry are important components of a comprehensive approach to criminal justice that seeks to reduce

recidivism and promote successful reintegration into society. Providing individuals with the support and opportunities they need to rebuild their lives makes it possible to promote a more just and inclusive society.

9. *What Kind of Social Work Services are Provided in the Prisons?*

In general, social workers in prisons may provide a range of services, including mental health and addiction treatment, family support and reunification, education and vocational training, and assistance with re-entry and reintegration into society.

Various professionals may provide these services, including psychologists, counsellors, and other mental health and social service providers. In some cases, these services may be provided by government agencies or contracted out to private organisations. In other cases, they may be provided by non-profit organisations or community-based groups.

Overall, social work services in prisons aim to provide individuals with the support and resources they need to address the underlying causes of their criminal behaviour and successfully reintegrate into society. Providing access to these services can reduce recidivism and promote a more just and inclusive society (Nelson Mandela Rules, 2008; United Nations, 2011).

In 2003, the Head of the Representative Office of DVV International in, Uwe Gartenschleger, initiated the project 'Creation of a Training and Production System in Penitentiary Institutions in the Republic of Uzbekistan' (DVV International, 2022). After discussing the possibility of cooperation with the Main Directorate for the Execution of Sentences of the Ministry of Internal Affairs of the Republic of Uzbekistan and the administration of institutions, the project began its life and is currently ongoing, with the financial support of the Federal Ministry for Economic Cooperation and Development (BMZ). NGOs that officially cooperate with DVV International can take part in the project.

DVV International has been active in Central Asia since 2002, with a regional office in Tashkent, Uzbekistan. In 2009 and 2012 respectively, DVV International country offices were opened in Tajikistan and Kyrgyzstan. Regional cooperation plays an important role in Central Asia. The exchange between adult education providers and various stakeholders from different countries is an important part of the work of DVV International in the region. In 2018 the regional office moved from Tashkent to Bishkek in Kyrgyzstan.

The annual summer academies are significant exchange forums that bring together experts, trainers, and other players involved in adult educa-

tion. The topics of these regional events include, for example, methods of adult education, networking, lobbying, or the international education agenda.

Examples of regional cooperation are the projects for improving educational provisions for prisoners in all three countries in the region. Intensive exchange and mutual consultation take place, both among the civil society partner organisations and the competent public authorities, as well as the teams responsible for project implementation.

Another pillar of the regional approach is to support cooperation between national adult education associations from Central Asia and regional and national partners and networks in the field of adult education. Special mention should be made here especially of PRIA (Participatory Research in Asia), based in India and ASPBAE (Asia South Pacific Association for Basic and Adult Education). Cooperation takes place within the framework of joint study tours, summer schools, and workshops (DVV International, 2022).

10. Barriers to the Development of Social Work in Prisons

There are many barriers to providing effective social work services in the prisons of Uzbekistan. Significant barriers include inadequate funding, lack of trained personnel, and limited access to programmes and services (Acca Media, 2021).

One of the significant challenges facing social workers in Uzbekistan prisons is inadequate funding. Jails can be underfunded and lack the resources to provide adequate support to incarcerated individuals. This can make it difficult for social workers to provide the services and support that individuals need to address the underlying causes of their criminal behaviour and successfully reintegrate into society (Acca Media, 2021).

Another barrier to practicing social work in prisons is a lack of qualified social workers or other mental health and social service professionals to provide the needed support. The lack of social workers is a problem for all other spheres of Uzbekistan (Faizieva, 2020). This can make it difficult for individuals to access the services they need, leading to inadequate support and higher rates of recidivism.

In addition, many prisons have limited access to programmes and services to support the successful reintegration of individuals into society. This includes education, vocational training, mental health and addiction treatment, and housing and employment assistance. Without access to

these services, it can be difficult for individuals to rebuild their lives after successful release.

Overall, many barriers exist to providing effective social work services in prisons. Addressing these challenges requires a comprehensive approach that addresses the underlying causes and seeks to promote successful reintegration into society.

11. How Can These Challenges Be Addressed?

The creation of the Ministry of Social Protection has been discussed for many years, but it has yet to appear. Uzbekistan needs an updated social protection system and the introduction of educated, professional social workers to work with those in need. There are already professional employees in the country, but due to the lack of a single state body and staff units, they cannot work according to their profession (Umarova, 2018).

The transfer of the CCES (Committee of the Penitentiary System) from the Ministry of Internal Affairs to the Ministry of Justice is one of the recommendations of the UN Committee against Torture. In addition, an NGO representative (Yergalieva, Kazakhstan) recalled that at present, among the Post-Soviet countries, only in Belarus and Uzbekistan does the penitentiary system continue to remain under the jurisdiction of the Ministry of Internal Affairs.

Upon analysing the data related to social work within the prison system in Uzbekistan, it is clear that improvements need to be made in the work of non-governmental organisations (NGOs) in the penitentiary system as regards the provision of social assistance. To address this issue, several suggestions can be made (EurasiaNet, 2020).

Firstly, it is recommended to strengthen the work of NGOs in the *mahallas*, or neighbourhoods, that assist individuals who have been released from prison. This can include the involvement of psychologists and social workers who can support these individuals as they reintegrate into society.

The rules for establishing NGOs that work within penitentiary institutions should be simplified. This will make it easier for such organisations to operate within the prison system and provide much-needed support to inmates.

Another suggestion is to establish a Ministry of Social Assistance and Protection, which would oversee the provision of social assistance to individuals within the prison system. This would ensure that the needs of inmates are being met and that they are receiving the support they need to successfully reintegrate into society.

Furthermore, the work of prisons should be transferred from the Ministry of Internal Affairs to the Ministry of Justice. This would align the work of prisons with the broader justice system and provide a more cohesive approach to addressing the needs of inmates.

Additionally, regulations should be developed to govern the work of NGOs in prisons and their provision of social assistance to inmates. This could include guidelines for providing medical care, additional education, and psychological assistance.

NGOs should also develop a programme to work with individuals who have recently been released from prison. This could include offering assistance with employment, education, and financial support to help these individuals reintegrate into society.

Regulations related to prisons should also be amended to indicate that social assistance and support are an integral part of the work within the prison system. Furthermore, laws related to social assistance should be amended to include provisions for the most vulnerable segments of the population, such as individuals in prison and those who have recently been released, with a focus on resocialisation and rehabilitation.

It is also essential to address the stigmatisation of convicted persons in civil society and to provide social assistance to the families of convicts who are left without a breadwinner.

Lastly, the issue medical and social assistance for convicts suffering from HIV, HBV, and HCV should be resolved, focusing on providing medical rehabilitation and treatment to those who need it.

Conclusion

The Republic of Uzbekistan has been actively making efforts to reform its prison system with a focus on improving prison conditions and promoting the resocialization and rehabilitation of convicts. The government has invested in constructing new, modern prison facilities that meet international standards for prison conditions to provide a more humane environment for prisoners. In addition, various educational and vocational training programs for convicts have been developed. These programs aim to help convicts acquire skills and knowledge that can be useful upon their release, thus reducing the likelihood of recidivism and promoting their reintegration into society.

The government of Uzbekistan has also introduced programs and initiatives to promote convicts' mental and physical well-being. This includes providing access to medical care and sports and recreational activities.

These programs are intended to help convicts maintain their physical and psychological health during incarceration, which is an essential aspect of their rehabilitation.

It is important to note that the process of reforms takes time, and it's important to have a long-term vision and strategy to achieve the goals. It's also essential to have accurate data and statistics to measure the progress and evaluate the efforts made to improve the system. However, it can be said that Uzbekistan has made progress in improving the prison system and promoting the rehabilitation of convicts. However, there is still room for improvement in fully implementing international standards and addressing ongoing issues such as overcrowding and access to medical care. The government and stakeholders need to work together to address these issues and continue to make progress in the ongoing process of prison system reform.

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8 Compulsory Drug Treatment in China

Hang Su

Introduction

A compulsory drug rehabilitation centre is a location where drug users are placed in mandatory isolation while receiving specialised drug treatment from the public security authorities.

1. Legal Framework

The compulsory drug rehabilitation system is a legal system based on the coercive power of the state, which facilitates the implementation of mandatory isolation drug rehabilitation as an administrative act. China's present drug treatment system is comprised of compulsory drug treatment, coupled with voluntary and community-based drug therapy. This system is in line with the Law of the People's Republic of China on Drug Control, the Regulations on Drug Rehabilitation, and the Judicial Administrative Organs from a legislative standpoint.

The first provides the legal status for compulsory drug rehabilitation as its primary legal basis, defining the specific scope of application, decision-making bodies, decision-making procedures, the duration and start date of treatment, and other systems, whereas the second and third primarily stipulate the provision and management of places for mandatory isolation drug rehabilitation (Hu S, 2021).

2. Organisational Structure

The public security and judicial authorities are the primary executive agencies in charge of mandatory isolated drug treatment. The general security authorities are primarily in charge of approving and carrying out short-term drug rehabilitation assignments (shorter than three months). The judicial authorities' compulsory isolation drug rehabilitation centres, on the other hand, are the principal enforcement bodies in compulsory

isolation drug rehabilitation and are in charge of longer-term rehabilitation endeavours (three months to two years).

The public security authorities that set up the compulsory drug rehabilitation centres are responsible for their management, and the names of the compulsory drug rehabilitation centres are unified as 'Xxx Compulsory Drug Rehabilitation Centre for Public Security Authorities'. Typically, the public security organs of the People's Governments at or above the county level propose a project and submit it to the People's Governments at the same level for approval, in accordance with the unified plan of the People's Governments of the provinces, autonomous regions, and municipalities directly under the central government, and then report it to the Ministry of Public Security for the record. Public security organs may not form a collaborative venture with any unit or individual to run a mandatory drug rehabilitation centre. At the same time, the mandatory drug rehabilitation centre must have a director, one to three deputy directors, and civilian police officers such as correctional officers, medical and nursing officers, and finance officers, depending on the needs of the job.

3. Governance

The State Council regulates the establishment, operation, and funding of obligatory drug rehabilitation centres in China. With the implementation of the People's Republic of China's Anti-Drug Law in June 2008, compulsory drug rehabilitation, previously the responsibility of public security authorities, and re-education through labour, previously the responsibility of administrative and judicial authorities, were integrated into compulsory isolation drug rehabilitation. In terms of location, the Measures for the Administration of Compulsory Isolation Drug Treatment Facilities for Public Security Organs require that compulsory isolation drug treatment facilities be equipped with appropriate professional monitoring, medical, and correctional staff as needed, as well as monitoring and video systems, emergency response systems, advanced medical equipment, and various functional rooms for physical therapy. The facility is governed by legislation and stringent rules. To achieve the aims of standardised management, institutionalisation of treatment, diversification of rehabilitation, socialisation of help and education, and standardisation of building, its management has adhered to strict legal, scientific, and civilised principles.

4. Types of Drug Rehabilitation Facilities

In China, there are three types of drug rehabilitation centres: compulsory isolation drug rehabilitation centres under the supervision of public security authorities, compulsory isolation drug rehabilitation centres under the control of judicial and administrative charges, and drug rehabilitation medical institutions under the supervision of health authorities. People in compulsory isolation and detoxification programmes are subject to obligatory sequestration for a maximum of twelve months, after three to six months in a compulsory isolation and detoxification centre managed by public security officials, according to the legislation. The judicial administration department transfers them to a location of compulsory isolation and drug rehabilitation to continue their obligatory isolation and drug rehabilitation.

The compulsory isolation drug rehabilitation system currently integrates and replaces the public security authorities' compulsory drug rehabilitation and the judicial and administrative rules' re-education through labour drug rehabilitation. It currently comprises the basic system of drug rehabilitation measures in the People's Republic of China, together with voluntary and community-based drug rehabilitation.

In the seventh year (1729) of Yongzheng's reign of the Qing dynasty, administrative measures were enacted, largely in the form of sanctions and drug rehabilitation. In 1952, New China's central government decided to launch anti-drug efforts. No drug rehab agencies or laws existed at the time. Drug users were forced to detoxify, but not to work. Drug users might all be detoxified within three years with medical help. Eventually, the government rehabilitated them (Yao ZH, Xue L, 2004).

In the 1980s, with the country's reform and opening up, the government implemented a series of laws and regulations, and re-education through labour and compulsory drug rehabilitation became required in China. Obligatory drug rehabilitation is a result of a decision by public security authorities to detect drug abusers swiftly, house them for a short time, and assist them in becoming physically segregated from narcotics. The term of compulsory drug rehabilitation is three to six months. Those drug users who have attended compulsory drug rehabilitation run by public security authorities and subsequently took or injected drugs again are sent to re-education-through-labour centres to kick their habit. Re-education via labour lasts one to three years and can be prolonged by a year. The places described above lack medical competence and have trouble re-socialising drug rehab residents, and thus, the search for a drug rehab system continues (Wu M, 2012).

In recent years, drug rehabilitation legislation, regulations, and institutions have been strengthened. With the implementation of the Anti-Drug Law of the People's Republic of China on 1 June 2008, the compulsory isolation drug rehabilitation system has been unified and labour drug rehabilitation has replaced the public security authorities' drug rehabilitation and the judicial and administrative rules' re-education. The Anti-Drug Law outlines the circumstances for applying compulsory isolation drug rehabilitation, including decision procedures, duration, facility management, and physician availability. After 20 years of development and adjustment, China has 678 public security and judicial compulsory isolation drug rehabilitation facilities with about 300,000 beds and about 100 voluntary drug rehabilitation institutions run by the health sector with about 3,000 beds. 59 of the 70 pilot projects for drug rehabilitation sites set up by the National Development and Reform Commission have been put into use. Finally, a total of 67,755 drug rehab bases (sites) have been constructed, with 326,000 people rehabilitated from opioid addiction and a 30.4% employment placement rate (Applied Clinical Medicine for Drug Addiction, 2020).

5. The Population

5.1. Incarceration Rates – Male /Female Ratio – Age Structure

By 2021, there were 1.486 million drug users nationwide, 17.5% fewer than the previous year, and 121,000 newly detected drug users in China. The numbers of existing and new drug users have dropped consistently for the past five years, and drug abuse management is effective.

According to global survey statistics, obligatory isolation drug treatment clinics account for a substantial share of male drug users, with young and middle-aged people dominating. The Xuzhou City Compulsory Isolation Drug Treatment Centre, created on 5 December 2014, welcomed 549 drug users of all types, 81.8% of whom were male; 46.4% were between the ages of 18 and 30; 0.5% were under 18; 32.2% were aged 31 to 40; and 19.9% were over 40 (Xuzhou Health, 2022).

5.2. Social and Health Issues

Although various measures have been taken to improve the effectiveness of drug rehabilitation management in compulsory drug rehabilitation centres, there are still some problems and issues.

(i) Increased management resistance. Most drug users in compulsory segregation and drug rehabilitation institutions are repeat trainees, who are more inclined to confront management mistakes openly. Some trainees misinterpret the Drug Law and coerce and urge other trainees to create disturbances in the facility.

(ii) Security concerns. Some drug users have a weak sense of right and wrong, a paranoid personality, a manic mood, and a strong sense of self-centredness, which are reflected in poor self-control, a poor understanding of compliance with rules and regulations, and more impulsive behaviour that arises without warning, which increases the chance of various kinds of danger: first, self-harming behaviour, such as drug users trying to escape practice work and management correction by swallowing foreign objects; second, trainees ganging up on other drug users.

(iii) Rehabilitation is harder. Most drug users have tried multiple treatments but can't quit. Because of their long history of drug addiction and the depth of their addiction, their treatment is not always effective. Second, the new drugs are more addictive and permanent and make users physically dependent, making it harder to quit. Third, most of the drug users have personality defects and disorders, making it difficult for them to adapt to the drug rehabilitation centre's environment. This complicates rehabilitation (Ling X, 2018).

(iv) Health complications. Unlike criminals, persons in compulsory isolation have suffered from long-term drug misuse. They have heart disease, kidney disease, diabetes, liver disease, tuberculosis, venereal disease, AIDS, mental illness, and physical handicaps. These disorders are like ticking time bombs that can lead to relapse or death if not controlled during discipline. Several drug users have suffered from heart disease, liver disease, TB, and mental disorders. In some instances, this even leads to death. Severe infections and the deaths of detainees can strain the police force, finances, and aftercare, and undermine other inmates' emotional stability and the facility's treatment order (Zhou YC, 2014).

5.3. Human Rights Issues

The Anti-Drug Law states that drug users are 'patients, offenders, and victims', emphasising that drug addiction is a general offence and that users are not discriminated against in school enrolment and employment. All of these laws represent the 'humanism' of the new drug rehabilitation system, which protects human rights under mandatory isolation.

To protect the rights of drug users and their families, as well as the users themselves, from the hazards their drug addiction brings to them, their families, and society, drug users who are subjected to compulsory isolation are temporarily segregated in special drug rehabilitation facilities, where they are given physical and psychological treatment, physical rehabilitation training, health, moral, and legal education, and vocational training. The goal is getting users completely off drugs. By isolating drug users, both their right to live and their human rights are protected. Providing a relatively secure facility for drug users to receive treatment and education not only helps them kick their addiction but also minimises drug-related criminal activity and drug misuse, lowering the harm to society created by drug users and sustaining social security and public safety. By isolating drug users, their families and the public are also protected (Deng YX, 2013).

6.Social Work

6.1. Social Work Services

Social organisations participate in mandatory drug rehabilitation in addition to their regular activities, which are usually project-based with certain temporal and objective requirements, such as anti-drug propaganda, follow-up visits, training seminars, etc. Shanghai Self-Strengthening Social Service General Association is a drug rehabilitation organisation (Wang YJ, 2020).

From the perspective of drug rehabilitation centres, the five main types of social organisations that currently need to be involved are those that work in the following areas: (i) admission to aid and education. Early intervention can be in the form of letters, phone calls, and help. Education refers to anti-drug social workers or volunteers entering drug rehabilitation centres to provide face-to-face help, talking therapy, and education to specific drug users. From a national perspective, education is the most significant way for social forces to participate in compulsory isolation drug

rehabilitation work. (ii) Peer education. This is a form of inpatient help and education, which allows successful drug users to lead others through rehabilitation. These 'peers' or 'role models' have social visibility and influence. (iii) Community engagement. This helps link drug rehab centres with the community, as the term implies. Shanghai's anti-drug social workers help the Narcotics Control Office and public security authorities manage drug users (rehabilitated). If a community drug user violates the community drug treatment (rehabilitation) agreement or relapses, they may be subject to compulsory isolation; after release, they are usually subject to community rehabilitation or community drug treatment under the Drug Control Law and the Drug Rehabilitation Regulations. Anti-drug social workers coordinate drug treatment procedures for users. (iv) Support and assistance. This includes helping drug users receive subsidies and deal with issues they can't handle at home, such as employment and subsidies after release, housing relocation, elderly and children's health and education, etc. Local governments must cooperate and address all concerns, and anti-drug social workers handle them. (v) Follow-up visits. Follow-up visits for released or altered drug users are also an important aspect of Shanghai's recent efforts.

6.2. Medical Services

Since the Anti-Drug Law was implemented in 2008, drug users are treated in mandatory isolation facilities across the country. Medical treatment for drug users in compulsory isolation refers to the activities of medical institutions in drug rehabilitation centres that provide complementary medical treatment, care, and rehabilitation to help users reduce their drug dependence and promote physical and mental rehabilitation. Internal medicine, surgery, psychiatry, addiction treatment, and medical/technical departments are established. Medical technicians are regulated. Drug users get regular check-ups and have their health records managed. Health and family planning departments set treatment norms. Drug users are treated for addiction, hospitalised, and discharged. Infections and mental problems are prevented and treated. We've built a sound system for treating diseases and a medical 'shortcut' to ensure every sick drug user receives effective medical care (Shanxi Province Drug Rehabilitation Administration, 2020).

6.3. Education and Correction

Scientific skills and methods with specific forms and contents of education are used to educate, correct, and rescue drug abusers (Zhang KS, 2020). According to the acceptance level of drug users in rehabilitation, the police will develop a tailored education and correction plan to assist them in correcting their misunderstandings and restoring their physical and mental health.

Drug treatment aims to reintroduce users to society after isolation. The education programme is scientifically designed and includes a variety of social actors, making full use of social resources, so drug users can correct their cognitive biases, develop confidence, acquire knowledge about drug rehabilitation, reshape their nutritive values, and receive training in employment skills to improve their confidence in sobriety, reduce the likelihood of a relapse, and kick their addiction. They can also learn job skills to boost their confidence in withdrawal, reduce the relapse risk, become clean, and reintegrate into society.

To socialise drug rehab education, it is important to open the doors to the community and bring together universities, public interest organisations, social support groups, enterprises and institutions, human resources, and social security bureaus to create a team of social support volunteers who will regularly visit drug rehab centres to provide support. The educational content includes drug users' circumstances and policies, rebuilding social support systems, follow-up care and publicity, employment assistance, etc.

6.4. External Help through Families and Support Groups

The family environment in which a drug addict lives is the most significant aspect in keeping their integrity upon their return: upbringing and family education play an important role in developing a person's character and behaviour. Drug abusers are imprisoned at a drug rehabilitation centre for two years. This is a unique opportunity to mend and improve the family support system. Family interactions boost motivation for sobriety.

6.5. Participation of Non-Profit Organisations in Social Work

From the end of the past century to the beginning of this century, non-profit organisations were established in economically developed regions like the Pearl River Delta and the Yangtze River Delta on the south-east coast to acquire government services for social and public service projects. Non-profit involvement in drug recovery is minimal nationally. The Self-Strengthening Service Society (SSSS), founded in Shanghai in 2003, was the first non-profit in the field of drug recovery (Guo HW, 2012). The Shanghai Anti-Drug Commission Office supervises the SSSS, which provides social work for substance abusers. The SSSS's main work includes community prevention, school prevention, early intervention, community drug rehabilitation (recovery), peer support counselling, family-based programmes, loving support, and professional support groups. Early intervention, community drug treatment (rehabilitation), and peer support counselling are closely tied to mandatory isolation. The other five function together to varying degrees.

6.6. Barriers for Social Work in the Compulsory Drug Rehabilitation Centre

First, social work in mandatory drug isolation has not yet been perfected. The largest hurdle to social work in China's mandatory isolation drug treatment is that the enabling legislation has not been implemented and the related system has not been completely developed. With the new drug rehabilitation concept, the social work services were introduced. However, there are no precise legal procedures to stipulate actual difficulties, like job procedure, drug addict control, and team development.

Second, social organisations and mandatory drug treatment centres have limited cooperation projects. Due to professional upgrading and refined management, most social organisations participate in the main cooperation projects of mandatory isolation drug treatment work, which focus on follow-up visits and peer education.

Third, social work intervention in drug treatment can be difficult. Social work agencies in China do not have a fixed funding agency, and the public finance system is not well established, especially in economically underdeveloped areas, so the sources of funding are narrow; each agency itself cannot raise funds on its own; and the restricted sources of funding lead to a lack of guarantee for the operating funds of the agency. Some of their routine work is restricted, and even when it is reluctantly implemented, it doesn't generate major benefits.

Fourth, anti-drug social workers are scarce. The lack of legislation, the poor level of payment, and the low social recognition for the profession have created an unstable drug recovery workforce. Most anti-drug social workers are older and untrained, making it difficult for them to provide help to drug users.

6.7. Solutions to These Challenges

There are four possible solutions here. First, increase drug rehabilitation's top-level design and social responsibility. Drug rehabilitation requires the collaboration of numerous sectors and departments. Drug recovery involves community support. Therefore, it is vital to increase social organisation engagement in drug rehabilitation, encourage the opening of mandatory isolation and drug rehabilitation work to the outside world, and encourage favourable public opinion propaganda.

Second, expand social organisations' involvement in drug recovery. The involvement of social organisations in compulsory isolation and drug rehabilitation can be deepened in terms of form, substance, and audience, and gradually increased in intensity. For example, participation does not need to be limited to project outsourcing, topic research, volunteer services, etc. Social workers shouldn't limit drug rehabilitation to existing users. Instead, it should encompass drug users' relatives, co-workers, foster homes, drug rehabilitation professionals, and society in general.

Third, develop volunteer drug recovery services as part of an innovative approach to social work. Volunteers are vital to drug rehabilitation worldwide. Shanghai's Anti-drug Volunteer Association has a rehab committee. We should employ this creative method to strengthen drug rehab volunteer services, recognition, incentives, and financial support.

Fourth, develop specific specialisations within the field of drug treatment isolation. With the drug rehabilitation police force set, introducing – through social organisations – a team of specialised drug rehabilitation professionals, such as medical personnel, rehabilitation trainers and psychological counsellors, teachers, and fellow drug rehabilitation workers, can improve the professionalism of drug rehabilitation social organisations and strengthen their business competitiveness.

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9 Compulsory Drug Treatment in Kazakhstan

Mariya Prilutskaya, PhD, Kazakhstan

Introduction

Despite the success in implementing the evidence-based, multidisciplinary support approaches in drug addiction medicine, at best only one in six people who might benefit from drug dependence treatment has access to treatment programmes (WHO & UNODC, 2020). Among the range of factors that lead to this appalling statistic, one factor relates to the stigmatisation and criminalisation of those who are involved in drug use. As a result, the measures to treat drug users can include isolation, restriction, and coercion posed upon people with drug use disorders. Even though WHO and UNODC's international standards declare availability, access, attractiveness, and appropriateness as the main principles for the treatment of drug use disorders (WHO & UNODC, 2020), a number of current public health systems support the idea of varied forms of treatment programmes, with involuntary options for drug-addicted patients being one of the poles on such a spectrum (UNODC, 2022a).

According to Wild (1999), compulsory drug treatment can be defined as the mandatory enrolment of individuals, who are often but not necessarily drug-dependent, in a drug treatment programme. Proclaimed by public health politicians as a cost-effective alternative to criminal penalisation and palliative-oriented services for severe, terminal forms of addictions, for decades compulsory treatment programmes have provoked controversy all over the world in the context of ethical dilemmas and risks to human liberties (Werb *et al.*, 2016). In 2009, an international survey carried out in 109 countries discerned that 69% of state systems exercised compulsory treatment options in various forms, from flexible outpatient programmes to strictly structured and isolating inpatient communities (Israelsson & Gerdner, 2012).

Investigating the acceptance of compulsory treatment in Sweden, Palm & Stenius (2002) mentioned two types of motives underlying the persistence of coercion in drug treatment systems: utilitarian motives (compulsion to protect society) and paternalistic motives (compulsion to promote the well-being of the individual). Exploring the social basis for coercion

exertion in the current sphere of mental health, Szmuckler & Appelbaum (2009) suggested substituting it with the more ethically appropriate term 'treatment pressure'. The authors concluded that pressure, to different extents, has become more relevant in the social agenda over the last two decades. Sophisticated legal regulations and acts, especially in developed countries, tend to increase the integration of people with mental issues into communities. In the meantime, the community is provided with more opportunities and duties including those initiating pressure towards resisting patients. The authors defined the forms of treatment pressure as follows: persuasion, interpersonal leverage, inducement, threats, and compulsory treatment.

In terms of drug addiction treatment, the literature data present various definitions of the types of involuntary treatment where the extent of free choice limitation matters. According to Australian authorities in drug policy development, involuntary treatment is defined as a more restrictive type of mandatory approach, whereas milder forms of compulsory commitment to treatment are referred to as coerced programmes. Models of mandatory treatment can be split into five main categories: court-mandated treatment, drug courts, compulsory, prison-based treatment, civil commitment, and centre-based compulsory rehabilitation (Vuong et al., 2019). The wide variety of models and country contexts contributes to the discrepancies in the assessment of programmes providing services without the free will of patients. This entails contradictions and arguments in policymaking circles all around the world.

The experts in the field highlight the role of general political regimes and the degree of free will acknowledgement as the scope for the controlling, restrictive measures in addiction treatment systems. In this regard, it is of considerable interest to gain insights in post-Soviet territories, which inherited contradictory public health systems that were supposed to be totally community-oriented but made use of forced labour and severe stigmatisation of people with addictions (Lunze et al., 2016). Sharing this common experience with other post-Soviet countries, the case of Kazakhstan's compulsory treatment is useful as an example of the transitional reforms in drug addiction treatment systems, whereby the involuntary sector partly stagnates due to a combination of factors, whilst, at the same time, keeping its contradictory yet stable positions alongside humanisation processes in other law enforcement fields (Chubaeva, 2021).

1. Methodology

Despite the proliferation of various prevention, treatment, and harm reduction approaches addressing drug addictions, the ethical issues of freedom limitations for drug-using patients continue to be on agendas all across the globe, regardless of country incomes and budgets invested into the field. To what extent could the treatment systems, on behalf of the public and state, exercise coercion and impose mandatory requirements in order to reduce attrition rate, increase treatment compliance, and ensure safety in communities? How could the balance between the community and patient well-being be achieved, putting into practice the public mandate of compulsory drug treatment measures? What are the arguments and legal basis to support the status quo for constraining approaches with disputable effectiveness? What interventions are available or, in contrast, underrepresented in compulsory sectors, compared to voluntary drug treatment?

Addressing these questions, this chapter describes the case of compulsory treatment in Kazakhstan as a representative example of the Soviet inheritance of restrictive and isolating treatment approaches for people with severe addictions. It yields insights about the organisational structure, legal regulations, and services in the compulsory sector, which takes a similar key place to the voluntary sector in the state drug treatment system.

In Kazakhstan, only compulsory forms of involuntary treatment are established. A legal basis for coercive programmes does not exist. In other words, in Kazakhstan there is not a court procedure, if the involuntary treatment can be offered to a drug-using convict as a more merciful alternative to a prison sentence. Therefore, in all of the further analysis in this chapter, the terms 'compulsory', 'mandatory', and 'involuntary' will be used as synonyms.

In carrying out the research, a combination of two methodological approaches was employed. In the first step, desk research was conducted to identify all of the officially available information on compulsory drug treatment in Kazakhstan. Additionally, the internally used compendiums, annual statistical reports, and short communications were analysed. In the second step, a series of three expert interviews was carried out. All the experts have at least five years' experience in the organisation or provision of compulsory treatment in two regional clinics in Kazakhstan (Pavlodar and Semey) and gave their feedback on the working routine, regiments, and social characteristics of treated patients.

Expert #1, male, 40 years old, a psychiatrist, has five years' experience of working in the compulsory treatment department in Pavlodar city and has the same amount of experience as a doctor in charge of that department. The department provides treatment for addicted patients from the whole Pavlodar region (with a population size of 750,000). The compulsory department is a division of the central drug addiction hospital and includes 60 beds for male patients with four doctor positions and ten nurses.

Expert #2, female, 65 years old, a psychiatrist, has ten years' experience of working in the compulsory treatment department in Semey city. The department provides treatment for addicted patients from Semey city and its suburban areas (with a population size of 300,000). Like expert #2, her department is a division of the central drug addiction hospital and includes 80 beds for male patients with five doctor positions and ten nurses.

Expert #3, female, 55 years old, a chief analyst at the epidemiology and drug policy department of the Republican Scientific and Practical Centre of Mental Health (Pavlodar city) (with 10 years' experience). Her expertise covers the processing of data with regards to compulsory treatment departments nationwide.

For all the experts, a semi-structured interview was carried out (40–60 minutes). All the records were transcribed verbatim and analysed according to thematic coding in correspondence with the chapter sections. Some of the expert explanations that clearly clarify or exemplify the researched topic are quoted in excerpts throughout the chapter. Internally operational materials and statistical data provided by Expert #3 have also been used in the analysis, in addition to officially published information.

2. *Legal Regulations*

Kazakhstan's compulsory treatment system was inherited from the Soviet narcological structure, first introduced in the form of medical and labour dispensaries ('*profilactoriums*') on 8 April 1967. The main principles and aims of compulsory treatment were established more than 55 years ago and have not changed radically since then (Grishko & Derenova, 2022).

The subject of compulsory treatment has been on the policy agenda of public health managers for the last decades, during which time experts have questioned the effectiveness and principles of the treatment in the medical setting with social restrictions of different extents (Kozhakhmetov,

2019). Kazakhstan's legal standards stipulate two forms of compulsory treatment: within the penitentiary system alongside criminal punishment (which was described in the previous chapter) and in community clinics under the Ministry of Public Health as a form of sanction against misdemeanours, offences, and severe addictions. The main principles and rules of compulsory treatment were established at the highest legal level (after the constitutional level) of the Code of the Republic of Kazakhstan: On public health and healthcare system (2020). Before that, compulsory treatment procedures were regulated by the Law of the Republic of Kazakhstan: On compulsory treatment of patients with alcoholism, drug addiction, and substance abuse No. 2184 (1995). The current standards are listed in Articles 171–174 of the Code and include (i) descriptions of the basic rights, social guarantees, and duties of patients during compulsory treatment, (ii) the motives for and procedures of pre-court preparations of compulsory treatment cases, (iii) the regime and safety requirements, and (iv) discharge steps.

Additionally, the articles include references to a range of operational acts and algorithms that elucidate the structure, organisation, and rules for the medical departments and clinics in the provision of compulsory services. As of September 2022, there were two acts that describe inner order rules for compulsory treatment facilities and the basic anti-relapse services rendered to patients upon release (Ministry of Healthcare of the Republic of Kazakhstan, 2020a; Ministry of Healthcare of the Republic of Kazakhstan, 2020d).

According to the state standards, compulsory treatment within the community drug treatment setting is sentenced in case of antisocial behaviour extreme microsocial maladaptation, and fierce resistance to voluntary treatment. Plaintiffs in a lawsuit in these cases could be family members, labour collectives, public organisations, internal affairs bodies, prosecutor's offices, or child protection authorities. The court's decision, based absolutely on two factors (the degree of patient compliance and addiction severity), can result in various treatment sentences, ranging from six months to two years (or three years for repeat cases) (Eremenko, 2006).

According to the state standards, referral to specialised medical institutions is not applicable to the following persons: severely disabled people with mental and somatic diseases, pregnant women or women with children under the age of eight, minors, males over 60, and females over 55.

Considering the critical role of isolation and security in the provision of the compulsory treatment regimen, the legal documents establish different modes of surveillance for patients. Most patients are placed under *general* surveillance, which guarantees their free movements within compulsory

departments and outside (with a time limit). If a patient does not comply with the daily routine and violates the freedoms of other patients or medical staff, he/she is placed under *intense* surveillance, which means that leaving the department is strictly prohibited. Some of the patients requiring assistance due to mental and somatic issues are put under strict surveillance on a special ward to minimise risks for their health. The most restrictive surveillance is imposed for patients who violate the treatment rules and threaten the life and health of others. For these extreme cases, every compulsory department has a confinement ward with a round-the clock security officer. The rooms on this ward resemble prison cells, with a bed, table, and toilet zone. During the confinement period, a patient is not allowed to leave the ward. Being moved to a special ward can only be imposed as an ultimate sanction by the head doctor of a clinic, who must report to a controlling prosecutor and ensure the period does not exceed ten days.

During the course of compulsory treatment, patients are guaranteed to be able to receive and send parcels, money, and postal orders, and subscribe to periodicals; to be employed in accordance with the labour legislation of the Republic of Kazakhstan; to purchase – using funds held on a personal account – food and essentials, as well as other items (board games, musical instruments, hygiene products, etc.) that are not prohibited for storage and use in the department; to meet with close relatives and their spouse (wife); and to take daily walks in accordance with the daily observational plan, accompanied by a medical worker and an employee of the security organisation.

A person with a mental or behavioural disorder (disease) associated with the use of psychoactive substances can only stop compulsory treatment and be discharged from an organisation providing mental health care by a court order in the following cases: following the expiration of the determined period of compulsory treatment; upon the identification of concomitant serious diseases; and ahead of schedule due to successful treatment, but not more than six months early.

Despite these detailed descriptions of release options, the current standards do not describe the indicators of compulsory treatment success, which are concluded only based on a discretionary decision by the responsible doctors. From a practical perspective, patients have to adhere to the minimum treatment requirements mentioned in the standards: 1) to comply with the internal regulations; 2) to fulfil the official requirements of the administration and medical personnel; 3) to undergo the prescribed treatment; 4) to participate in cultural, leisure, and sports events and socially useful work, taking into account medical recommendations; 5)

to take care of the clinic's property; 6) to maintain cleanliness and order in the department, as well as take their turn in cleaning the area for a maximum of two hours a week; 7) to maintain personal hygiene.

In the event that a patient breaches the rules, the clinic's administration is permitted to apply to the court for a one-year extension to the term of the treatment.

The working conditions of persons with drug use disorders in compulsory treatment clinics are determined by the general labour legislation of the Republic of Kazakhstan, and there are neither special qualifications regarding the condition of being in a restricted area nor any rules regarding additional payments or salary guarantees.

During the period of release preparation, the administration of the organisation providing the compulsory treatment has to inform the local executive body at the patient's place of residence about their release from the medical organisation to assist in accommodation and labour arrangements and to organise further medical surveillance and voluntary anti-relapse treatment. To fulfil the latter requirement, patients have to register at local treatment centres for dispensary surveillance programmes upon release. If they evade registration and supportive treatment, a person may be subjected to forcible transfer by the internal affairs bodies. This can be considered an extra restrictive measure in treatment services that is supposed to ensure compliance and provide continuity in medical support for resistant individuals with a history substance abuse. On the other hand, this action is imposed without a court statement and provided directly by collaborating doctors and police officers.

The legal standards that regulate the anti-relapse and support treatment upon release from compulsory treatment were firstly introduced in parallel to the Code of the Republic of Kazakhstan: On public health and healthcare system (2020) in November 2020 and there were no earlier versions (Ministry of Healthcare of the Republic of Kazakhstan, 2020c). These standards list the minimum basic requirements for supportive treatment interventions in the form of an individual treatment plan that includes various interventions. Diagnostic methods include biological drug tests for drugs, an HIV test, psychometric tests, a quality of life and social functioning assessment, and laboratory and neurophysiological tests. Pharmacotherapy covers the prescription of psychopharmacotherapy, symptomatic therapy, therapy for comorbid somatic and mental pathology, and antagonistic therapy using opioid receptor blockers. Psycho-social support should include medical, psychological, and social counselling for patients and their families, and individual and group psychotherapy sessions.

In their form, all of these basic requirements meet the principles of recovery management, which emphasises the importance of the chronic disease paradigm and underlines the unprecedented role of long-term comprehensive supportive programmes (Scott et al., 2007). Meanwhile, the current standards do not include community-based support resources and services focusing only on outpatient clinical capacities. Furthermore, they lack such evidence-based approaches as recovery communities (e.g. twelve-step peer support), recovery education and coaching, harm reduction trainings, and intoxication first aid trainings. Environmental interventions aimed at reducing substance use and criminal behaviour are also beyond the scope of the current standards for post-compulsory management. According to World Health Organization & United Nations Office on Drugs and Crime (2020), it is necessary to involve the whole system, integrating all treatment modalities and the participation of all stakeholders outside the health sector to provide effective recovery management. Multiple stakeholders in communities play a key role and should be engaged in the recovery process. These include families and caregivers, friends, neighbours, mutual self-help groups, spiritual and community leaders, stakeholders from the educational sector, the criminal justice system, and sports and recreational facilities.

3. Organisational Structure and Statistical Data

Despite the obvious drawbacks and disputable effectiveness of compulsory programmes declared by a wide array of studies, involuntary treatment remains prevalent in Kazakhstan's public health system. According to the official statistical data, the proportion of compulsory treatment within the whole drug treatment sector amounted to 13% of all drug treatment in 2020 (Figure 1).

As the graph depicts, from 2018 the rate of compulsory treated patients has been on the rise, which could be attributed to various factors. One of them is the substantial increase in the total number of drug-addicted inpatients, alongside the reduction in the total bed capacity of public clinics (e.g. 4,029 beds in 2019, compared to 3,938 in 2020). Thus, this increase is more likely to be relative because the absolute number of cases experienced a slight decrease, like in the voluntary sphere (e.g. 3,813 patients in 2019, compared to 2,814 patients in 2020). The proportion of compulsory hospitalisation cases is characterised by the disparity at the local level. In 2020, the compulsory treatment proportion was extremely

high in the Kostanay (63.5%), Pavlodar (31.1%), and West Kazakhstan (31.0%) regions (Expert #3, 2022).

Compared to 2020, the number of beds for compulsory treatment in 2021 decreased by 170 and totalled 1,894 beds. The absolute number of beds for compulsory treatment has decreased in the Akmola, Almaty, West Kazakhstan, Kyzylorda, and Turkestan regions.

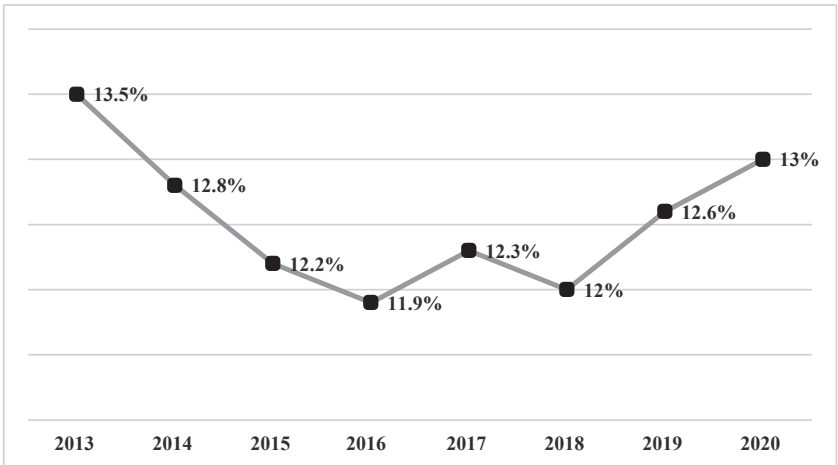

Figure 1: Compulsory Drug Treatment Cases in the Public Health System, 2013–2020

The excessive prevalence of compulsory treatment within the public health system is reflected in the large percentage of bed capacity allocated to involuntary services. In 2020, compulsory beds accounted for 55.4% of all drug treatments, with just a slight reduction from 2,067 beds in 2019 to 2,064 in 2020. Local public health offices all across Kazakhstan tend to reduce the number of beds at the expense of hospitalisation opportunities in the voluntary treatment sector, while maintaining the apparent predominance of compulsory treatment facilities in all regions (with the exception of Astana city and the Kyzylorda region). In contrast, beds for psychosocial interventions comprised no more than 9.5% as of 2020 (Figure 2), with this form of treatment being absent in the Pavlodar, Mangystau, and North Kazakhstan regions (Republican Scientific and Practical Mental Health Centre, 2021). In parallel with the rise of compulsory treatment beds, there is a steady decrease of beds for psychosocial interventions provided for voluntary treatment in public hospitals.

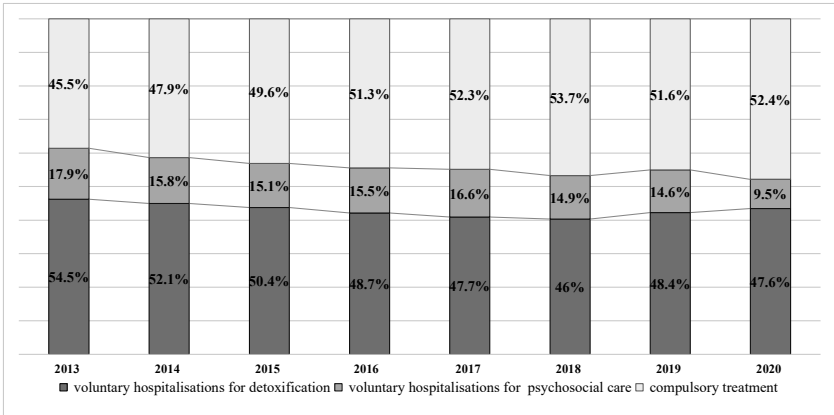

Figure 2: Structure of Public Beds for Hospitalisations Due to Substance Addictions

In contrast with the increased bed capacities of the compulsory sector, the proportion of budgets allocated to involuntary programmes remain low. For instance, in 2016 and 2017, the proportion of the treatment budget for compulsory patients accounted for only 31.2% and 31.9% respectively (Expert #3, 2022). It should be added that all compulsory treatment programmes are financed by the state and excluded from private funding. With the introduction of the health insurance model to the national public health system in 2017, various options for chemical addiction treatment (including compulsory) were introduced and have since been covered by the guaranteed finance package, with free provision for all citizen across all regions of Kazakhstan (Gulis et al., 2021; University Medical Center, 2022).

Drug addiction treatment costs are calculated using operational algorithms that include a special formula and a coefficient that depends on the number of patients officially registered by local clinics (Ministry of Healthcare of the Republic of Kazakhstan, 2020b). In turn, local administrations are entitled to allocate the budget to various options (from primary prevention to recovery services). In general, in 2019 the proportion of addiction treatment costs accounted for 7.61% of the total sum of the free guaranteed package (886,238,610 tenge) (Expert#3, 2022). The current data on the republican budgets for compulsory treatment have, to the best of our knowledge, not yet been published.

As of 2021, the medical staff coverage in compulsory treatment departments was sufficient and amounted to 95% of the required number of doctors (Table 1).

Table 1: Compulsory Treatment Staffing in 2021 (Doctors)

Regions	Percentage of occupation of planned positions	Real number of doctors
Akmola	11.75	6
Aktobe	4.0	4
Almaty	2.5	3
Atyrau	2.0	2
West Kazakhstan	10.0	7
Zhambyl	4.25	4
Karaganda	6.5	6
Kostanay	9.0	4
Kyzylorda	2.0	2
Mangystau	1.5	1
Pavlodar	6.75	4
North Kazakhstan	0.5	0
Turkestan	2.5	2
East Kazakhstan	15.25	14
Nur-Sultan	2.5	2
Almaty	11.0	10
Shymkent	3.0	3
Kazakhstan	**95.0**	**74**

With regard to clinical diagnoses, Kazakhstan's compulsory system has provided treatment services predominantly to patients with alcohol use disorders (Figure 3) over the span of about ten years. This tendency is consistent with the voluntary treatment sector, where alcohol use disorders prevail in patients of both genders and in all regions of the country. Polysubstance addictions take second place in the diagnosis structure of compulsory treated addictions (Republican Scientific and Practical Mental Health Centre, 2021).

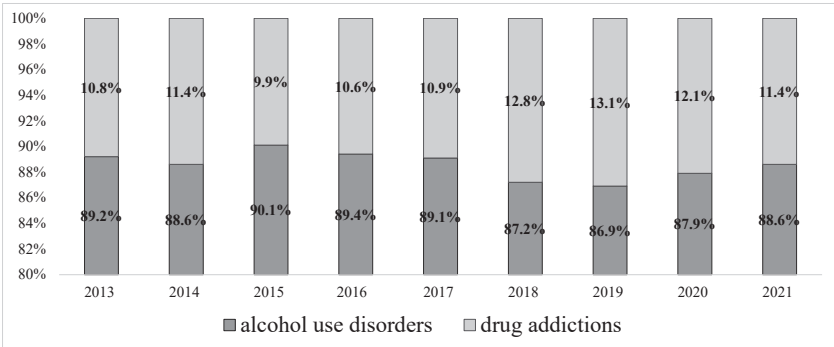

Figure 3: The Structure of Diagnoses Registered in the Compulsory Treatment Sector

In terms of organisational structure and subordination, the reform in the public mental health sector resulted in a reduction in the number of independent medical organisations that provide exclusively compulsory drug treatment services after merging with regional mental health centres. For example, there were six medical organisations for compulsory treatment with 850 beds in 2013 versus one medical organisation with 102 beds in 2020. As of 2022, compulsory treatment is provided only in departments under the jurisdiction of 17 local mental health centres. The aim of this merging is to unify and standardise business processes as well as to ensure consistency in treatment services from the unified providers in each region of Kazakhstan.

According to the public health economics approaches, the cost-benefit characteristics of medical hospitals are measured by the period during which clinical beds remain occupied and medical services can be utilised respectively per year. Ideally, from a public health management perspective, a bed is expected to 'function' 365 days a year. As for the compulsory treatment sector, the average number of bed occupation days was 310 per year in 2021, an increase of 11 days compared to 2020 (299.4 days). However, the mean indicator has unequal distribution in different regions. In some territories, compulsory beds tend to remain vacant for too long and become unprofitable. In these cases, the directors of clinics where compulsory beds are underutilised have to contemplate reprofiling them in favour of departments specialising in psychosocial support. This practical tendency closely corresponds with the operational goals of the Ministry of Health, which specifies capacity building in psychosocial rehabilitation for mental disorders to be the top priority in the field (Ministry of Health-

care of the Republic of Kazakhstan, 2019). Meanwhile, according to the aforementioned statistical data on the stable number of compulsory beds (Figure 2), the reprofiling process has been going much more slowly than planned. One of the reasons for this, according to experts, is the COVID-19 pandemic, which stagnated the reforms compared to the previous two years (Expert #3, 2022).

Among the other indicators of compulsory treatment effectiveness, which are officially registered by state statistical systems, are those that reflect the number of escapes from treatment facilities (Figure 4) and the rate of compulsory rehospitalisations. The latter is directly associated with the quality of post-treatment remissions (Expert #3, 2022).

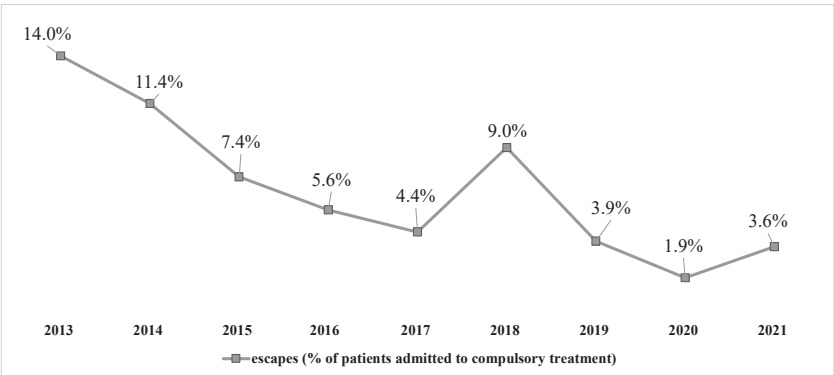

Figure 4: Number of Escapes from Compulsory Drug Clinics, 2013–2021

Attempts to escape from compulsory clinics can be equated with dropouts in the voluntary sector. Brorson et al. (2013) proved the association between the failure to complete voluntary treatment and a range of unfavourable effects: elevated risks for relapse, legal and health problems, and readmissions to the addiction treatment. A similar tendency was revealed for patients sentenced to compulsory clinics. In their study, Padyab et al. (2015), analysing more than 4,000 compulsory treatment cases with a significantly high rate of dropouts (59%), substantiated the association between noncompletion and an elevated mortality risk (16% increase), especially for men with a history of criminal behaviour. It should be noted that this strong association between treatment noncompletion and further social and health risks relates to compulsory treatment with psychosocial care (in Sweden) and might be different for mandating systems without supportive services, as is the case in Kazakhstan. Unfortunately, the data

testing this association in the context of Kazakhstan's compulsory system are not available yet. Meanwhile, every escape from compulsory facilities entails additional costs for the return of fugitives by means of police force involvement, prolonged terms of courses of treatment, and the increased likelihood of patient readmissions with a higher degree of resistance and non-compliant behaviour.

As regards the frequency of compulsory rehospitalisation in Kazakhstan, it was observed that almost every second patient admitted to compulsory treatment did not display any positive effects (e.g. remission) from a previous treatment episode. For example, 3,813 patients were admitted in 2019, of which 48.0% were rehospitalised in the same year, in 2020 the rate of readmittance was 60.8%, and in 2021 it was 46.3% (Expert#3, 2022).

The regional structure of readmittance cases varied significantly, from 1.8% (in Astana city) to 100% (in Almaty city) (Table 2). This observation can be explained by discrepancies in the hospitalisation approaches between regions. Doubtless, the regions with a high rehospitalisation rate provide a lower quality of service. On the other hand, the regions where rehospitalisations are strikingly low might impose controlling measures to prevent frequent rehospitalisations or experience too high a demand on services for new patients. For example, this is relevant for Astana city, which has seen rapid population growth due to internal migration processes.

Table 2: Regional Structure of Compulsory Rehospitalisation Cases

Region	Rehospitalisation Rate (%)		
	2019	2020	2021
Akmola	47.0	42.2	25.9
Aktobe	43.7	48.2	55.7
Almaty	84.3	70.2	70.2
Atyrau	1.7	25.6	0.0
West Kazakhstan	32.2	63.1	47.6
Zhambyl	89.7	75.9	92.7
Karaganda	11.5	35.4	7.6
Kostanay	33.3	53.0	38.3
Kyzylorda	61.5	69.5	90.1
Mangystau	20.3	42.9	35.3

Region	Rehospitalisation Rate (%)		
	2019	2020	2021
Pavlodar	48.5	48.3	52.3
North Kazakhstan	50.9	78.6	40.1
Turkestan	35.2	84.6	92.7
East Kazakhstan	36.9	30.3	20.8
Nur-Sultan	21.1	1.1	1.8
Almaty	87.9	100	100
Shymkent	64.4	86.5	55
Kazakhstan	**48.0**	**60.8**	**46.3**

The latest data available from official statistics that assess the prevalence of at least one-year remissions following compulsory treatment clearly question the effectiveness of these drug treatment services (Republican Scientific and Practical Mental Health Centre, 2021). As of 2017, the rate of one-year remissions was less than 4% (Figure 5).

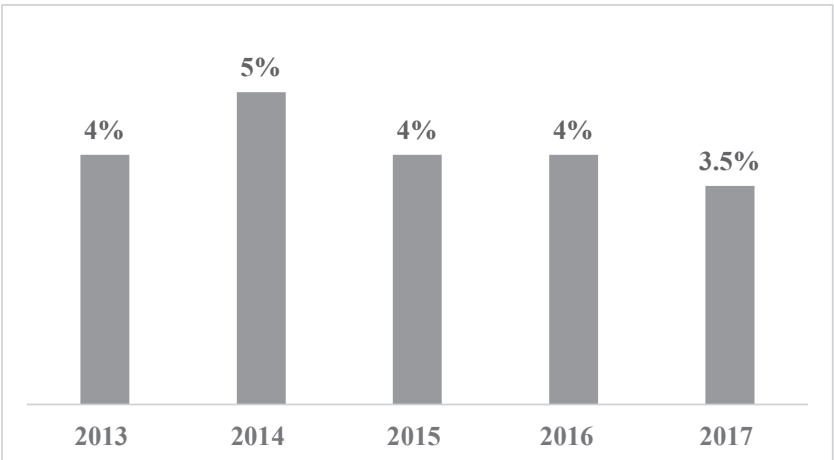

Figure 5: One-Year Remission Rate for Patients on Compulsory Courses of Treatment

The number of incidents (such as physical aggression, riots, or protests) was also high in 2017 (21.9% of the total number of involuntarily hospitalised patients was involved in such an incident) (Expert #3, 2022). In line

with the given statistical data, the annual reports from the ombudsman office have systematically registered cases of active destructive resistance to the treatment rules and regime requirements that entail stricter surveillance of non-compliant patients with temporary restrictions of their rights and social guarantees. Additionally, the human rights defenders underlined the lack of psychosocial rehabilitation interventions within compulsory treatment programmes and consider this finding to be the common key obstacle in violence de-escalation and therapeutic compliance facilitation (Human Rights Commissioner in the Republic of Kazakhstan, 2022).

4. Social Characteristics of Compulsory Treatment Patients and Services

Information on the demographic and social profiles of patients undergoing compulsory treatment in Kazakhstan are sparse and often contradictory. The media companies exploit images of marginalised alcohol and drug users who have been neglected by their relatives and 'imprisoned' in the treatment facilities 'as a punishment for an immoral lifestyle'. Mostly, these mass-media publications underline the social pertinence of restrictive measures to maintain public order and highlight the importance of police officers placing patients in clinics at the right time (Diapazon, 2018; Khabar24, 2021). This agenda encourages the stigmatisation of addicted people and prone to consider addictions through the penalisation prism. On the other hand, some media reports reflect criticism of compulsory approaches, exploiting a popular slogan about the absolute ineffectiveness of coercion with addicted patients (Sputnik Kazakhstan, 2018; KazTAG, 2020). In their eagerness to promote their specific angle, neither media approach properly substantiates their message with accurate and reliable statistical data and research results. Furthermore, accurate, peer-reviewed data and research projects are available only for patients who receive drug addiction services on a voluntary basis in Kazakhstan. To the best of our knowledge, there are only sporadic papers and references in local journals yielding brief insights into the compulsory population characteristics and services provided in clinics.

According to the assessment undertaken in the Karaganda compulsory clinic (situated in Central Kazakhstan) by Turtbayev et al. (2009) between 2006 and 2008, the most prevalent diagnosis was alcoholism, which matched the republican trend. However, the proportion of patients with drug addictions was also sizeable. In 2006, the percentage was 25%, in 2007 it was 24.5%, and in 2008 it was 22%. Persons aged 31 to 40 years prevailed among other age groups. Most of the assessed patients

had completed secondary education. According to Turtbayev, residents of urban areas had more chance of being referred to compulsory treatment. The authors attributed this finding to the active work of police officers in cities and towns and their availability to proceed such legal cases in courts, in collaboration with doctors. In rural areas, drug and alcohol addictions were more stigmatised and, as a consequence, more frequently hidden from the community services by relatives. Another explanation was related to lower levels of trust in police officers in villages where inhabitants 'do not want problems with police'. A large proportion of the patients identified themselves as belonging to the Russian ethnical group, which corresponds with the data retrieved from voluntary treated patients (Rossinskiy, 2006).

In social terms, the majority of patients that took part in the Karaganda assessment (up to 86%) were unemployed and did not have supportive family connections (up to 84%), which deteriorated their maladaptation and reduced the likelihood of them reintegrating into communities after completing the compulsory course of treatment (Turtbayev et al., 2009). Meanwhile, the modalities and social services provided to the patients were not described in the Karaganda assessment. Among the interventions practised in state clinics, Eskalieva et al. (2009) listed only psychopharmacological therapy, which was aimed at the reduction of resistant behaviour, the alleviation of depressive symptoms, and the controlling of cravings. This published information corresponds with the feedback from the expert who worked in Pavlodar compulsory clinic and confirmed that the principal focus over the whole course of treatment was on psychopharmacological therapy.

> The main principle for therapy in our department was medicine prescription. Our patients had to receive psychopharmacological treatment every day, regardless of the duration of their terms. That was normal practice, to receive tablets for six plus months in a non-stop fashion (Pavlodar expert).

The psychopharmacological treatment prescribed to patients does not differ from that used in voluntary programmes. In practice, patients received medications to treat withdrawal, depressive symptoms, dysphoria, and cravings (Eskalieva et al., 2009). Besides the correction of mental symptoms and comorbidities, the patients in the Karaganda compulsory clinic visited various kinds of medical specialist, although physician consultations were most prevalent (four consultations per patient). The patients had the opportunity to attend neurologist and dermatologist consultations (once a year per patient). Dental care was also available for the patients (up

to 30%). As a result of these consultations, in half of the cases, various somatic diseases were diagnosed (Turtbayev et al., 2009). The authors necessitated the reduction of compulsory treatment terms for addicted patients and mentioned the risk of patients losing their motivation for sobriety while being clinically imprisoned. The authors exemplified the experience of preterm releases from the Karaganda clinics (Figure 6).

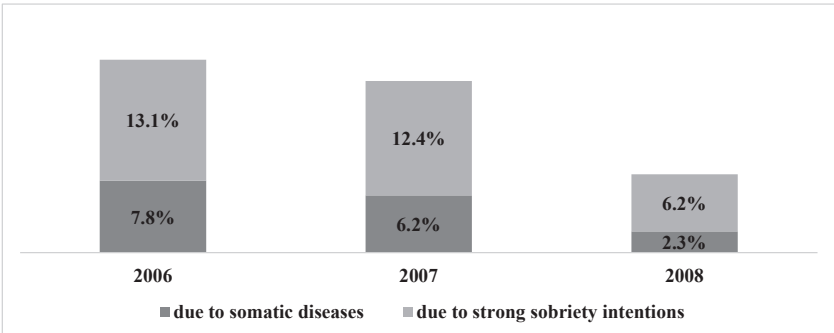

Figure 6: Preterm Releases from the Compulsory Treatment Clinic in Karaganda (based on the Data of Turbaev T.A., 2009)

A substantial proportion of preterm releases were considered by the authors to be successful cases of compulsory treatment, which they demonstrated to promote ideas about introducing a flexible duration of compulsory treatment in contrast to the existing punishment-oriented treatment model. Contrary to the Karaganda experience, the Pavlodar compulsory courses of treatment were more fixed in duration and patients had fewer chances to be released early due to successful recovery.

> At our compulsory department, all patients knew that the chance of being released earlier was minimal. That issue was determined only by responsible judges that required very good reasons for preterm termination. That was especially relevant for those who were in clinic less than six months (Pavlodar expert).

Countrywide, the average duration of compulsory treatment has been decreasing over time. For instance, it amounted to 183.7 days in 2021, having slightly declined in comparison to 2020 (192.9 days). From this mean value, it is obvious that preterm releases (less than six months) are rare practice in the sector (Expert#3, 2022).

In parallel, it is of great importance to understand not only for how many days patients are exposed to the treatment, but also to analyse to what extent compulsory-treated addicts have access to basic psychosocial help. Abundant evidence supports the idea of the importance of psychosocial interventions for drug use treatment. The voluntary basis for these services is a key element for their effective implementation and utilisation, even when provided for detained persons.

A number of studies show the effectiveness of psychosocial support in prisoners with mental issues and drug addictions (United Nations Office on Drugs and Crime, 2022b). In a systematic review of 21 studies, Thekkumkara et al. (2022) revealed the positive impact of various psychotherapy and counselling modalities (motivational intervention, interpersonal therapy, cognitive behavioural therapy, positive psychology intervention, music therapy, and acceptance and commitment therapy) on depression, anxiety symptoms, and addiction symptoms.

Meanwhile, the existence of the compulsory approach raises additional questions about the relevance and feasibility of acknowledged and standardised interventions in without-consent treatment regimens imposed on non-compliant persons barely meeting international recommendations and standards while increasing risks of human right violations. This goes in parallel with significant challenges caused by political factors and centralised systems of programme coordination in these countries (Vuong et al., 2017).

Meanwhile, provision of psychosocial support in the compulsory context could be also found in high-income countries. For instance, the US, New Zealand, and Swedish government acts establish compulsory treatment programmes with the obligatory inclusion of cognitive behavioural therapy (CBT) with family counselling, and peer and occupational therapy support for those with severe addictions, socially destructive behaviour, and voluntary treatment denial (Hazelden Betty Ford Foundation, 2017; New Zealand Ministry of Justice, 2020; Ledberg & Reitan, 2022; Palm & Stenius, 2002). Even advanced compulsory programmes that include psychosocial support fail to achieve results comparable with those gained in voluntary settings.

The data of Ledberg & Reitan (2022) draw attention to the elevated mortality risk immediately after discharge from Swedish compulsory treatment programmes that, in contrast to those in Kazakhstan, only last up to six months. Over this shorter period, Swedish patients struggle to maintain social relationships and suffer from feelings of isolation, depression, and anxiety. In their study, Petterson et al. (2021) postulated the lack of attention to patient inter-personal connections within detention institutions

and the negative effects of strict regimes on the social functioning of patients. The aforementioned Swedish data could be useful in implying the extent of personal, health, and social problems that Kazakhstan's severely addicted patients face when serving their court treatment sentences.

Compared to developed countries where strict, restrictive approaches are combined with evidence-based interventions, Kazakhstan has focused on the implementation of psychosocial support only in the voluntary sector. To the best of our knowledge, there is no legal act or normative document establishing anything other than pharmacological interventions within compulsory treatment. The interviews with the experts displayed sporadic attempts to implement some elements of rehabilitation programmes: motivational counselling, psychoeducation, individual sessions with psychotherapists, peer support groups, art therapy, and structured leisure activities.

> When I worked at a compulsory treatment department, it was our duty (for doctors) to provide different kinds of psychotherapy. Every day I assembled my patients in a special room to hold various sessions. I brought for them paints for art therapy, prepared lectures about addictions and somatic diseases. Every now and then, they participated in trainings. Over the span of their terms, I did my best to motivate them to sustain sobriety after release. At first, it was quite a challenge with newcomers. After a while, my patients got used to attending group sessions. I understand now that those 'psychotherapy' interventions were implemented only thanks to our head doctor. [There were] no legal standards, only local initiatives, extrapolation from voluntary departments (Expert #2).

As mentioned above, relatives and concerned significant others play a key role in drug addiction treatment programmes. In this regard, interventions and supportive care for families in combination with direct patient-oriented measures should be considered as more comprehensive and effective anti-relapse services than those focusing only on patients. These practical observations remain pertinent even in the context of compulsory treatment.

The research data describing the isolation process during compulsory treatment from the patient's perspective underlined feelings of isolation and anxiety entailing emotional withdrawal, shame, and guilt (Petterson et al., 2021; Ridley & Hunter, 2013; Walker et al., 2018). The Swedish quantitative study by Berg et al. (2021) revealed that even among medical professionals, there was no consensus as to how the main principles of social contact enhancement could be implemented in practice.

The basic right of having the freedom to talk to contacts and concerned significant others was challenged by the restrictive rules of compulsory treatment. On the one hand, isolation was seen as necessary for the client's recovery process. On the other hand, relatives were essential motivators for patient compliancy, especially among resistant patients. Berg et al. (2021) discerned that the balance in this issue was mostly attributable to the expertise of the medical staff, which encompassed the ability to systematically evaluate patients and analyse their family systems, communicative resources, and social capital.

From the perspective of relatives, restrictive treatment conditions are mostly considered as the last opportunity for patients to overcome self-destructive behaviour and to reduce potential social and health risks. In the study by Silva et al. (2021), relatives' expectations regarding compulsory treatment were strikingly high, accompanied by the belief that the justice system was able to sensitise their loved ones to addiction and to mobilise their resources. In Kazakhstan, the role of relatives for compulsory treatment admissions is essential as their applications and calls are the main inclusion criteria for the initiation of the court processes. Therefore, the motivations, expectations, and extent of relatives' involvement are of the utmost relevance for patient pathways in compulsory programmes.

To the best of our knowledge, there was only one mention of relative attitudes towards compulsory treatment in local publications. According to Ibrayeva et al. (2014), half of the surveyed relatives evaluated the quality of drug addiction services negatively, while a third of them agreed with the relevance of compulsory options. The family members of compulsory treatment supporters were more likely to have a severe form of addictions (76%) with high rates of unsuccessful re-admittance episodes and resistance to rehabilitation.

The interviews with the experts disclosed that support care for relatives was not available on a systematic basis in their clinics.

> Relatives were able to control and monitor the courses of treatment of our patients. They had regular meetings with the heads of the departments. Unfortunately, those discussions were only formal information exchanges, clarifications about clinical symptoms. In our department [Pavlodar], there were not any special sessions with psychologists or psychotherapists for family members. On the other hand, we did not limit face-to-face contact between our patients and their relatives. The rule was only that their family relevance had to be confirmed with documents (marital certificates for husbands/wives, certificates of birth for parents and siblings) (Expert #1).

> In Semey, we did not have special regulations for working with relatives. That was the duty of our head. But in parallel, we informed them about our local initiative 'Visavi' – a community of parents and relatives involved in addictions. 'Visavi' held regular meetings in outpatient facilities and organised peer-supported groups with psychologists and psychotherapists (Expert #2).

Considering the lack of standards and requirements for psychosocial support within compulsory treatment, it could be implied that family-oriented care is beyond the scope of capacity building for the whole involuntary treatment sector in Kazakhstan. Fragmentary examples of care options for families are provided through NGOs or as part of anti-relapse procedures at the local level at particular regional clinics. To the best of our knowledge, this has not yet been adapted for the compulsory context.

According to case studies and expert information, social work is not represented in Kazakhstan's compulsory sector at the systemic level. Social work positions in compulsory departments are mostly organised for nurses to provide sporadic social services: help with ID regulations or other legal issues and counselling regarding vocational problems and social allowances. Meanwhile, the wide array of scientific literature and evidence-based policies underline the key role of social workers in the organisation and management of holistic treatment processes for addicted patients based on an ecological approach and case management principles (Wells et al., 2013).

The establishment of resourceful social networks with comprehensive assessment and planning are of the utmost importance, especially for those patients who suffer from severe forms of addictions and have had negative experiences with numerous treatment failures. In this regard, professionally trained social workers could provide interventions for the integration and resocialisation of patients over the span of a compulsory treatment term, utilising various interventions (motivational therapy, CBT, contingency management). In practice, the expert interviews revealed that social workers were not included in this evidence-based model. None of the experts was aware of internationally acknowledged competencies in social work with drug-addicted people while pointing out the principal role of clinical staff in compulsory treatment. However, the limited competencies in social counselling and the high caseload (up to 50 patients per doctor) do not allow doctors to provide balanced, accurate, and individual support for their patients.

Conclusions

This analysis of the compulsory drug treatment sector revealed a wide range of problems in service provision, among which the absence of evidence-based technologies is of the utmost concern. According to international research data, even involuntary conditions should be accompanied by psychoeducation, motivational counselling, CBT, and supportive family care. In Kazakhstan's compulsory treatment sector, some of these elements have been introduced in particular departments but without any supervision or systematic approach. Meanwhile, official statistical data cast doubt on the effectiveness of compulsory methods as a whole. The high readmittance rate indicates the need for major revisions of compulsory principles. The current countrywide mental health reforms aim to reduce the number of compulsory beds and transform them into psychosocial places for voluntary-admitted inpatients. However, the discussions and debates in Kazakhstan society, including in professional circles, prove that the drug treatment system is not ready to eliminate compulsory departments totally, taking into account the absence of other alternatives for severely addicted patients with aggressive and anti-social behaviour.

More attention should be paid to strengthening compulsory treatment programmes and developing evidence-based care that focuses not only on the reduction of the addiction symptoms but also on the well-being and social adaptation of patients and their families. Considering the high percentage of compulsory-treated patients, the involuntary facilities could be the starting point for motivational work and case management aimed at raising readiness and adherence to more comprehensive voluntary rehabilitation programmes. Moreover, the role of social workers at the compulsory treatment departments should be revised. It is impossible to actualise the topic of effective involuntary treatment without increasing access to evidence-based case-management models and patient reintegration into the community. All of these warrant increasing the relevance of social work for the multidisciplinary teams working in drug addiction treatment programmes, especially those with restrictive conditions.

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Overview of the conducted interviews

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10 Resocialisation Programmes in Kazakhstan

Dalida Mukasheva, Medet Kudabekov, Dinara Yessimova, Nurlan Tulkinbayev, Anna Konvisar

Introduction

In mid-2021 the prison population of the Republic of Kazakhstan (RK) was around 33,000, a decrease by half compared to the prison population in 2010 (Fair & Walmsley, 2021). 8,051 people were released from prison in 2020, and 8,130 in 2021. Each year, about one quarter of the prison population in Kazakhstan undergoes the process of resocialisation and prepares for release and life in the community.

The decline of the prison population in Kazakhstan over the last 30 years is an indication that the penitentiary system is being reformed towards humanising criminal punishment and showing respect for human rights. The decrease in the prison population is also linked to the introduction of alternative measures for imprisonment, in particular the introduction of probation services for juveniles and women and the creation of centres for adaptation and rehabilitation.

But problems remain and new approaches need to be found. This is evident by the fact that the total number of registered criminal offences is not decreasing but, on the contrary, increasing. For instance, in 2022,127,480 crimes and offences were registered, which is 1.8% more than in 2021. Of these, 86% were crimes and 14% were criminal offences (Legal Statistics, 2022). Moreover, a significant proportion of the prison population has personal and psychological problems. For example, 13.1% of inmates suffer from addiction to alcohol and drugs and have various infectious diseases. Overall, 40% of inmates suffer from mental disorders. The educational level is low, especially among young people in prison (Konvisar, 2022).

After leaving the penitentiary system, ex-inmates face numerous barriers to their successful resocialisation, such as problems with housing, work, and social relationships. It is important to address problems of employment by engaging those (to be) released from prison in socially useful work and/or training and resocialisation programmes, including anti-drug and alcohol programmes or other forms of social activities (Legal Policy Concepts of the Republic of Kazakhstan, 2009).

When it comes to the process of executing the deprivation of liberty and the serving of the sentence, the resocialisation of prisoners is the main challenge facing the penitentiary system (Comprehensive Strategy, 2016). The scientific development of this problem can contribute to the identification of the most effective areas and methods of social work to impact prisoners positively. As the international instruments and the positive experiences of foreign practices show, the effectiveness of the resocialisation process depends on many circumstances, including the preparation of prisoners for release and the social and psychological assistance provided during the post-release adaptation period, as well as the competence of the institution's staff.

The Kostanai Academy of the Ministry of Internal Affairs, named after Shrakbek Kabylbayev, trains social work staff for the penitentiary system in Kazakhstan. At the academy, the training of specialists in social work has been carried out since 2012 by the Department of Organisation of Social Work in Internal Affairs Bodies (Konvisar & Mukhtabaev, 2018).

The introduction of social work into the practice of the penitentiary system is a necessary condition for the humanisation of criminal sanctions. However, the concept of social work in the penitentiary system as the most important means of correcting convicts is only at the early stages in the RK. The process of creating the legal framework and the organisational and administrative measures in the penitentiary system is currently underway (Seipieva, 2013).

The management of the Committee of the Penal and Correctional System of the Ministry of Internal Affairs of the RK recognises the need to improve the quality of professional training in the field of social and humanitarian knowledge. It is important for an employee of a modern penitentiary institution to have knowledge of social work and of the prevention of antisocial, criminal, or victimising behaviour in prisoners. The development of social work in the penitentiary system in the RK certainly has prospects, as social work has a universal nature that allows for the best consideration of the problem of an individual and the construction of the optimal way out of the problem (Seipieva, 2013).

In this chapter, we describe the process of resocialising prisoners in Kazakhstan and outline the main problems and prospects of social work in the penitentiary system based on a review of the literature and the results of our empirical research. We present the results of a joint study between the Department of Sociology at L.N. Gumilyov Eurasian National University (within the framework of the SOLID project) and the Department of Social Work Organisation in the Internal Affairs of the Academy

on 'Organisational and Legal Aspects of Social Resocialisation of People Released from Imprisonment'.

More specifically, we identify the main directions of social work in the penitentiary system in the RK. The resocialisation of inmates is a continuous process that requires regular monitoring and a continuous search for new approaches to social work, as it is related to various interrelated problems, including health, poverty, drug use and stigma. Moreover, we have analysed the problems and prospects of the resocialisation of inmates in Kazakhstan in comparison with the best social work practices. Political support, finances, and human resources play an important role in the successful resocialisation of inmates. Furthermore, we compare the national legislation with minimum international prison standards, including the Mandela Rules, the Beijing Rules, and the Bangkok Rules. Kazakhstan's national legislation complies with international standards, but the status and powers of a social worker are not specified in the legislation.

We address the following research questions: 'What social values may deter a person released from a penal institution from re-offending?', 'Who should ensure that those released from prison return to their families?', and 'Who should address the issues of housing and employment of those released from the penitentiary system?' Lastly, we analyse the resocialisation problems and prospects that prisoners in Kazakhstan face, in comparison to social work best practices. Overall, this chapter includes the following sections: Main trends in social work in the penitentiary system in Kazakhstan, national legislation and international standards for working with prisoners, analysis of problems and prospects for the resocialisation of prisoners in Kazakhstan, results of secondary data analysis, discussion and recommendations.

1. Main Trends in Social Work in the Penitentiary System in Kazakhstan

The penitentiary system of the RK is a social state institution, the main purpose of which is to combat crime, enforce penalties and other criminal-legal measures, and create conditions for the correction and resocialisation of convicts. It consists of 80 institutions, including 64 penal institutions and 16 remand centres. It also includes territorial probation bodies as well as economic, material, and technical support structures and specialised educational institutions. The highest governing body of the penitentiary system is the Committee of the Penitentiary System under the Ministry of Internal Affairs. At the regional level, there are territorial management structures called departments.

The first Article of the Constitution of 30 August 1995 states that the RK 'proclaims itself a democratic, secular, law-based and social state whose highest values are the individual, his life, rights, and freedoms'. The reform of criminal legislation, including the penitentiary system, began with the humanisation of legislation to protect the rights and interests of citizens. A significant step in this direction was the moratorium on the death penalty. Furthermore, the expansion of the use of alternative forms of punishment is supported not only in order to reduce the cost of incarceration and the number of prisoners but also as change in the focus of the state's criminal policy. This work is a continuation in the efforts to humanise legislation.

The main positive aspect of alternative punishments is that convicts are not deprived of their liberty and are given the opportunity to fully use and exercise their rights to work, choose their place of residence, communicate with their loved ones, and pursue other activities not prohibited by their court sentence (Leonov, 2018). In 2011, Kazakhstan legislated the possibility of using alternative means of conflict resolution in various spheres – family, civil, labour, and other legal relations. The enshrinement of mediation in the legislation of the RK was exclusively based on the analysis of the experience of foreign states (Mitskaya, 2018). The main outcome of humanisation has been a reduction of the prison population, which has improved Kazakhstan's position in international rankings on the prison index (Sevryugina & Kuchukov, 2022).

The second area of reforms aimed at humanisation is the development of the probation service. The probation service of the RK was established in 2012, based on the previously existing penitentiary inspectorates. By now it is an integral part of the state law enforcement system and performs executive and administrative functions to ensure the execution of criminal sanctions without isolation from society (Zakhvatov & Baidildina, 2019). Particular attention is paid to the organisation of providing social and legal assistance to persons registered with the probation service. Social rehabilitation, the employment prospects of people serving criminal sentences, and psychosocial work with convicts are the main tasks and functions of the probation service in the RK.

One of the ongoing measures of the RK (2009) is the specialisation of courts, such as the development of juvenile courts and courts for judicial cases. Thus, reforms in the sphere of legal policy and the penitentiary system have been declared at state level, but when implemented, these reforms have not ultimately led to the penitentiary system being deinstitutionalised and transformed in line with international standards. In the opinion of many experts, this is primarily due to the lack of human

resources in the system and the incomplete integration of social security, health care, and rights protection systems for convicts.

However, the adaptation of ex-prisoners is not only a task for the penal system. This complex issue can be supported by the integrated cooperation of all authorised state bodies and non-governmental organisations (NGOs). The effectiveness of resocialisation depends on the extent to which different systems (justice, education, health, social protection, and community) can integrate around a person's needs (Abibulaeva & Kuatov, 2019). Personal formation (socialisation) is the 'multifaceted humanisation process' of an individual's active adaptation to existing social conditions and the realisation of the experience gained through communication, behaviour, and activity. In recent years, the concept of 'resocialisation' has been increasingly used in the scientific literature alongside the purpose of punishment, such as 'correction'. These categories require a legal distinction. In the penal law of the RK (2014), resocialisation in penitentiary institutions is understood as the correction of a convicted person through assistance to restore them to the social status of a full member of society and return them to an independent life in society, whereby they respects the law and the generally accepted rules of conduct.

The problem of resocialising of convicts was expressed in the resolution of the Seventh UN Congress on Crime Prevention and Criminal Justice (Milan, 1985). Here, the international community for the first time turned its gaze towards the problem of the integration of societies, of which the problem of resocialisation is a special case (Kairbayeva, 2010). The first step regarding the issue of resocialising convicts was to improve the effectiveness of law enforcement and the judicial system in the RK by transferring the organisation and implementation of the rehabilitation of ex-prisoners to local executive bodies. Since 2011, the legislation has been amended so that the social rehabilitation of people released from prison has been entrusted to local executive bodies (Comprehensive Strategy, 2016).

The humanization of criminal and penal legislation places new demands on law enforcement and the probation service, which must be met. The efficiency of the probation service of the Ministry of Internal Affairs of the RK depends on the fulfilment of the tasks set for it by the Law 'On Probation', including the provision of social and legal assistance to registered people. Social and legal assistance to persons registered with the probation service is provided on the basis of the existing normative legal acts. These normative legal acts are used by employees of the penal system, the probation service, representatives of local executive bodies, public and NGOs.

Among the whole body of normative legal material, the following should be highlighted: the constitution of the RK, the Criminal Executive Code of the Republic of Kazakhstan, 'On Probation' (rules of the Probation Service, 2014), rules of providing free travel, food, or money to persons released from prisons to travel to the place of residence or work (Resolution of the RK Government, 2014), rules for carrying out educational work with imprisoned convicts, rules for the organisation of probation services (Rules of the Probation Service, 2014), the model regulation of the advisory body under local executive bodies to facilitate the activities of institutions and bodies executing criminal sanctions and other measures of criminal influence, as well as the organisation of social and other assistance to persons who have served criminal sanctions (Order of the Minister, 2014).

The leading role in the penal and correctional system of Kazakhstan to provide persons released from prison and registered with the probation service with the necessary amount of social and legal services is given to the state bodies, public associations, and citizens. Particular attention is paid to increasing the efficiency of interactions between all actors. The scope of social and legal assistance is determined by taking an individual approach. However, it should be noted that the probation service does not have all the necessary resources.

A great deal of social and legal assistance is provided by the local executive authorities. The local executive body is called an *akimat* – a collegial executive body, headed by the *akim* of the region (a city of republican significance) and the capital of the district, which is responsible for the local public administration and self-governance in the relevant territory. Local executive bodies establish consultative and advisory bodies, provide measures to promote employment, provide special social services to people in difficult situations in accordance with the legislation of the RK. The procedure for the provision of social and legal assistance is regulated by the Rules for the Provision of Social and Legal Assistance to Persons Registered with the Probation Service (2014). The rules are quite concise and regulate only the formation of an individual programme of social and legal assistance, as well as the hand over to the local executive authorities. The RK pays close attention to the problems of the penitentiary system and works with citizens serving sentences in places of detention, as well as with persons registered with the probation service.

As explained in this chapter, the preparation for the release of persons serving sentences begins on the first day of their stay in an institution. The Labour and Welfare Officer is responsible for organising this work, and the institution's staff members are also involved in preparing for

release (Minister's Order, 2014). In addition, the provision of social and legal assistance is also reflected in the Probation Service Regulations. These rules define the organisation of probation service activities, including the provision of socio-legal assistance (Probation Service Rules, 2014). An advisory and consultative body has been established under the local executive authorities to make proposals on social and other assistance and the rehabilitation of persons who have served criminal sentences, as well as on the activities of the bodies and institutions of the penal correction system. The consultative and advisory body is a legitimate form of activity directly enshrined in the legislation of the RK. The tasks of the consultative and advisory body include assisting in the employment and living arrangements of released convicts and organizing social and other assistance to persons who have served their criminal sentences. It is composed of the heads of the local executive bodies responsible for the administration and coordination of health care, employment, social programmes, culture, education, business, industry, land relations, and physical education. However, it should be noted that the decisions of the consultative-advisory body are of an advisory nature.

2. National Legislation and International Standards for Working with Prisoners

The revised Standard Minimum Rules for the Treatment of Prisoners, adopted by the UN General Assembly in 2015 and known as the Nelson Mandela Rules are the newest international legal instrument containing anti-torture provisions. They are of great importance for the development of the national penal legislation, which has the current Penal Enforcement Code at its core. It contains a provision that 'the penal and correctional legislation of the RK is based on the constitution and on universally recognised principles and norms of international law'. Thus, Kazakhstan prioritises international legal acts devoted to the sphere of criminal justice and the treatment of convicts. It is necessary to note that the significance of international legal acts is highlighted in penitentiary science, where it is recognised that these standards 'support the development of humanisation in the penal system'.

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) entered into force in January 1976. The ICESCR has been ratified by the Republic of Kazakhstan (International Covenant on Economics, 1966). Of particular relevance to the rights of prisoners is Article 11, which establishes the right of every person to an adequate standard of living. It includes the right to adequate food, clothing, and housing and

the continuous improvement of living conditions. In addition, Article 11, Paragraph 2, recognises the fundamental right of every person to be free from hunger. Additionally, Articles 6-13, and 15 of the ICESCR detail the right to work; the right to suitable conditions of employment; the right to organise trade unions; the right to social security and social insurance; the right to protection of the family and children; the right to health; the right to education; and the right to take part in cultural life, respectively. The Committee on Economic, Social, and Cultural Rights (CESCR) oversees the implementation of the ICESCR.

Many countries have had positive experiences with resocialising convicts and international standards represent one of the most important levers for improving the penitentiary system. International standards force one to pay attention to current practices and promote more effective and humane management of penitentiary institutions. Other countries' experiences with penitentiary probation show that the functions of service staff of penitentiary institutions can include working with inmates to strengthen special adaptation, as well as protecting and representing the inmate in their relations with family members, social authorities, employees of educational institutions, and possible employers. The service staff's main activity is to prepare inmates for social adaptation after release. However, probation officers also do other things to help prisoners maintain contact with the outside world such as establishing links with lawyers, etc.

The participation of the RK in the combat of transnational crime, which is becoming increasingly organised, socially dangerous and affects the security interests of many states, brings with it the task of making national criminal legislation conform with the principles and norms of international law and agreements. The process of implementing and developing new standards is gradual, involves multiple components, and is associated with a range of pitfalls. In this regard, the analysis of international experiences and case studies can provide insight into the challenges faced and overcome. It is useful to draw lessons from the experience of other countries and the international contexts achieved so far worldwide.

In Germany, the Federal Constitutional Court defined the resocialisation of prisoners as the purpose of the execution of criminal punishment in 1973, which is also enshrined in the Corrections Act, which came into force in 1977. The norms of this law state that correctional institutions are designed to 'incorporate' those released from prison so that they can 'live a life without crime in the future in a socially responsible manner'. In Germany resocialisation includes the following activities: counselling on personal problems, predicting the difficulties that the inmate may face after release and ways to overcome them, working to build and increase

the motivation to improve one's life, provision of material assistance in the form of various types of benefits and assistance in finding housing, and assistance in gaining a general or vocational education. The application of specific measures is determined on a strictly individual level, based on the needs of the inmate.

In Germany, various projects individually support persons released from prison in their everyday lives. For example, in the Resocialisation and Social Integration Programme, which began in Cologne in 2009, support was provided for young offenders between the ages of 14 and 17. The social manager established contact with the inmates while they were still incarcerated. After their release, the social manager helped the inmate look for a place to live and apply to the state authorities for social assistance in the form of benefits and employment assistance. During the time the programme was running, the repeat offence rate for the juveniles who took part was 7.7% (Moeller, 2020).

It should be noted that a similar practice exists in the UK. Here, the National Association for the Provision and Resettlement of Offenders plays the main role in the social adaptation of released prisoners. It takes care of the employment and medical care of released prisoners, as well as the protection of their rights and interests. The medical, social, and psychological aspects of inmate rehabilitation are the responsibility of social workers and psychologists. It is imperative that they are part of the staff of all units of the penitentiary system.

In Sweden the rehabilitation of incarcerated people is based on training them in a variety of professions and enabling them to continue their general education. Prisoners sentenced for more than one year are transferred from the national prison to local prisons to undergo a period of pre-release adaptation. Sweden's correctional system includes 140 factory farms and 25 agricultural and forestry associations, where a wide variety of products are produced, and logging and forestry work is carried out. Rehabilitation programmes provide regular two-to-three day exits for prisoners and even short releases before they are officially released. In general, prisoners are given time before their release to prepare for integration into society. Note, for example, that in Sweden there is one social worker for every five prisoners. If the state does not have sufficient resources – sponsors, councils, foundations etc. play an important role in society. These types of channels also exist for the social rehabilitation of prisoners.

Many scholars have identified a range of significant factors to advance social work policy, practice, and research in prisons. Given the inherent tension between prison security goals and prisoners' mental health needs, social work can serve as a facilitator to address this issue (Fedock, 2017).

Well organized work based on international standards contributes to the mental and physical health of prisoners, the creation of collective relationships, successful preparation for release, and further resocialisation.

In Finland, prisoners are, by law, allowed to choose their working hours. This can be work or study. Both activities are paid for by the state. Production activities include metalworking, carpentry, construction, agriculture, fiberglass boat manufacturing, crafts, etc. Working hours are 40 hours per week, with Saturdays and Sundays off. In some prisons prisoners are held only at night and work in civilian enterprises during the day.

In many countries, prisons employ specially trained counsellors and social workers to conduct a risk assessment of all prisoners' risk of reoffending as soon as they arrive in prison. Based on the risk assessment, this staff develops and updates individual plans for reintegration into the community. There are various options for dealing with the lack of housing upon release, such as finding rental housing, living with family or friends, living in public or subsidised housing, finding housing in 'halfway houses' or transit centres, or finding housing in specialised centres for ex-prisoners that are maintained by community and religious organisations, where the necessary resocialisation assistance is provided (Williams, 2016).

In Italy, the emphasis in terms of the resocialisation of prisoners is on preserving and strengthening family ties. For this reason proposals are being made to increase the duration and frequency of meetings between inmates and their families, as well as to lift restrictions on the number and duration of telephone calls or video calls between inmates and their families. The Roman Catholic Church and NGOs play an important role in the resocialisation of convicts in Italy.

3. Problems and Prospects for Resocialisation Programmes in Kazakhstan

In order to obtain a professional opinion on the issue of social resocialisation of persons released from prison, we used methods of statistical and comparative analysis, reviewed the content of the regulatory framework and implemented NGO projects with state funding for 2017–2021, and conducted a survey among employees of penitentiary institutions using a questionnaire. Interviews with the employees of penal institutions were conducted under the supervision of the Kostanai Academy of the Ministry of Internal Affairs. Overall, 268 staff members of penal institutions were interviewed about their attitudes towards the social resocialisation of persons released from prisons using a formalised questionnaire.

In order to understand what the main problems of resocialisation are, we performed three main analytical tasks: we explored the views of staff in penal institutions, we examined the process of resocialising convicts and the main obstacles in implementing the programme in Kazakhstan and we examined the role of NGOs and the state in the resocialisation and social adaptation of convicts. Due to the specific nature of the topic, there were limitations surrounding data collection, and this affected the number and quality of respondents' answers. The questionnaires were sent to the heads of the penal and penitentiary institutions and distributed to the staff. The questionnaire was originally intended for employees who work directly with inmates and assist them after their release, but we could ultimately not control which employees actually completed it. For the analysis of qualitative data the main themes were coded in order to categorise them and identify a pattern. The coding enabled us to see which answers to the various questions were most common among respondents.

The majority of respondents were between 26 and 45 years old, of whom 190 (84.1%) were included as they worked directly with inmates. In those aged 18–25, 29 employees (12.8%) were included, and of those aged 46–60, of whom 7 (10.7%) were interviewed.

Table 1: Level of Education

Education level of respondents	**Qty**	**%**
Vocational secondary	49	21
Unfinished higher vocational	10	5
Higher professional	169	74

As can be seen from Table 1, the majority of respondents (74%) completed higher education, and 21% have a vocational secondary education.

In Kazakhstan, the main type of institution within the penitentiary system is the correctional institution. In contrast to prison, it introduces inmates to labour activities, as well as vocational and general educational training. By type of penal and correctional system institution, the number of respondents was as presented in table 2. Depending on the criminal-legal and correctional characteristics, a distinction is made between colonies with general, strict, and special regimes. Women serve their sentences in colonies with general and strict regimes, juvenile convicts, as well as convicts left in educational colonies until the age of 21 serve their sentences in educational colonies with general and reinforced regimes (for boys) and general regimes (for girls). In addition, there are semi-open-type facilities

(open-type colonies) and closed-type facilities. Thus, representatives of all major types of prison system took part in the survey.

Table 2: Types of Institutions Respondents Were Employed In

Type of institution within the penal system	Qty	%
Medium security institution	72	33.2
Maximum security institution	33	15.5
Emergency security institution	39	18
Total security institution	44	1.5
Mixed security institution	50	23
Minimum security institution	194	8.8

We had initially planned to conduct a survey of those employees who are directly involved in the resocialisation of inmates. However, as we did not have the opportunity to monitor the process of questioning in the institutions, this was not possible. As a result, we could only analyse the data we did manage to collect. The main competencies of the interviewed employees of the penal system are presented in table 3. As illustrated respondents directly worked with inmates and thus the main kinds of activities in penal institutions are represented in the survey.

Due to the limitations of the database, secondary data analysis was used to obtain a broader picture of the issue. These secondary data consisted of a review of existing data (statistics, strategy, protocols, and other research) shared by other professionals in the penal system.

Table 3: Professional Competencies of Respondents

Professional competency	Qty	%
Educational	61	28
Security	20	9.2
Operational and regime	58	26.6
Labour organisation	18	8.3
Social rehabilitation	5	2.3
Psychological	10	4.6
Employees performing all professional competencies within institution	19	8.7

4. Findings

This section presents the findings of the study. As noted in the methodology section, the findings are based on secondary data from official bodies and the results of the analysis carried out.

5. Results of the Survey

The analysis of the Penal Enforcement Code of the RK has shown that the organisation of theological rehabilitation work with convicted persons in penitentiary institutions is also a part of resocialisation. The purpose of the penal and correctional legislation of the RK is the restoration of social justice, correction of convicts, and prevention of new criminal offences committed by both convicts and other persons.

The respondents of the survey indicated that the most successful form of social reintegration used in the penal and correctional institutions of Kazakhstan is the school for preparing inmates for release from the penal system (45%), followed by direct links with businesses for the employment of released persons (21%) and the labour exchange (20%) (Figure 1).

The formation of social services within the penitentiary system of the RK provides the opportunity not only to restore the missing links in the penal system but also to give it integrity, consistency, and a qualitative structure. As part of the resocialisation of prisoners, the administration of the penitentiary institution determines the means of correction to be used and assists inmates in their social adaptation. Social adaptation and psychological assistance (Article 125) are provided to prisoners on an individual basis according to their needs. State bodies, local executive bodies, and the public may also be involved in providing social and legal assistance to convicts.

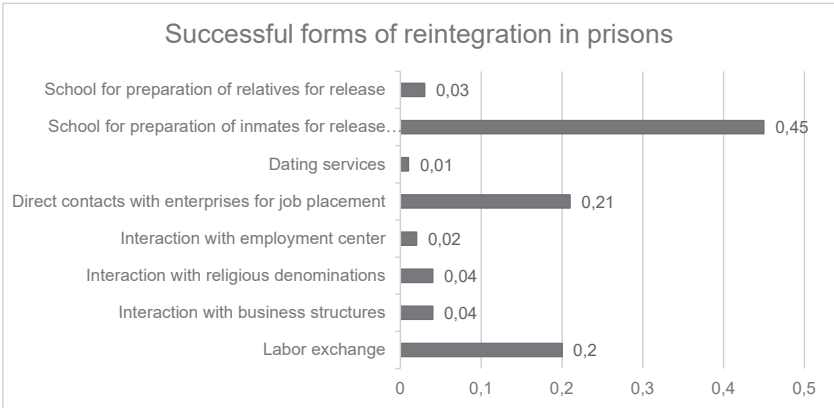

Figure 1: Successful Forms of Reintegration in Prison.

The following question was asked: "Mark the forms (directions) of social reintegration that, in your opinion, are successfully applied in the institution of the penitentiary system in which you work." Multiple answers are possible.

The penal and correctional legislation of the RK includes a chapter entitled 'Assistance and supervision of convicts released from serving their sentences'. This resocialisation programme involves convicts who have reached the end of their sentence. In this case the prison administration notifies the local executive bodies and the internal affairs authorities at the convict's chosen place of residence of their impending release, their housing situation, ability to work, and possible professions. The prison administration prepares an individual programme for the inmate regarding the amount of social and legal assistance required for social adaptation after release, which is sent to the local executive body at the inmate's chosen place of residence. If convicted persons with disabilities or of retirement age do not have housing they may be referred to medical and social institutions for the elderly and disabled. Other persons in need of social assistance can also apply or be referred to social adaptation centres.

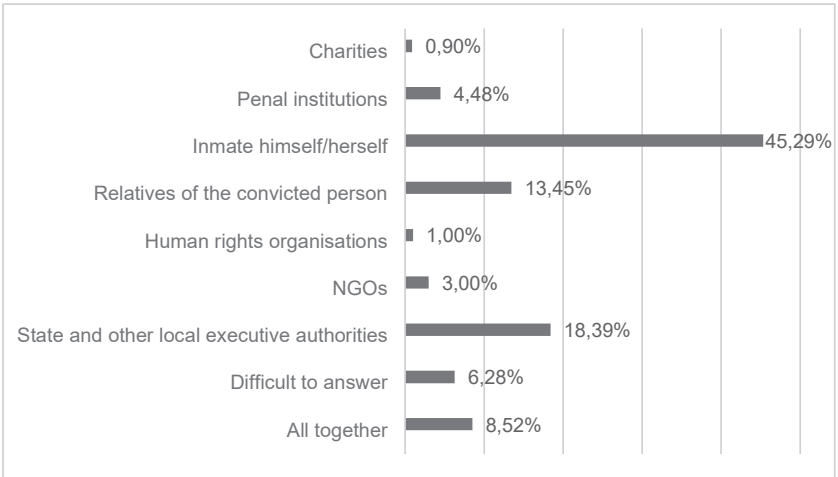

Figure 2: Attitudes of Prison Staff with Regard to the Responsibility for Helping People Released from Prison to Find Housing

The following question was asked: "Who, in your opinion, should primarily ensure that persons released from the penitentiary system find housing?" Multiple answers are possible.

An overview of the answers to the question 'Who, in your opinion, should be responsible for helping people released from prison to find housing?' is presented in figure 2. When it comes to the resocialisation of convicts, the probation service's priority is the employment of those released from prison. The state employment policy aims to ensure that citizens find full, productive, and freely chosen employment that is implemented, inter alia, through measures that facilitate the employment of persons experiencing difficulties in finding a job (Comprehensive Strategy, 2016).

Persons released from serving a punishment in the form of arrest or imprisonment are provided with free travel to their chosen place of residence or work, as well as food or money for the journey within the territory of the RK. If a person is released from an institution and does not have the necessary seasonal clothing or footwear, or funds to purchase them, he/she is provided with clothing and footwear at the expense of the institution that executed the punishment. In many Kazakh cities, rehabilitation centres have been set up for those released from prison. NGOs and religious associations are involved in the provision of social services. However, there are no statistics on service providers.

Next, the respondents' opinions on what social values they believe help to keep a released prisoner from reoffending were investigated (see Figure 3). It turned out that family was the key indicator (55%), followed by material resources (14%) and social environment (10%). These responses are in line with the responses of the convicts, who also view family as the most important factor (80.1%). This finding allows us to conclude that, according to the prison staff, the family of an inmate is the most likely to be capable of ensuring the social adaptation of an inmate upon release and thereby prevents reoffending. Material resources and social environment are also considered important factors for inmates that help them to successfully resocialise.

Therefore, we would like to emphasise the necessity of convicts to maintain family relations. The social worker, too, can play an important role by providing social assistance, support, and protection to a particular individual to prepare them for life on the outside.

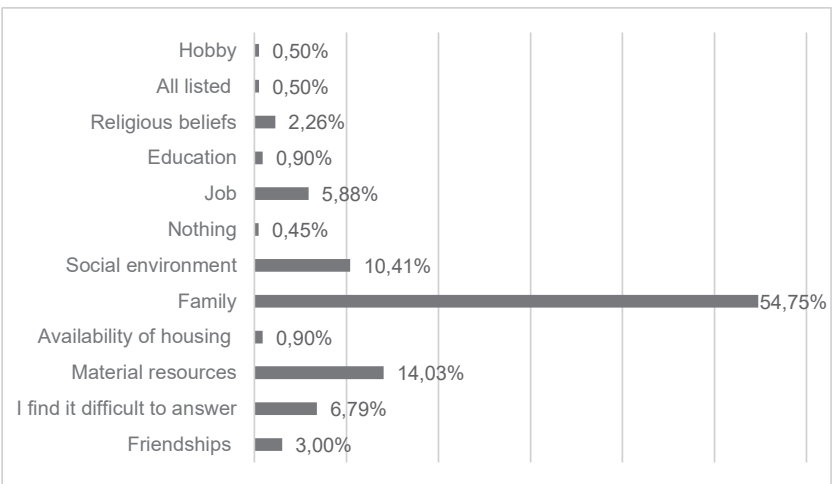

Figure 3. Attitudes of Prison Staff – What Keeps People from Reoffending?

The following question was asked: "What social values may deter a person released from prison from reoffending?" Multiple answers are possible.

The Penal Execution Code and the Law on Local Public Administration and Self-Governance state that *akimats* are responsible for the social adaptation of prisoners who have served their sentences in places of detention (Law RK No. 148-II, 2001).

Specifically, they are responsible for providing persons released from prison with assistance regarding employment as well as in everyday life, allocating quotas of jobs, as well as encouraging the employee to support and assist them.

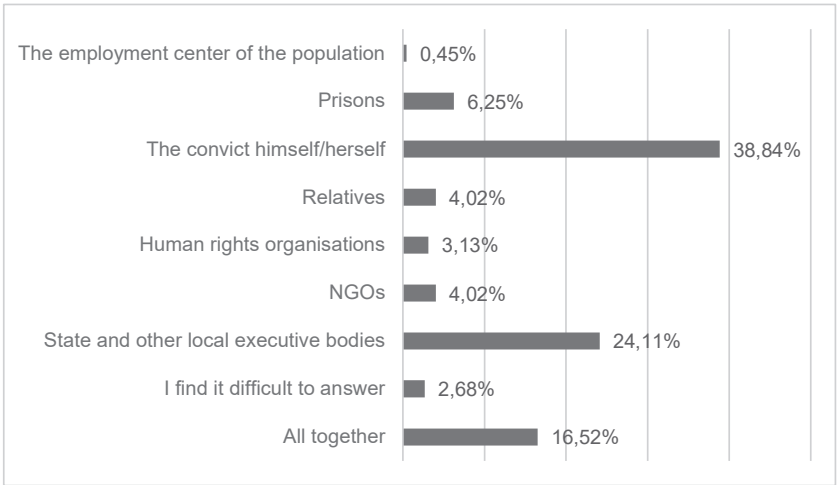

Figure 4: Attitudes of Prison Staff towards the Responsibility of Finding Employment for People Released from Prison.

The following question was asked: "What social values may deter a person released from prison from reoffending?" Multiple answers are possible.

As mentioned previously, for successful resocialisation it is important to start planning the release process as early as possible When we asked prison staff respondents about who, in their opinion, should primarily be responsible for ensuring that persons released from penal and correctional system institutions find employment, the majority answered: the convicted person (39%); followed by the state and local executive bodies (24%) (Figure 4). The resocialisation of persons deprived of their liberty includes the process of restoring the social functions, roles, and status that they lost as a result of committing a crime, being convicted, and serving their sentence in a place of detention. An array of measures, including medical, psychological, educational, and, social measures, are necessary to regain full social functioning.

At present, one of the problems is the issue of resocialising ex-convicts. Our state has formed and operates a probation service, similar to most

European countries. Therefore, in the process of preparing an inmate for release, it is necessary to use the possibilities of the Probation Law, which provides for a new type of probation within the penitentiary system. On the basis of this law, various measures aimed at the successful social adaptation of convicts after serving their sentence should be carried out. Within this process, the support of state organisations and their joint work with public organisations is of great importance.

In general, we can conclude that the penal and correctional legislation of the RK does not make use of all possibilities for the resocialisation of convicts. In practice, inmates released from prisons cannot always rely on the administration and staff of the institution, as our research shows (see Figure 4).

Table 4: Is Preparing Inmates for Release from an Institution Part of Your Professional Responsibilities?

Answer options	**Qty**	**%**
Yes, included	111	49.8
No, not included	108	48.4
Yes, previously	4	1.8

Preparing inmates for release from the penal system institutions is part of the professional duties of 111 respondents (49.8%), not part of the professional duties of 108 respondents (48.4%), and four persons (1.8%) that they used to be engaged in such activities. Thus, the total number of respondents with direct knowledge of the problems surrounding the social resocialisation of persons released from prison is 115 (51.6%).

In the opinion of penitentiary system staff, the following measures, which can be roughly divided into two groups, should be taken to intensify the social resocialisation of persons released from institutions: The first group of measures is related to the activities of state bodies. It includes the adoption of a separate state programme for the social resocialisation of persons released from correctional institutions (72 people [32.9%] agree), the inclusion of this direction in Kazakhstan's priority national projects (25 people [11.4] agree), and creating additional incentives for entities providing assistance in social resocialisation (37 people [16.9%] agree). The priorities named by the staff on the resocialisation of persons released from the penitentiary system are consistent with the respondents' positions on the importance of the activities of other state bodies in addressing resocialisation, and the lack of political will and economic incentives for participation in social resocialisation to address the problem.

The second group of measures is related to the increased involvement of the population, NGOs, and businesses in the resocialisation of persons released from the penal system. One measure, for example, is the active involvement of business structures in this work, something that 20 people (9.1%) suggested should be put into practice. Another is the implementation of the idea of public-public partnership in the field of social resocialisation, which 11 respondents (5%) indicated as a priority. Fifty-one people (23.3%) expressed a different opinion (which they did not indicate) or responded that they found it difficult to answer the question.

6. *Results of Secondary Data Analysis*

An individual's behaviour after serving their sentence does not only depend on the impact of the educational influence of the penal institution, but also on the influence of the post-penitentiary adaptation period. Therefore, re-establishing normal communication links is an important process in the social adaptation of prisoners.

The central role in assisting the social adaptation of prisoners released from the penal system is assigned to local executive bodies, public associations, and NGOs. Our analysis of the problems surrounding social adaptation for those released from the penitentiary system has shown that social adaptation is very problematic without the help of the staff of the penitentiary system, the probation service, and representatives of other state bodies. For persons released from the penitentiary system, the social adaptation process is a rather complex problem whose solution depends not only on the timeliness of the releasees' domestic and labour arrangements but also on the probation services of authorised state bodies and public organisations monitoring the behaviour of the released person during the period of their social adaptation.

Today, NGOs are the state's most important partners in the social sphere. According to a desk study, in 2021 over 22,000 NGOs of various orientations, 3,700 religious associations representing 18 confessions, 3,500 media organisations of various forms of ownership, 234 public councils, and three major national trade union associations, including 36 sectoral and 19 territorial organisations, were officially registered in Kazakhstan. Notably, the activities of half of the NGOs were concentrated in three regions (Almaty region, Astana and Karaganda). Fewer NGOs operate in Northern and Western Kazakhstan.

Using the keywords 'probation', 'resocialisation', 'convicts', and 'prisoners', the search engine of the official website 'NGO Database' (NGO, 2021)

of the Committee on Civil Society Affairs of the Ministry of Information and Public Development of the RK identified 265 NGOs dealing with the resocialisation of prisoners for the years 2017–2021.

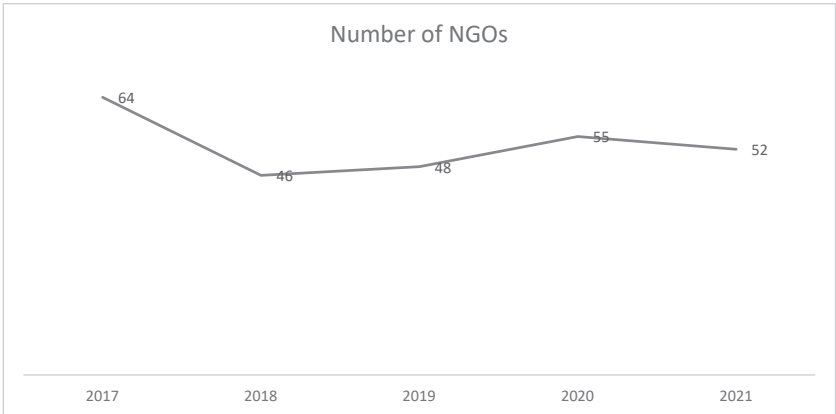

Figure 5. Number of NGOs Working on Resocialisation Programmes in Kazakhstan (2017 to 2021)

According to Figure 5, we see a slight decrease in the number of NGOs dealing with issues relating to convicts and crime prevention among young people in 2021 compared to 2017. According to reports from 2021, the organisations financing the most projects are Penal Reform International in Central Asia (Astana city), the Public Fund Taldykorgan, the Regional Fund of Employment Assistance (Almaty region), the Public Association Rakhim-Sauap (Turkestan region), the Public Association Support of People Living with HIV (Kuat), and the Public Fund Answer East (Kazakhstan region).

Figure 6 shows that with increased funding, project activity also began to increase from 2019. For example, in 2017, the average funding for one NGO did not exceed 10 million tenge, and the number of active NGOs was at the level of 50%. For comparison, in 2021, funding for one NGO increased by 50%, while NGO activity increased by 12%. Thus, we conclude that funding has little effect on the active work of NGOs.

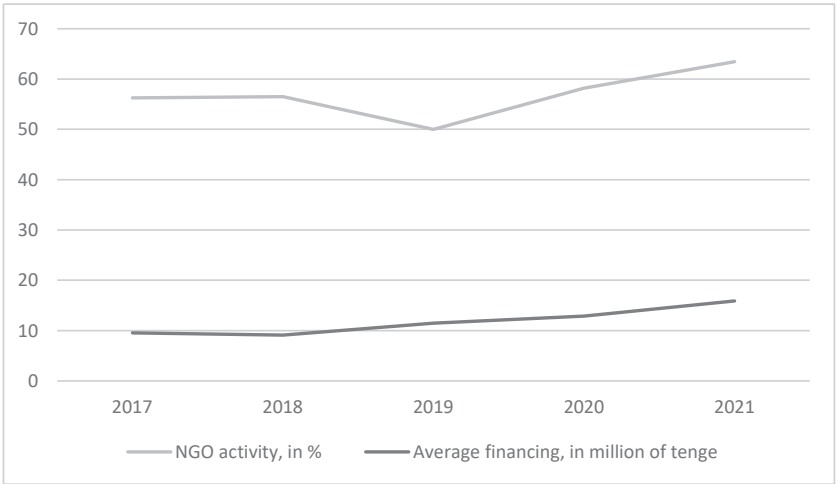

Figure 6. NGO Activity and Average Project Funding

According to the plans of grants for NGOs to assist probation services in the provision of social and legal assistance to persons in custody 27.3 million Kazakh tenge was allocated for the following topics: support for social adaptation services for persons released from prison (5.278 million Kazakh tenge), a set of counselling services for young people released from prison (22.017 million Kazakh tenge), (Civic Initiatives Support Centre, 2021). The main activities implemented by NGOs are aimed at raising inmates' awareness about their rights and providing counselling services aimed at the social rehabilitation of young people in difficult life situations. These activities include the establishment of a social adaptation service for persons released from prison in cooperation with probation services and the provision of temporary accommodation for young people released from prison.

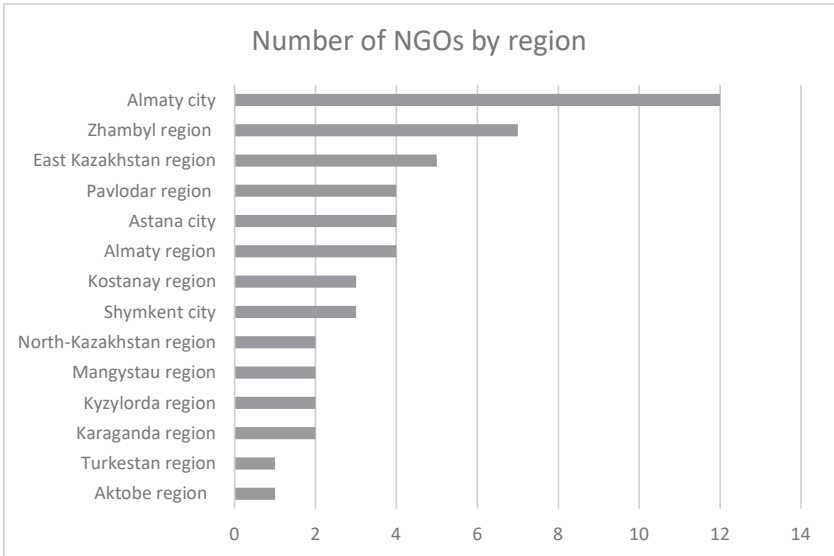

Figure 7: Number of NGOs by Region in 2021

The region with most NGOs providing services to people who have been released from institutions registered with the probation service is Almaty city (12), followed by the Zhambyl region (7), and the East Kazakhstan region (5). The smallest number of registered NGOs providing resocialisation services is in the Turkestan (1) and Aktobe regions (1).

According to the results of the analysis, we can conclude that in most parts of the RK, there is an uneven distribution of NGOs. This means that social services do not sufficiently cover all regions of Kazakhstan to aid the resocialisation of inmates released from prison. Local executive bodies should expand and develop social services for these citizens to ensure their successful resocialisation and prevent reoffending.

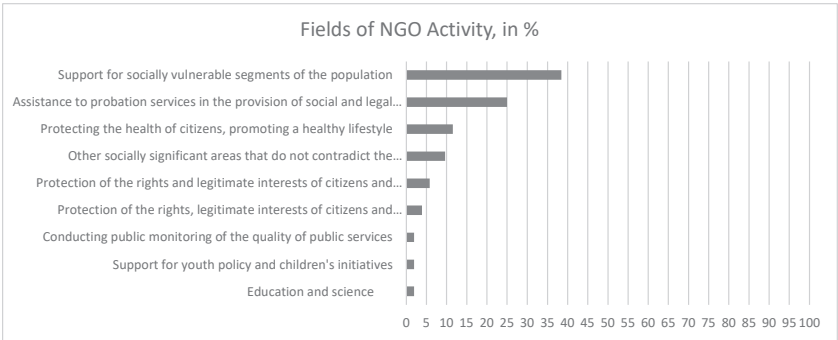

Figure 8: Fields of NGO Activity in 2021

An analysis of the NGO activities in 2021 showed that 25% assisted probation services by providing social and legal support. 40% support socially vulnerable segments of the population. For convicts who are at the stage of resocialisation, the main criterion for receiving social services is a difficult life situation. The state mainly allocates funding not for the prevention of crime and resocialisation of all convicts, but to help vulnerable groups.

The state is the main, but not only, source of funding for NGOs. Businesses, donors, the fundraising system, social media, and traditional media also play an important role. Civil society and the rule of law are united by a number of structural links, without which neither can exist successfully. In the Constitution of the Republic of Kazakhstan, the concept of the rule-of-law state implies the mutual management of civil society and the state, and the reduction of the state monopoly on power through a change in the freedom ratios of the state and of society simultaneously, in favour of the latter and the individual.

7. Discussion

An analysis of the current situation has shown that the state has created the conditions for further improvement of and introduced mechanisms for the social rehabilitation of citizens released from prison and registered with the probation service. It has done so by qualitatively improving the activities of state bodies, involving NGOs in these activities, and strengthening interdepartmental cooperation and interaction between the state and society.

There are many tools in the scientific literature to enable successful implementation of resocialisation programmes for inmates, or at least to reduce the negative impact of prison subculture and personal values, especially for young people. Naturally, these processes require the state and the administrations of penitentiary institutions to change their approaches to working with people. One example of this is the Inside-Out Prison Exchange Program (Smoyer, 2020), which promotes dialogue and learning across deep social divides through in-prison courses involving higher education students and incarcerated students. This programme might motivate an enthusiasm for learning by encouraging participants to find their own unique voice and think about how they can change the world. The programme also provides equal opportunities and a chance to have positive experiences in developing and striving to change lives for the better.

Naturally, innovative approaches to working with inmates, such as the Inside-Out Prison Exchange Program, require legislation, political support, funding, and training. The lack of political will of the authorities to invest in the rights of prisoners is a recurring theme among those interviewed and is seen as a particular challenge to the implementation of such innovative approaches (Prais, 2021).

8. Recommendations

One of the ways to improve the assistance in the social adaptation of those released from the penitentiary system, in our opinion, is to introduce penitentiary probation in Kazakhstan. Here probation officers would establish contact with the relevant services of the penitentiary system in order to assist in the social adaptation of inmates after release. They should conduct visits to inmates, prepare them for release, plan follow-up supervision, and continue the education that was carried out while they were serving their sentence. The term 'probation' was not used in the legislation of the Republic of Kazakhstan until 2012 (Law of the Republic of Kazakhstan, 2012).

But the institution of probation in Kazakhstan cannot work effectively without the active support of social services and the civil sector. NGOs are not only providers of social services but also an active element in changing policy and public opinion to reduce the harm caused by the penitentiary system. Looking at the data we found that NGOs do not pay sufficient attention to resocialisation services. For example, in 2021 only three applications were submitted to the Centre for Support of Civic Initiatives for

social support for citizens released from places of incarceration, aimed at their effective resocialisation.

Thus, we can conclude that NGOs are not very active in terms of resocialisation. Perhaps this is because the policy of the penitentiary system remains punitive, a punishment for the 'unworthy' citizens of society. Accordingly, funding for projects aimed at innovative approaches is not always supported by the state and society, due to the strong stigmatisation of the status of 'prisoners' and prisons. For example, in 2021, NGOs implemented 4,297 social projects, of which only 23 projects were for people on probation and those released from prison.

At the moment, the labour activities of inmates are not planned by the state. At the same time, due to the difficult economic situation and subsidies of some entities of Kazakhstan, there has been a significant reduction in funds allocated for the implementation of regional programmes in recent years. Furthermore, new programmes do not include support of productive activities within the penitentiary system. Thus, many people released from prison have lost all their job skills, making it difficult for them to find employment. At the same time unemployment leads to a high level of recidivism.

Lastly, the analysis shows that the main source of funding for NGO projects is the state budget. However, the state does not fully support the development of services in this area. The main donors are international organisations, not the state. We recommend increasing the state's investment in resocialisation services for convicted persons.

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11 Legal and Regulatory Frameworks of Social Work with Drug Users in Kyrgyzstan

Tynchtyk Estebes Uulu

Introduction

In this chapter the drug situation and the development of social work services for drug users in the Kyrgyz Republic will be discussed. According to the 'Anti-Drug Programme of the Cabinet of Ministers of the Kyrgyz Republic' (2022), the main factors contributing to the formation of trends that, in turn, have led to the development of the current drug situation in the Kyrgyz Republic are: negative social processes that create and maintain a steady demand for illegal drug transit, the international transit of drugs through the territory of the country, the availability of raw materials in Kyrgyzstan for the illicit manufacturing of drugs.

In the field of harm reduction, there are a number of trends that cause some concern. Although the country's harm reduction programmes have been very successful among the prison population, there are a number of prisons that have not yet been given access to these programmes. Also, the law enforcement agencies' temporary detention facilities are not covered by the harm reduction programmes (Anti-Drug Programme, 2022).

To understand the legal basis for social work with drug users in Kyrgyzstan, this chapter provides a discussion of social work services available for drug users both in the prison system and alternatives to imprisonment. Based on the above, this chapter answers the research question: How is social work with drug users regulated in the Kyrgyz Republic?

In order to address the research question, the chapter provides a general discussion of harm reduction, methadone maintenance treatment, needle and syringe exchange programmes, prevention of overdoses from opioids, standard of psychosocial support, standard of outreach work, standard of a social institution, and the social work with drug users in the probation system and prison system.

The legal basis for social work with drug users in Kyrgyzstan is regulated by the Constitution of the Kyrgyz Republic (2021), as well as its' codes, laws, and other normative legal acts. . This also includes the generally recognised principles and norms of international law, as well as

international treaties that have entered into force in accordance with the legislation of the Kyrgyz Republic.

As a full member of the UN, the Kyrgyz Republic implements the political principles proclaimed by the UN General Assembly. In this regard, Kyrgyzstan, when preparing drafts of laws and regulations applies rules such as the Nelson Mandela Rules[1] and the Tokyo Rules[2].

According to Article 1 of the Constitution of the Kyrgyz Republic (2021), the country is a social state. Based on this, the Kyrgyz Republic has developed a system of social services and medical care.

The basic legal regulations in the field of social services are established by the Law of the Kyrgyz Republic 'On the Basis of Social Services to the Population in the Kyrgyz Republic' (2001). According to this law, in Kyrgyzstan, social and legal services and material assistance, as well as the social adaptation and rehabilitation of citizens, are carried out by social service organisations.

The state system of social services consists of republican, city, and regional state bodies that are state property and are under the jurisdiction of state authorities. However, social services are also provided by institutions not owned by the state. The state supports and encourages the development of social services regardless of who owns the institution.

According to the Law of the Kyrgyz Republic 'On the Basis of Social Services to the Population in the Kyrgyz Republic' (2001, Article 3), social work is a form of state and non-state influence on a person or a group of people in order to provide them with socio-medical, psychological, pedagogical, and socio-legal assistance to ensure an appropriate standard of living and activate their own capabilities to overcome difficult life situations.

According to Article 4 of the Law of the Kyrgyz Republic 'On the Basis of Social Services to the Population in the Kyrgyz Republic' (2001), people with substance use disorders have the right to social services.

1 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Adopted by the General Assembly in A/RES/70/175 on 17.12.2015.

2 United Nations Standard Minimum Rules for Non-Custodial Measures (the Tokyo Rules). Adopted by the General Assembly in A/RES/45/110 on 14.12.1990.

1. Methadone Maintenance Treatment

In the Kyrgyz Republic, methadone maintenance treatment for people who inject drugs has been carried out since 2002, using methadone hydrochloride. Methadone maintenance treatment is a carefully researched and science-based medical intervention aimed at treating opioid addiction (AFEW Kyrgyzstan, 2019).

The implementation of methadone maintenance treatment was launched in the Kyrgyz Republic in 2002 with the support of the Soros Foundation-Kyrgyzstan and UNDP. From 2005 until today, the activities of methadone sites have been funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Centre for Prevention and Control of Infections (AFEW Kyrgyzstan, 2019).

Methadone maintenance treatment in Kyrgyzstan is carried out in accordance with the Clinical Protocol 'Treatment of Opioid Addiction Based on Maintenance Treatment with Methadone' (2005), approved by the Ministry of Health of the Kyrgyz Republic dated 29.05.2015 and the 'Clinical Guidelines for Substitution Maintenance Treatment with Methadone in Opioid Addiction Syndrome' (2010), adopted by the Expert Council for Quality Assessment of Clinical Guidelines/Protocols and approved by the Ministry of Health of the Kyrgyz Republic No. 497, dated 11.10.2010 (AFEW Kyrgyzstan, 2019).

The Clinical Protocol 'Treatment of Opioid Addiction Based on Maintenance Treatment with Methadone' (2015) is structured as practical, step-by-step instructions to ensure the protocol is easy for medical staff to understand and implement and to facilitate a unified approach in the provision of maintenance treatment to people with opioid addiction. It is important to note that this unified approach does not only concern the knowledge and skills used by medical specialists but also the information about the treatment process, which must be provided to patients in a timely manner and throughout the maintenance treatment. The Clinical Protocol describes instructions for adjusting methadone dosages at all stages of maintenance treatment and for the management of pregnant women. It also includes advice on psychosocial interventions as well as all the necessary applications for the provision of quality maintenance treatment.

The instructions of the Clinical Protocol 'Treatment of Opioid Addiction Based on Maintenance Treatment with Methadone' (2015) on the psychosocial support of patients includes the identification of priorities, i.e. the patient's most important and urgent needs, such as psychological

state, family relationships, housing issues, legal issues, employment, and education.

Furthermore, the Clinical Protocol 'Treatment of Opioid Addiction Based on Maintenance Treatment with Methadone' (2015) contains instructions regarding the actions to be taken when a patient is imprisoned or released from prison. According to these instructions, patients can continue to participate in the methadone maintenance treatment programme in case of imprisonment and release from prison.

According to the Clinical Protocol 'Treatment of Opioid Addiction Based on Maintenance Treatment with Methadone' (2015), patients are admitted to a methadone maintenance treatment programme on the basis of an application. Then, an agreement is drawn up between the patient and the healthcare institution or institution of the prison system that will run the methadone maintenance treatment programme.

According to the agreement, the institution provides the participant with complete information about maintenance treatment. It has been proven that maintenance treatment in combination with psychological support gives the best results in reducing the frequency of illegal drug use (AFEW Kyrgyzstan, 2019). Thus it is essential to provide the participant with consultations with an addiction specialist, psychologist, and social worker alongside maintenance treatment. Continuity of treatment is an essential factor. In this regard, it is necessary to provide the programme participant with daily methadone delivery and ensure the uninterrupted operation of the methadone site for the duration of the programme, as specified in the schedule. In turn, the patient should visit the methadone site daily to take methadone at a set time and under the supervision of staff. Also, for maintenance treatment to meet the clients' needs, it is necessary to make an individual treatment plan for the participant and discuss possible changes in the treatment regimen, etc. Also, patients should provide all information about concomitant diseases to the doctor to facilitate comprehensive and effective treatment, as well as the timely adjustment of methadone dosages.

On the other hand, the effectiveness of maintenance treatment depends not only on healthcare institutions or institutions of the prison system, but also on patients. Consequently, the patient of the methadone maintenance treatment programme needs to follow all of the doctor's instructions, including filling out the required questionnaires to track the condition of the disease and the dynamics of treatment. Patients take urine tests at the request of the staff to determine the level of drugs in the urine. Since there are risks and health consequences linked to concomitant use of other illegal psychoactive substances. Furthermore, patients can inform staff if

they wish to stop taking part in the programme. It means that human rights are an integral part of maintenance treatment.

According to the Republican Centre of Psychiatry and Narcology under the Ministry of Health of the Kyrgyz Republic (2023), as of January 2023, 24 methadone treatment sites are functioning in healthcare organisations across the Kyrgyz Republic, on the basis of which methadone treatment is provided.

As part of the harm reduction strategy, programmes such as 'Atlantis' and 'Clean Zone' are being implemented within the country's prison system. Atlantis is a rehabilitation programme for people addicted to alcohol and drugs, in which the 12-step Minnesota model of addiction treatment is used. Clean Zone is a rehabilitation and social adaptation centre. At the end of the 12-step addiction treatment programme at Atlantis, graduates (former injecting drug users) continue to live in the Clean Zone until the end of their detention period (AFEW Kyrgyzstan, 2019).

At the same time, according to the 'Anti-Drug Programme of the Cabinet of Ministers of the Kyrgyz Republic' (2022), the number of cases of HIV transmission though injection are decreasing as a result of the measures taken in the Kyrgyz Republic.

2. *Needle and Syringe Exchange Programmes*

A needle and syringe exchange programme is an important structural component of the harm reduction programme for the implementation of preventive work among people who inject drugs. It is regulated by the 'Standard of the Needle and Syringe Exchange Service', approved by the Ministry of Health of the Kyrgyz Republic, dated 25.12.2009, No. 838 (2009).

A needle and syringe exchange programme is one of the main elements designed to prevent new cases of HIV infection and reduce the level of HIV infection among people who inject drugs.

Tasks of the needle and syringe exchange programme include providing people who inject drugs with information on HIV infection prevention and ways to reduce the health risks related to drug use. The programme also includes exchanging used syringes/needles for sterile ones and distributing sterile syringes/needles, as well as the provision of other means to protect clients and their family members. Social work in the programme is carried out by referring clients to medical/social services and organising consultations with specialists as well as access to testing for HIV and other infections, and pre- and post-test counselling. Being an integral part of

methadone treatment, a needle and syringe exchange programme assists in providing access to drug addiction treatment, in particular to opioid substitution treatment. From the above, it is clear that this programme is the most important factor in HIV prevention among people who inject drugs.

According to the Republican Centre of Psychiatry and Narcology under the Ministry of Health of the Kyrgyz Republic (2023), as of January 2023, there are a total of 14 exchange points for syringes and needles throughout the prison system of the Kyrgyz Republic.

3. Prevention of Overdoses from Opioids

As the 'Anti-Drug Programme of the Cabinet of Ministers of the Kyrgyz Republic' (2022) states, the main direct causes of death from drug use are overdoses and autoimmune diseases caused by infectious diseases and their complications. The main indirect causes are accidents associated with the dangerous behaviour of drug addicts (suicides, injuries, hypothermia, and others).

To reduce deaths from opiate and opioid overdoses, the 'Standard for the Prevention of Overdoses from Opioids Using Naloxone' (2010) was adopted. It reflects the mechanism for providing naloxone to active opioid users in order to prevent overdoses.

The purpose of this standard is to create a system of continuous, preventive activities among medical workers and outreach workers to reduce deaths from opioid overdoses. Another line of thought on prevention of overdoses from opioids demonstrates that the standard should ensure people who inject drugs have access to naloxone by dispensing it directly to them. In addition, it is essential to provide information to active opioid users on how to identify the signs of an overdose and methods of providing first aid and emergency medical care. The strength of such a standard is that its implementation is carried out at all levels of assistance to opioid users, including on the basis of a syringe/needle exchange programme.

As a result of the measures taken to distribute naloxone for free, it was possible to significantly reduce deaths from opiate and opioid overdoses ('Anti-Drug Programme of the Cabinet of Ministers of the Kyrgyz Republic', 2022).

4. Psychosocial Support

The purpose, tasks, and forms of psychosocial support are reflected in the 'Standard of Psychosocial Support' (2011). According to this standard, psychosocial support is an activity that pays special attention to the social and psychological aspects of a client's difficult life situation.

The purpose of psychosocial support is to maintain a balance between the client's mental health and the intersystem relationships that affect their life. The essence of this form of support is the client's effective participation in solving their psychological, interpersonal, and social problems.

To further understand the role of social work with vulnerable groups this section explores the idea that psychosocial support is a combination of various forms of support. First, psychosocial support should provide training on the socio-psychological basics of functioning in everyday life, the development of practical life-planning skills, and health care. Second, it is vital to improve clients' quality of health and life by providing early access to psychosocial support and medical care. Third, it is crucial to motivate representatives of vulnerable groups to attend voluntary counselling and testing for HIV infection, since it will create opportunities to prevent HIV transmission by educating representatives of vulnerable groups on the problems related to injecting drug use and HIV/AIDS. Finally, vulnerable groups should be provided information about the services of harm reduction programmes.

The most common and recommended forms of social work within psychosocial support include informational consultations, lectures, trainings, individual and group counselling, family groups, and mutual aid groups. Of equal importance is practical assistance – assistance in organising and managing daily life (cohabitation with people who inject drugs, training in safe behaviour skills, and development of practical life skills such as life planning, budget management, health care). The essence of psychosocial assistance is improving clients' social relations with their environment, relatives, or friends and establishing psychosocial functioning in the family, at work, or at school. Within psychosocial support it is essential to establish contacts with socio-psychological services that have the opportunity to expand the scope of socio-psychological assistance and psychotherapeutic support.

Psychosocial support can be provided by different kinds of specialists (medical professionals, psychologists, social workers, addiction therapists, and others) who have been trained in psychosocial support.

5. Outreach Work

The purpose and tasks of outreach work are reflected in the 'Standard of Outreach Work' (2009). According to this standard, outreach work is a form and method of interaction with closed groups of people who inject drugs, with whom contact through existing health services is difficult.

Outreach work is an integral part of the activities of a syringe/needle exchange programme, complements its work, and at the same time can be the main form of work of an organisation providing harm reduction services for people who inject drugs.

Outreach work in places of gathering/residence can be carried out both by employees who do not have specialised education and by specialists (social workers, doctors, secondary health workers, psychologists, sociologists, volunteers who are also representatives of target groups).

The purpose of outreach work is to provide wider access to closed groups of people who inject drugs on 'their territory' to facilitate the effective implementation of measures for the prevention of HIV infection and other diseases.

The main task of outreach work is to find, establish, and maintain contact with people who inject drugs. Also, outreach work involves people who inject drugs in syringe/needle exchange programmes, medical, social, and legal assistance programmes, and testing for HIV and other diseases. Outreach work plays a significant role in informing and training people who inject drugs to practice less dangerous behaviours. It is also important during sociological research for example when assessing therapeutic programmes (antiretroviral therapy, tuberculosis treatment, methadone replacement treatment), when outreach workers help to survey people who inject drugs.

6. Social Institutions

The next section provides a general discussion of a social institution. According to the 'Standard of a Social Institution' (2009), the concept of a social institution includes a set of services aimed at the social adaptation and reintegration of vulnerable groups within drop-in centres, social hostels, halfway houses, flophouses, community centres, social support, etc.

The purpose of the social institution is to counteract the spread of HIV infection through the provision of services aimed at improving clients' quality of life and reducing the harm associated with drugs, as well as risky sexual behaviour.

Social work in social institutions is carried out by ensuring teamwork between professional specialists, volunteers, and clients in order to encourage clients' commitment to less risky behaviour in relation to sex and drug use. In particular, social institutions implement measures aimed at informing and educating clients on HIV issues and AIDS. Also, if necessary, social institutions interact with relevant services in order to increase clients' access to health care and social and other forms of assistance, including harm reduction programmes for drug users, sex workers, and people living with HIV.

In addition, a social institution should be based on the principles of self-help and mutual assistance of clients and be built in a way to ensure the maximum involvement of clients in the activities of the social institutions and the process of providing assistance.

A drop-in centre is a point of implementation of a set of low-threshold services aimed at drug users, sex workers, or people living with HIV. The activities of a drop-in centre are aimed at providing clients with affordable types of information, medical and psychological services, and social support.

A social hostel is a service for the implementation of low-threshold services aimed at drug users, sex workers, or people living with HIV. The activities of a social hostel are aimed at providing clients with a place of residence.

A halfway house is a service for the implementation of low-threshold services aimed at drug users, sex workers, or people living with HIV. The activities of a halfway house are aimed at providing clients with the opportunity to undergo a course of adaptation therapy. Also, clients can participate in rehabilitation programmes for addiction and further social adaptation. Furthermore, a halfway house does not only provide clients with the possibility of a long stay (up to six months) in the halfway house, but also implements measures aimed at the reintegration of clients into society.

A flophouse is a low-threshold service aimed at drug users, sex workers, or people living with HIV. The activities of a flophouse are aimed at providing overnight accommodation services to clients.

A community centre is a low-threshold services aimed at drug users, sex workers, or people living with HIV. The activities of a community centre are aimed at creating conditions and providing clients with opportunities for communication, leisure, and mutual assistance.

Social support refers to a number of services within harm reduction programmes that ensure clients have timely and coordinated access to appropriate health services, continuous care programmes, and legal, social,

and psychological support. Services also include the constant monitoring of client needs.

7. *Probation System*

To further understand the role of social work with drug users, this book chapter will next consider the probation system of Kyrgyzstan. On 24 February 2017, the Law of the Kyrgyz Republic 'On Probation' was adopted, which entered into force on 1 January 2019. In the same year, the Probation Department was established under the Ministry of Justice of the Kyrgyz Republic.

The principles of probation, the rights and obligations of clients, the control, supervision, and measures of educational influence, and the regulatory framework all comply with the Tokyo Rules.

The United Nations Standard Minimum Rules for Non-Custodial Measures (1990) contain a set of basic principles to promote the use of non-custodial measures, as well as minimum guarantees for persons who are sentenced with an alternative to imprisonment.

Offenders should, if necessary, be provided with psychological, social, and material assistance and opportunities should be provided to strengthen ties with society and to facilitate their return to normal life in society.

Appropriate mechanisms should be established at various levels to facilitate the establishment of links between non-custodial services, other bodies of the criminal justice system, and social development and welfare institutions – both governmental and non-governmental – in areas such as health, housing, education, and employment.

Based on the above, the goals of probation are to ensure the safety of society and the state, to create conditions for the correction and resocialisation of probation clients, and to prevent them from committing new offenses (Law on Probation 2017, Article 1).

Probation is a socio-legal institution of the state that applies to probation clients a set of measures of state coercion and public influence. It demands clients' participation in individual socio-legal programmes that are based on social research on the individual and are aimed at correcting the probation client, preventing them from committing further offenses, providing them with social assistance, and taking measures to facilitate their resocialisation (Law on Probation 2017, Article 3).

Probation clients are required to participate in re-socialisation programmes. The process of achieving the goals and tasks of probation is carried out by assisting probation clients in getting out of a difficult

life situation, facilitating their resocialisation, and developing and implementing individual socio-legal programmes. It is implemented through interaction of state bodies, local self-government bodies, and local state administrations with correctional institutions and probation clients. Furthermore, the probation system carries out social research on people at the pre-trial stage of criminal proceedings, in accordance with the procedure established by the criminal procedure legislation, as well as on convicted people subject to parole (Law on Probation 2017, Article 7).

Probation, depending on the tasks and stage of its application, is broken down into the following types: pre-trial probation, executive probation, penitentiary probation and post-penitentiary probation (Law on Probation 2017).

Pre-trial probation is based on a socio-psychological assessment of the accused's personality. Based on the assessment, the risks of relapse are determined, as well as the possibility of correcting the accused person without isolation from society. In other words, the possibility of applying criminal penalties that are not related to isolation from society are considered (Law on Probation 2017).

Executive probation is a set of social and legal measures to assist probation clients in getting out of a difficult life situation, as well as to control and supervise their behaviour and the performance of their duties (Law on Probation 2017).

Penitentiary probation (Law on Probation 2017) is applied to prisoners upon their preparation for release from prison. Penitentiary probation is aimed at the social adaptation of prisoners preparing for release. For instance, among other things, the measures are aimed at establishing relationships with NGOs that provide services to people who find themselves in a difficult life situation or establishing contact with medical institutions for registration and the continuation of treatment after release.

Post-penitentiary probation (Law on Probation 2017) is applied to people released on parole from prisons. Social support and resocialisation activities carried out in prisons will continue in relation to people released on parole from prison.

When preparing people for release, probation authorities provide assistance and take the following measures, including restoring lost documents (passport, birth certificate, driver's license, diploma or certificate of education, etc.) and lost rights (ownership, right to receive benefits and pensions, right to housing, right to inheritance, etc.), education, employment, housing issues, and legal issues. Moreover, the probation system helps to establish contact with NGOs that provide social work services and medical

institutions for registration and the continuation of treatment after release (Law on Probation 2017, Article 11).

In executive and post-penitentiary probation, the probation authority, state bodies, and local self-government bodies assist probation clients with resocialisation and getting out of a difficult life situation based on an individual approach and an analysis of information about their personality and needs.

Depending on the needs of the probation client, the individual programme of providing social and legal assistance includes measures such as social, legal, and psychological assistance, employment, education, restoration and formation of socially useful connections (Law on Probation 2017).

Probation authorities are working to refer probation clients in difficult life situations to rehabilitation centres. Referral to rehabilitation centres is carried out during the period of executive and post-penitentiary probation (Law on Probation 2017).

In order to resocialise and adapt to life in society, probation clients in executive, penitentiary, and post-penitentiary probation who do not have an education are assisted in obtaining basic, secondary or vocational education in accordance with the legislation in the field of education (Law on Probation 2017, Article 22).

In executive, penitentiary, and post-penitentiary probation, measures are taken to provide social assistance to probation clients.

Types of social assistance offered to probation clients include consultations with social services, assistance in obtaining the necessary documents, help registering with social security and health authorities (Law on Probation 2017, Article 25).

Work is carried out to restore and form socially useful connections for probation clients in executive, penitentiary, and post-penitentiary probation so that they are able to form a new system of attitudes, norms, and values, develop appropriate skills relating to social behaviour and preserve and improve their social status.

Probation authorities assist in strengthening probation clients' positive social ties with family, relatives, persons who have a positive impact on their behaviour, labour collectives, educational institutions, and NGOs.

NGOs, relatives of convicts, and other persons who have a positive influence on their behaviour are involved in the work of restoring, maintaining, and strengthening probation clients' family and socially useful ties (Law on Probation 2017, Article 25).

In executive, penitentiary, and post-penitentiary probation, probation clients – patients with substance abuse, tuberculosis, HIV/AIDS, hepatitis,

and other socially significant diseases – are assisted in obtaining medical services. Probation clients receive medical services through medical and preventive healthcare organisations at their place of residence (Law on Probation 2017, Article 27).

8. *Prison System*

Social work with drug users is also carried out in prisons. 'The Criminal Executive Code of the Kyrgyz Republic' (2017) complies with the Nelson Mandela Rules. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules, 2015) state that to the extent possible, prison staff should include a sufficient number of specialists, such as psychiatrists, psychologists, and social workers. Also, every prison institution should employ social workers who are responsible for maintaining and strengthening the prisoners' desired relationships with their family and social organisations that can benefit them.

The administration of correctional institutions carries out work on social adaptation and psychological work with convicts individually, in accordance with their needs.

The main tasks of social adaptation and psychological work with convicts are identifying and solving convicts' social problems and providing them with differentiated social assistance. The prison system organises and provides convicts' social protection, including obtaining documents, certifying the identity of the convicted person and confirming their right to social and pension security. Within the framework of social work with drug users, it is important to provide assistance with the restoration and strengthening of the convicts' socially useful ties and involve the public in solving convicts' social problems (Criminal Executive Code of the Kyrgyz Republic, 2017).

The main forms of social and psychological work with convicts include social diagnostics of convicts, development of individual programmes for social and psychological work, advisory, legal, and psychological assistance, individual and group therapy, etc. Also, social work in the prison system is carried out in terms of preparing convicts for release from prisons. Moreover, the prison system assists in strengthening convicts' positive social ties with the external social environment: with family, relatives, labour collectives, educational institutions, and religious organisations.

Conclusion

As has been shown, the Kyrgyz Republic adheres to an integrated and balanced approach to solving problems related to drug trafficking and is guided by the principle of paying attention to individuals, families, communities, and society as a whole in order to promote and protect the health, safety, and well-being of drug users.

The Kyrgyz Republic, based on the norms of international law, implements the principles of an integrated and balanced approach to solving problems related to drug trafficking control. Based on these principles, the state policy of the Kyrgyz Republic is formulated in such areas as reducing the supply of illegal drugs, reducing the demand for illegal drugs, reducing the harm from illegal drugs, as well as ensuring the availability of controlled substances and access to them exclusively for medical and scientific purposes.

However, successful responses to challenges require close cooperation and coordination between government agencies at all levels, especially in the health, education, justice, and law enforcement sectors. At the same time, civil society – together with the scientific and academic communities – plays an important role in solving and combating the drug problem.

In the future, one of the priorities of the state policy should be harm and mortality reduction. As the country's harm reduction programmes have been very successful among the prison population, it is essential to expand harm reduction programmes by ensuring drug users in all penitentiary institutions have access to harm reduction services, sterile needles and syringes, and substitution treatment programmes.

It is necessary to inform drug users and those around them about overdoses and their prevention and treatment. Since it was possible to significantly reduce deaths from opiate and opioid overdoses by distributing naloxone for free.

In spite of a number of positive changes related to the development of the regulatory framework for social work with drug users in the Kyrgyz Republic, it is necessary to further improve the regulatory framework and create a favorable legal environment for the implementation of treatment, care and social support for drug users. It is also essential to improve international cooperation by strengthening the regulatory framework, and interstate mechanisms for information exchange. In this sphere the state should implement, if necessary, international drug prevention standards and ensure national approaches to drug prevention are compatible with international recommendations.

In order to improve social work with drug users, the state should support the development of a network of social institutions (drop-in centres, halfway houses, community centres, etc.).

Despite a number of positive changes related to drug use, the state of affairs in primary drug prevention still does not meet the degree of danger associated with modern challenges and threats emanating from drug trafficking.

Scientific work leaves much to be desired, and due attention is not paid to family issues, which is the main factor affecting the drug situation.

Drug prevention in schools and workplaces, as well as at the level of local communities, is carried out in an inactive manner and does not correspond to the modern scientific vision.

Despite the undeniable successes achieved in the treatment and rehabilitation of drug addiction, there are still many unresolved problems in this area. They are primarily associated with an imperfect regulatory framework and inadequate financing. In this regard, it is necessary to further improve the regulatory framework for countering the spread of drug addiction and create a favourable legal environment for the effective reduction of drug demand.

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12 Syringe Exchange Points in the Penitentiary System of Kyrgyzstan

Heino Stöver, Jarkyn Shadymanova

Introduction

Central Asia is one of the few regions of the world where the HIV epidemic is growing (WHO, UNAIDS & UNICEF, 2011; Aids Center, 2022). Currently, the epidemic in Kyrgyzstan is at a concentrated stage, and one of the most common forms of HIV transmission is still the use of shared syringes and needles by drug users.

Kyrgyzstan is on one of the largest drug-smuggling routes from Afghanistan, which leads to the availability of relatively inexpensive heroin and the high prevalence of drug addiction in the country. The rapid increase in the number of injecting drug users (IDUs), combined with population migration, contributes to the active spread of HIV infection, parenteral viral hepatitis, tuberculosis, and sexually transmitted infections (STIs) (Zelichenko, 2004).

The high prevalence of injecting drug use coupled with risky sexual behaviour, including low levels of condom use among the general population, IDUs, and prisoners alike increases the likelihood of a rapid spread of HIV (AFEW, 2019).

According to Iriskulbekov (2019), 1,680 drug users were living in prisons in 2018. People with drug addiction make up 15.9% of the total number of people in the penitentiary system. Intravenous drug use can have serious medical and social consequences.

In this chapter, we discuss the syringe exchange points (SEP) programme in the Kyrgyz penitentiary system. We aim to find out what has been achieved in the programme since its inception in 2001. Next, we want to understand the barriers that made programme implementation difficult in the context of the Kyrgyz prison system.

1. Implementation of Harm Reduction Programmes

The targeted introduction of preventive programmes in correctional facilities in the Kyrgyz Republic began in 1998 with the support of a joint project of the government, UNDP, and UNAIDS, before the first cases of HIV infection among prisoners were reported. Initially, these were educational programmes for the prevention of HIV/AIDS among convicts and personnel.

The development of harm reduction programmes began in 1998, when Raushan Abdildaeva, a narcologist at the Central Hospital of the institution No. 47 in Bishkek, participated in the first educational training course in Almaty, Kazakhstan, offered by UNDP to reduce HIV transmission in prisons. At the same time, Vladimir Nosor, the director of Colony No. 47, decided to take part in the training course.

The next steps focused on the improvement of hygiene standards in prisons. Sprayers filled with chlorine were placed in the bathrooms, so that IDUs could wash their syringes. The next stage, made possible by the support of the Soros Foundation in Kyrgyzstan, was the installation of washbasins with bleach for the disinfection of syringes and tattoo equipment.

In 1998, with the assistance of UNAIDS, the Kyrgyz Ministry of the Interior began educating prison staff about how to reduce HIV infections. The distribution of needles, despite the approval of key persons in the system, was not allowed until 2000, when the management of prisons was transferred to the Ministry of Justice.

The Ministry was alarmed by the overcrowding of prisons, the high incidence of tuberculosis, and the need to treat HIV among the prison population, so it sought the assistance of external experts as well as representatives of international organisations, such as the World Health Organization (WHO), to address the issue. A new non-governmental organisation, the 'Interdemilge', was founded with the support of foreign aid, and Raushan Abdyldaeva, a narcologist, became the director of the NGO. She introduced harm reduction in the penitentiary system. The NGO collaborated with the Ministry of Internal Affairs. Part of this collaboration was staff involvement in the harm reduction programme, whereby staff was assigned to distribute clean needles among IDUs in prisons.

Due to the scarcity of needles and syringes in the penitentiary system in the early 2000s, IDUs were forced to share injecting equipment. In 2000, an opportunity was provided for the disinfection of injection equipment used by drug users. To this end, containers with disinfectant solutions for the treatment of used syringes were installed in an accessible place in

every prison. In early 2003, permission was given for the needle exchange programme in all eleven institutions in Kyrgyzstan.

In February 2001, the Department of Correctional Institutions issued a decree on the prevention of HIV/AIDS in prisons in Kyrgyzstan, on the basis of which urgent measures were taken to prevent the spread of HIV infection among prisoners, such as the implementation of various HIV/AIDS prevention programmes. This included the provision of condoms and disinfectants to inform prisoners and staff about the prevention of HIV infections by peer education and voluntary testing for HIV. In 2019 alone, more than 2,800 condoms and 111,000 new syringes were distributed in prisons with the support of the SEP programmes (AFEW, 2019).

It was decided that the needle exchange should take place in a separate room with only the client and the SEP worker present, so that prison guards could not see the prisoners. Therefore, the medical unit was used as the place for needle exchange. Syringe exchanges were carried out in the narcological department of the central prison hospitals, and all prisoners had the opportunity to take part in and benefit from the programme. The pilot programme for the exchange of syringes began in 2002 at the Narcological Centre of the Central Hospital of Institution No. 47, which was responsible for the treatment of convicted drug users, with coverage of 50 people. To access the service, the prisoner needed to ask to go to the infirmary to receive medical care, and there he could exchange his syringes. At the start of the pilot project, each prisoner was given a syringe. The exchange was carried out on a one-to-one basis. Access to syringes was restricted to prisoners participating in the pilot project.

The positive results achieved during the implementation of the programme made it possible to start implementing it in all correctional institutions. By 2003, this programme covered four colonies. In September 2003, a total of approximately 470 drug users had received access to sterile needles through six exchange programmes. By the end of 2004, twelve institutions in Kyrgyzstan had adopted a syringe exchange programme. Altogether, there were 1,000 people enrolled in the NEP programme. By 2007, ten colonies in Kyrgyzstan had taken part in harm reduction programmes, in which 13 syringe exchange points operated.

The first positive results from the syringe exchange programme in penitentiary institutions in Kyrgyzstan were obtained in the context of three very important principles. Firstly, harm reduction trainings were started before the first case of HIV among prisoners was reported. Secondly, a voluntary HIV test, introduced subsequently, showed the importance of the intervention. In 2004, 56% of HIV cases in Kyrgyzstan occurred in prisoners (Wolfe, 2005:40). Thirdly, prisoners who have completed an

outreach training course offered by prison medical staff can offer outreach activities to their peers. This model was adopted due to concerns that the infirmary was the only place where prisoners could exchange syringes. Since needles could only be obtained from the infirmary during the day, and most drug-related activities happened in the evening, some inmates who did not use drugs themselves took sterile needles during the day and sold them at night to inmates who injected drugs. This problem was addressed through the adoption of the peer-to-peer outreach model. Since the outreach workers lived in the same prison cells, they were able to distribute sterile needles 24 hours a day and the sale of needles among prisoners ceased completely (Library and Archives Canada Cataloguing in Publication, 2005: 49). All medical personnel and prison officials had attended trainings and were aware of the importance of maintaining confidentiality for HIV-infected prisoners who may face violence and discrimination if their HIV status becomes known to others.

In addition to getting alcohol wipes, cotton wool, and sterile syringes for themselves, some volunteers took needles to perform a secondary exchange for prisoners unwilling or unable to come to the exchange office, and in some institutions volunteers were also involved in the programme. These were convicts from the IDU community who distributed syringes and needles at night.

At the beginning of the programme, a survey was conducted among drug users to determine which types of needles were most often used. Subsequently, the necessary types of needles were purchased. Employees and prisoners received – and continue to receive – continuous training in the prevention of overdose and transmission of HIV and hepatitis, and received information on safe sex. Prisoners themselves developed HIV prevention materials, which were discussed in focus groups and released for distribution throughout the prison system. In Kyrgyz prisons, syringe exchange is organised at the health units and hospitals of institutions where nurses are trained to treat abscesses or other complications associated with injection. Prisoners can visit and exchange syringes without showing other prisoners that they are using drugs.

The NGO 'Interdemilge', which introduced the syringe exchange programme in the penitentiary system, also began to introduce the Atlantis programme, a drug-free programme that offers prisoners a twelve-step set of meetings and also includes peer education and psychosocial counselling with psychologists for former drug users.

To continue with HIV prevention upon release, prisoners who were released from correctional institutions received an individual package consisting of a disposable syringe, disinfectant solution, multivitamins, and

a brochure with addresses of organisations involved in HIV prevention. The penitentiary system in the Kyrgyz Republic was, at that time, under the jurisdiction of the Ministry of Justice, which contributed to a greater openness towards reforms and the introduction of new forms of work in the field of the prevention of infectious and other diseases.

Awareness-raising and training work following the 'peer-to-peer' principle was widely conducted; peer-support and self-help groups were established and functioned under the guidance of consultants who are ex-drug users. At needle exchange points, as a structural component of the harm reduction programme, preventive work is carried out among people who inject drugs.

The main goal of the programme is to prevent the spread of HIV and other infections transmitted through injecting and sexual transmission among people who inject drugs and to involve new injecting drug users in the medical and social assistance programme.

The needle exchange point services include replacing used syringes and needles with sterile instruments; distributing alcohol wipes and standard condoms; dispensing naloxone to prevent overdoses from opioids; doing outreach work; referring drug users to AIDS service organisations and medical institutions; and sharing information orally and delivering handouts – in the form of brochures/informative materials – to injecting drug users on HIV prevention, sexually transmitted infections, viral hepatitis B and C, tuberculosis, and ways to reduce the health risks associated with drug use and overdose.

The provision of oral information is conducted in the form of consultations, conversations, and educational sessions. Also included in the programme is the conducting of rapid HIV testing on saliva and the accompanying of clients to medical staff for advice or medical services Another service is the redirection of clients for the testing of tuberculosis, sexually transmitted infections, viral hepatitis, and other diseases. Informational work also includes consultations with clients about the Atlantis rehabilitation centres and the Methadone Maintenance Therapy programme, as well as, on release, information on crisis centres, rehabilitation centres, self-help groups, and methadone maintenance centres in the civil sector.

2. Basic Normative Documents

In order to expand access to services for IDUs and PLHIV, Kyrgyzstan has adopted a state anti-drug policy. The country has strengthened its fight against drug addiction and drug trafficking. The legal basis for these activi-

ties is the Decree of the President of the Kyrgyz Republic, 'On Approval of the Concept for Combating the Spread of Drug Addiction and Illicit Drug Trafficking in the Kyrgyz Republic'. Other key documents are the state programme for the prevention of the HIV/AIDS epidemic and its socio-economic consequences in the Kyrgyz Republic for 2006–2010, aimed at creating new programmes and further developing the existing syringe exchange programmes in all regions of the Republic on the basis of state institutions and non-profit organisations. The aim of the programme was to strengthen the opportunities of existing programmes for injecting drug users.

In 2009, the Ministry of Health issued an order 'On the Opening of Syringe/Needle Exchange Points in Medical and Preventive Organisations in Bishkek and Chui Oblast'. According to this order, lists of SEPs in medical and preventive organisations in the Bishkek and Chui region as well as the standard for syringe and needle exchange services were approved. The standard regulates the requirements for premises, equipment, and the quality of medical supplies provided, as well as the procedure for syringe and needle exchange services, i.e. storage, collection, and disposal of used materials. In parallel, a body of operational documents and regulations was introduced to ensure the quality of syringe/needle exchange services and other harm reduction interventions and their availability, including:

- Clinical protocols for HIV infection, approved by the order of the Ministry of Health of the Kyrgyz Republic No. 29 of 22 January 2015.
- Order of the Ministry of Health of the Kyrgyz Republic No. 87 of 4 February 2016 'On Conducting Laboratory Diagnostics of HIV Infection in the Kyrgyz Republic'.
- Order of the State Penitentiary Service under the Ministry of Justice No. 123 of 18 March 2016 'On Approval of the Instruction on Prevention, Organisation of Examination and Treatment of HIV Infection and Sexually Transmitted Infections among Persons Held in the Institutions of the Penal System of the Kyrgyz Republic'. These documents regulate the diagnosis and treatment of HIV infection and sexually transmitted infections in prisons.
- Order of the State Penitentiary Service under the Ministry of Justice No. 602 of 28 November 2016 'On Approval of the Instruction on the Procedure and Conditions for the Provision of Narcological Assistance in Establishments of the Criminal Executive System for Persons with Mental Disorders Due to the Use of Psychoactive Substances'. This document regulates the procedure for rendering assistance to persons with drug addiction in prisons.

- The order of the SPS of the Ministry of Justice 'On Approval of the Instruction for the Implementation of the Methadone Maintenance Programme and the Needle and Syringe Programme in the Institutions of the State Service for the Execution of Sentences under the Government of the Kyrgyz Republic'. This document regulates the implementation of NSP programmes and maintenance therapy in prisons.

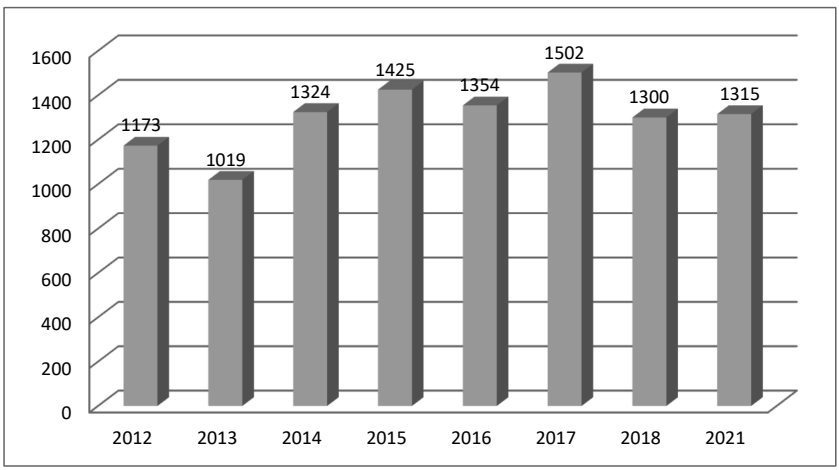

Figure 1. Number of Persons Covered in the SEP Project from 2012 to 2021

Source: Data from the RNC and GSIN 2022

3. Current Situation

As of 1 July 2017, the State Penitentiary Service under the Government of the Kyrgyz Republic operates 13 exchange points for syringes and needles in prisons and pre-trial detention centres. The SEPs are financially supported by the United Nations Development Programme with funding provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria and run under the project title 'Effective Control of Tuberculosis and HIV in the Kyrgyz Republic'.

The structure of syringe and needle exchange locations is as follows:

- in Bishkek: 2 (IK-47 and pre-trial detention centre No. 1),
- in the Chui region: 9 (IK-1, 2, 3, 8, 16, 19, 27, 31; medical facility 31 TLB ,

- in the Jalal-Abad region: 1 (IK-10) and in Osh (pre-trial detention centre No. 5),
- in the Issyk-Kul region:1 in Karakol (pre-trial detention centre No. 3).

As of 1 July 2017, the actual number of clients using syringe and needle exchange points was 1,502, out of which 13 were women (Harm Reduction International, 2018).

As of July 2019, there were 13 prisons in the penitentiary system; the number of clients was 1,643, of which 28 were women (AIDS Foundation East-West in the Kyrgyz Republic, 2019:19). According to the NEP programme, reporting data are provided quarterly to the UNDP Global Fund using reporting forms.

On a quarterly basis, the SEP coordinator, in conjunction with UNDP Global Fund experts, provided monitoring assessments on the quality of syringe exchange facilities in the institutions of the SEP.

Counselling for clients of the SEP programme is carried out on the issues of dependence, HIV testing, antiretroviral therapy for HIV, programme "equal-to-equal", safe behaviour, and re-adaptation and reintegration into society.

The organisation of the SEP programme works by providing services to clients by facilitating the provision of the syringe or needle with minimum requirements for the provision of services to customers; organising training and skills development for the staff at the exchange point; creating safe and favourable working conditions for the personnel at the exchange point; holding staff meetings and solving various organisational issues; controlling the timely delivery of syringes and needles to the exchange point; controlling the transfer of used needles and syringes c issuing and collecting used medical products as well as IOM and other funds in prescribed amounts; ensuring the timely disposal of material in accordance with existing regulatory and legal documents; and carrying out timely maintenance of required accounting and reporting documents.

At the client level, the SEP programme provides clients with information and training on all issues related to reducing risky behaviour, preventing overdoses, etc. (mini-session); helps clients acquire skills that reduce risky sexual and injecting behaviour; bears material responsibility for entrusted property (medical devices, equipment, etc.); provides first aid to SEP clients, including overdose assistance, within their competence; and interacts with clients in a friendly manner, without stigma or discrimination.

All SEP officers complete training sessions and pass courses before taking direct responsibility in the programme and interacting with clients.

This training includes factual information on less dangerous drug use; ways of preparing and using drugs; forms of transmission of a viral infection, types of risk, and risk behaviour; and how to do HIV testing. It also includes basic medical information on infections and their treatment and how to work with equipment for the disposal of used injections. SEP officers also learn how to establish contacts, communicate with consumers, and counselling, how to work confidentially, and how to carry out pre- and post-test counselling.

4. Coverage of the Syringe Exchange Points (SEP) Programme

№	**Indicators of result**	**2017**	**2019**	**2021**
1	Number of IDUs covered by preventive programmes	1,590	1,643	1,472
2	Number of NSP clients who have been tested for TB/STI/HIV	159	-	-
3	Number of NSP clients redirected and included in the OST programme	24	-	60
4	Number of NSP clients who have been tested for HIV (specify method) and who know their result	365	350	610
5	Number of NSP clients tested by drop of blood			23
6	Number of NSP clients tested by saliva			585
7	Number of NSP clients tested by blood sampling			2

Source: Data from the RCN and GSIN, 2022

5. Regulations for SEP Activities in Penitentiary Institutions

The premises and equipment of the NSP facilities must comply with the minimum requirements for premises and equipment specified in the Harm Reduction and Service Implementation Standards, approved by the Order of the Ministry of Health of the KR No. 482 of 22 August 2014.

If it is not possible to organise several rooms for SEP, the rooms should be divided into zones for:

- the exchange of syringes;
- storage of consumables;
- consultations;
- HIV testing;
- storage of used material.

The qualitative and quantitative requirements of the supplied expendable material for IDUs should comply with the requirements specified in the Harm Reduction Implementation Standards.

Responsibility for organising the collection, storage, and disposal of used needles and syringes is carried by the staff of the NEP and the head of the medical and sanitary department of the institution.

The collection, storage, and disposal of used syringes and needles are carried out in accordance with the Order of the Ministry of Health of the Kyrgyz Republic No. 59 dated 18 February 2013, 'On the Improvement of the Safe Management System for Medical Waste in Healthcare Organisations'.

6. Medical Services in the Penitentiary System

The medical service of the State Penitentiary Service is a service that directly organises and monitors the activities of the SEP in the SPS. The medical service is responsible for the regular process of monitoring and evaluating the quality of SEPs and the proper maintenance of the necessary accounting and reporting documentation.

SEP services in institutions are managed directly by the head of the medical and sanitary unit of the institution. The personnel of the exchange point are appointed by the Chairman of the SPS**.** SEP staff must have certificates in harm reduction training and have a basic level of knowledge. The activities of all staff involved in the SEP should be organised in strict accordance with the approved job responsibilities and supervised by the head of the health unit and/or hospital.

The medical service of the SPS is responsible for the implementation of the syringe exchange programme in the institutions of the SSEP.

The medical service of the SPS determines the strategy for the development of preventive programmes and implements the following:

- the planning, organisation, and monitoring of ongoing work to reduce the demand for drugs and reduce the harm from drug use in the institutions of the State Penitentiary Service,
- coordination of the work of the NEP programme, as well as all services of the Central Office and the institutions of the SSEP,
- analysis of incoming information on the activities of harm reduction programmes and the submission of the information to the leadership of the State Penitentiary Service, and Ministry of Health of the Kyrgyz Republic,
- interaction with other government bodies, public associations, and international organisations on the harm reduction, prevention, and treatment of drug abuse.

The coordination of the interaction of all SSEP services required for the implementation of the NEP programme is carried out by the heads of the institutions in the central office of the SSEP and by the deputy chairman of the SSEP.

The leadership of the SPS, including the heads of institutions, ensure attitudes towards IDUs are free from stigma and discrimination. They also ensure the non-interference of operative regimes in the activities of NSPs, promote the effective operation of harm reduction programmes in accordance with the assigned tasks in the institutions, and provide assistance to ensure IDUs have unimpeded access to NSP services, including overdose prevention programmes.

All medical staff at penitentiary institutions informs and motivates convicted persons in custody about the drug treatment services available in the institution (detoxification, Clean Zone, Atlantis programmes, and SEP, including the prevention of overdoses).

The content of educational programmes states that employees of the educational services of the institution are obliged:

- to directly support the practical implementation of harm reduction programmes and all activities related to this,
- to inform and motivate convicted persons in custody about SEP (including the prevention of overdose), without using any forms of coercion,
- to have basic knowledge of HIV prevention, harm reduction, overdose prevention (including pre-hospital care skills in case of overdoses), and the use of naloxone,
- to not discriminate against drug users,

- to promote the work of SEP volunteers and prevent the confiscation and destruction of the expendable material distributed at the SEP by other employees of the institution.

7. *Operational Services in Penitentiary Institutions*

The employees of the operational services of institutions are obliged to acquire basic knowledge on HIV prevention, harm reduction, overdose prevention (including the pre-medical care skills in case of overdoses), and the use of naloxone. Moreover, employees need to know how to apply coercive procedural measures in strict compliance with the law. They are not allowed to use patients' drug dependence to obtain confessions.

Within the scope of the harm reduction programmes, prison staff members are required to not discriminate or infringe on patients' rights. They must not act rudely, or do or say anything that could offend patients' honour or dignity. They must treat them tactfully, show no hostile feelings, keep calm, and practise self-restraint at all times. They should not act in any way that may prevent the normal functioning of harm reduction programmes.

Other responsibilities include conducting routine searches of the methadone points of SEP and searching employees directly involved in harm reduction programmes. These routine measures are carried out strictly with the permission of the head of the institution of the SPS. The main rules do not allow the confiscation of naloxone ampoules from drug users, or the destruction of ampoules. Staff should not interfere with the work of the SEP volunteers in the framework of their duties.

The following is the list of mandatory accounting reporting documentation on the implementation of SEP in SSEP:

1. Registration journal of medical devices.
2. Register of syringe/needle returns.
3. Client redirection log.
4. Code register of customers.
5. Reports on the movement of medical devices.

Employees of the regime and duty services of institutions are obliged to provide direct assistance to the personnel of harm reduction programmes in ensuring the requirements of the regime and internal regulations at the sites of events are met. Employees of the regime and duty services should have basic knowledge of HIV prevention, harm reduction, overdose prevention (including first aid skills in case of overdoses), and the use of

naloxone. They should work with convicts and persons in custody on the prevention of violations and the suppression of unlawful acts, including those directed at the implementation of harm reduction programmes. As a part of the project training, full information was provided on the programme, with the help of international consultants.

8. *Overdose Prevention*

During a special launch event in 2017, the Commission on Narcotic Drugs in Vienna, UNODC, and WHO presented the 'S-O-S Initiative' (Stopping Overdose Safely), focusing on overdose prevention. Funded by the US State Department's Bureau for International Narcotics and Law Enforcement Affairs (INL), the initiative was developed in response to the 2016 General Assembly Special Session on the World Drug Problem, as well as the CND resolution 55/7 on 'Promoting Measures to Prevent Drug Overdose, in Particular Opioid Overdose'. The initiative aims to prevent opioid overdose deaths in line with the recommendations of the WHO guidelines on Community Management of Opioid Overdose (World Health Organization, 2014). The ultimate goal is to contribute towards reducing deaths by preventing opioid overdoses.

This is a complex intervention consisting of four main components to be implemented at city level and involving a range of stakeholders:

1. Training of Trainers: identification and training of trainers who will train other trainers in their project countries on community management of opioid overdose.
2. Training of Service Providers: identification and training of people who are in regular contact with people likely to witness opioid overdose and provision of naloxone and associated equipment to them for further dissemination of training and medication.
3. Identification and training people likely to witness opioid overdose in overdose resuscitation and management and provision of naloxone and associated equipment to them for use when needed.
4. Increasing access to naloxone in the community, e.g. through community pharmacies and other means, depending on what is feasible in the project city.

In the institutions of the State Penitentiary Service, cases of overdose among prisoners often occur. Some NGOs, including AFEW, have addressed this issue.

In order to help with overdoses, since 2009 penitentiary systems have been using naloxone, an antagonist of opioid receptors.

Naloxone is an effective way to prevent death from overdose and is handed out to SEP clients. The distribution of naloxone within the penitentiary system was first introduced in Colony No. 47 (the central hospital of the State Penitentiary Service) in 2008. By 2015, the WHO mission noted that there were eight OST sites in prisons (out of 16 prisons), where almost 400 patients – or almost one third of the total number of OST patients – were being treated. In 2015, the State Penitentiary Service planned to open another OST site. By 2015, OST was available for women (in Colony No. 2) and for patients with TB and infectious diseases (in Colony No. 31) (Subata, Moller, & Karymbaeva, 2016).

9. HIV Testing in Prisons

HIV testing of SEP clients in the institutions of the SSEP is carried out by trained medical personnel in two ways: by blood sampling (ELISA) and rapid saliva testing. Rapid HIV saliva-based testing has been conducted in all institutions of the SSEP since 2014, with the assistance of the Global Fund 34 medical staff were also trained in rapid HIV saliva-based testing, with the assistance of the Global Fund and USAID. Prior to the tests, pre-test counselling is conducted, and post-test counselling is provided after the test results are received. HIV testing for SEP clients is performed no more than once every six months (Joint United Nations Programme on HIV/AIDS, 2015).

10. Access to Antiretroviral Therapy for SEP clients

Since 2005, the Global Fund has been funding antiretroviral therapy (ARVT) in penitentiary institutions in Kyrgyzstan. ARVT prisoners are appointed by specially trained medical staff of the institutions of the State Penitentiary Service.

Immediately after the diagnosis of HIV infection, ARVT is assigned to NSP clients. HIV-infected prisoners are systematically monitored by medical personnel. IDUs who have been diagnosed with HIV for the first time receive a consultation with the epidemiologist of the medical service of the State Penitentiary Service, and they are immediately put on the dispensary records in the RC of AIDS.

Every month, all PLHIV receive consultations with the specialists of the Republican AIDS Center and tests are periodically conducted for CD4 and viral load. Employees of NSPs monitor their clients' adherence to ARVT.

11. Results of the Implementation of the NEP Programme

- Relative stabilisation of the spread of HIV/AIDS and other infections transmitted via injections.
- The involvement of injecting drug users in prevention programmes (NES, Atlantis, ZPTM, social support).
- Comprehensive approach to HIV/AIDS prevention – a wide range of services.
- Increasing the level of identification of PLHIV among prisoners and providing them with appropriate assistance (ART, mutual help groups).
- Changing the mentality of staff and prisoners regarding HIV/AIDS prevention.
- Improvement of the penitentiary personnel's working conditions and the convicts' detention conditions.
- Increased awareness among prisoners about transmission routes and risky behaviours.
- Changing the behaviour of programme participants (safe behaviour, improving physical health,, employment, restoring relationships with family, social adaptation).
- Reducing the number of overdoses and overdose mortality.
- Cessation or reduction of drug use in SSEP institutions.
- Reduction of the social and legal consequences of drug use and the criminal behaviour of drug addicts.

NEP programmes are available both in communities and in prisons. NEP coverage in communities is quite high – 224 needles per person per year. NEP is now available in 13 prisons, whereas in 2013, it was available in just one (AIDS Foundation East-West in the Kyrgyz Republic, 2019:19).

12. Interaction and Cooperation with Other Organisations within the Programme

The staff members of syringe and needle exchange points cooperate with the following medical institutions and non-governmental organisations:

- Policlinic of the Ministry of Internal Affairs of the Kyrgyz Republic – testing clients for sexually transmitted infections
- Republican AIDS Center – testing and laboratory diagnosis of clients for HIV infection using ELISA; counselling and monitoring of antiretroviral treatment in PLHIV
- Republican skin and venereal dispensary under the Ministry of Health of the Kyrgyz Republic – testing clients for sexually transmitted infections
- AIDS Foundation East-West in the Kyrgyz Republic
- Atlantis rehabilitation programme for people addicted to alcohol and drugs
- Center for Rehabilitation and Social Adaptation
- PB Rance Plus (Bishkek, Chui region)
- Parents against drugs (Osh region and Batken region)
- 'Ulukman Daryger' (Karakol)
- Healthy Generation (Jalal-Abad)
- ZIOM (Talas)
- Needle and syringe programmes of NGOs are sponsored by GFATM

In the GSIN system, there are two further programmes in addition to those listed above, implemented as part of the harm reduction strategy:

- Atlantis rehabilitation programme for people addicted to alcohol and drugs (12-step Minnesota addiction treatment model, lasting four to twelve months).
- Center for Rehabilitation and Social Adaptation (TsRSA) 'Clean Zone'.

Upon completion of the 12-step addiction treatment programme at Atlantis, graduates (former PWID) stay in the Clean Zone until the completion of their term of imprisonment.

13. Training Activities for Employees at Syringe Exchange Points

Since the opening of NEP in the institutions of the penitentiary system, there has been a continuous need to train the medical personnel that is working in the programme. To this end, in 2006, the training manual 'Harm Reduction in Prisons' was developed by Raushan Abdildayeva, Chief Inspector of the Reform Department and coordinator of international HIV prevention programmes in prisons, and Natalia Pavlova, the psychotherapist of the Crisis Centre for Women and the Family 'Sezim', together with representatives of the penitentiary service of Moldova and

with the assistance of the AIDS Foundation East-West and the Harm Reduction Network of Central and Eastern Europe.

This guide is designed to help instructors to organise and conduct training seminars aimed at teaching HIV prevention methods in staff correctional institutions and prison management. Drug users play an important role here, as they can help other drug users learn safe behaviours.

Various aspects of harm reduction programmes include the following:

- Distribution of syringes (first organised at a number of correctional institutions in Switzerland, Germany, and Spain, first as a pilot project and then on an ongoing basis,
- Peer-to-peer programmes,
- Information support or training before release from prison to prepare drug-using prisoners for problems they may encounter when they leave prison (information about the increased risk of overdose after release, safer injection techniques, etc.) is already organised in several countries.

The main objectives of this guide were raising awareness of medical problems related to drug use, such as infectious diseases arising from the use of shared syringes and needles; raising the level of knowledge and skills of correctional staff in the field of harm reduction and the formation of a positive attitude among them towards risk reduction measures; assistance in the development of various channels for the dissemination of health information and support for prisoners and staff in correctional institutions; and the implementation of risk reduction measures.

The training programme 'Harm Reduction in Prisons' for the medical staff of the penitentiary service consists of three modules and is designed to be taught over three days:

- The first module is devoted to reviewing the problem of HIV/AIDS, in terms of the spread of HIV infections in the IDU environment. The second module focuses on the development of information and prevention programmes.
- The third module considers the development of harm reduction programmes.

The objectives of the training are providing an objective picture of the HIV/AIDS epidemic at the regional level in prisons; the presentation of the 'harm reduction' strategy in prisons in the context of HIV/AIDS prevention programmes; clarifying the main components of the harm reduction strategy: syringe exchange, condom distribution, counselling, the dissemination of information, and educational work; training personnel on the exchange of syringes in the IDU environment in correctional institutions;

training personnel as regards counselling, the dissemination of information, and educational work in correctional institutions; and the training of trainers to train staff for needle exchange, counselling, the dissemination of information, and educational work in correctional facilities. At the end of the training, all participants are given certificates.

In order to improve the awareness of the non-medical staff of the SSEP institutions on HIV prevention and harm reduction programmes, the NGO AIDS Foundation East-West AIDS organised mini sessions for the non-medical staff of the SPS in 2016 and 2017. In total, 350 non-medical staff from penitentiary system institutions participated in mini sessions over the course of the two years. In 2019, the mini sessions were conducted in all the colonies according to the programme and the compiled module. In each institution, mini sessions were held twice a day, at 10:00 and 13:00, with two groups of ten participants. The participants were provided with general information on HIV and AIDS. They discussed issues related to HIV transmission (how HIV is transmitted and under what circumstances HIV is not transmitted), measures for individual HIV prevention and sexual transmission, measures for prevention in the workplace, and post-contact prevention. Information was given on the four body fluids that contain the highest concentration of HIV and on window periods.

Detailed information was provided on methadone, the conditions for the adoption of the PTA programme, and the positive results from the introduction of the PTA and NSP programmes. The presentations also touched upon the issues of HIV treatment.

The participants were also provided with information on the implementation of methadone maintenance therapy programmes and needle and syringe exchange programmes in the institutions of the State Service for the Execution of Punishments under the Government of the Kyrgyz Republic.

14. Financing of the NEP Programme

Since 2010, the NSP programme has been implemented in the institutions of the SSEP with funding from the Global Fund. The funds of the Global Fund cover the purchase of medical products (syringes, needles, condoms, informative and educational material, alcohol wipes, and express saliva-based tests for HIV) as well as additional bonuses for medical personnel working in the NSP programme.

In 2020, the funding from the Global Fund in Kyrgyzstan was terminated. At present, the programme is funded by the Kyrgyz state budget.

In the future, additional payments for NSP staff in the institutions of the STS will not be carried out. In this regard, it is necessary to look for other ways to continue the NSP programme – for example, installing a special syringe and needle machine, like in Germany, which does not require any workers to be hired. In 2018, the SEP programme was transferred to NGOs like AFEW Kyrgyzstan, Atlantis, CRSA etc. but it is still funded by the Global Fund. Funding is still provided for the implementation of the SEP programme in Kyrgyzstan. There are still some challenging problems with the implementation of the NEP programme in the institutions of the SSEP.

According to Deryabina and El-Sadr (2017), one of the most basic problems is the lack of medical personnel in the penitentiary system and lack of qualifications among medical staff. In a number of the country's largest colonies, there is a lack of medical staff with a higher medical education. All the work of maintaining the health of prisoners is fulfilled by a small team of paramedics. The lack of sufficient medical personnel in correctional facilities makes it difficult to implement preventive programmes.

There is also high staff turnover, due to the specifics of the working conditions, such as the low salaries of SPCS staff and weak material and technical bases at health units, making them unable to provide quality medical services in correctional facilities.

The complex specificity of the work is another issue. For example, medical workers are involved in performing duties that are not related to their professional activities, which adversely affects confidential relations between the patient convicts and medical personnel, thereby creating ethical problems and the problem of having to choose between subordination to operational management and the performance of medical duties. Often, the obligation to take care of patients contradicts the position of the administration, and medical staff has fundamental differences in the conditions of detention, medical services for convicts, and sanitary and epidemiological surveillance.

Insufficient supply of medicines is also challenging. There are difficulties in prescribing appropriate medical treatment for IDUs with somatic pathology and viral hepatitis C, and PLHIV with concomitant infections. In addition to the fact that the coverage of SEPs in the country lags far behind the recommendations of international organisations, the financing of these programmes entirely depends on external donors. The NEPs were fully funded by the GFATM HIV project, with no resources coming from national or local health budgets (Deryabina, A. et al. 2017). The NEPs are currently being implemented by AFEW with the help of GFATM and CDC (AIDS Foundation East-West in the Kyrgyz Republic, 2019: 22).

Another problem is the weak continuity of services between the prison and civilian sectors. It is very important for a prisoner who, for example, started to receive SEP services to be connected with an NGO that realises SEP programmes so that when they leave prison, they continue to exchange syringes and thus continue their safe behaviour.

Conclusion

Despite the achievements and measures taken by the state and the non-governmental sector to provide quality HIV prevention activities, there are a number of gaps for sufficient coverage of recommendations of international organisations. In addition, the coverage of NSPs in the country lags far behind the recommendations of international organisations. The main barrier to attracting and retaining new clients to the opioid substitution therapy programme is mandatory drug registration, which creates grounds for violating the rights of people who use drugs, making them an easy target for police officers.

In this chapter, we discussed the history of the implementation of harm reduction programmes in Kyrgyz prisons normative documents relating to regulation harm reduction programmes and drug treatment, and the diagnosis and treatment of HIV infections and sexually transmitted infections in the criminal-executive system. Furthermore, we analysed SEP and NEP programme policies, activities, and results in Kyrgyzstan. The chapter elaborated on the problems in the implementation of the NEP programme in SPCS of Kyrgyz Republic. The findings reinforce the need for more active state participation, particularly in terms of funding issues because after the main GFATM HIV project ended, the number of SEPs in prisons decreased, which means coverage of PWID will be less consequently prevention of infectious and other diseases will be challenged.

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13 Naloxone as Overdose Prevention in the Prison Setting and in the Community. A Comparison of the Situation in Germany, Kyrgyzstan, and China

Zhyldyz Bakirova, Tynchtyk Estebes Uulu, Simon Fleißner, Ulla Pape, Heino Stöver, Hang Su

Introduction

Naloxone is used worldwide in medical emergencies to reverse respiratory depression caused by opioid overdose and has become a key intervention in preventing opioid overdose deaths (Moustaqim-Barrette et al., 2021). Naloxone was discovered and patented at the beginning of the 1960s. In 1983, the World Health Organisation (WHO) added naloxone to its Model List of Essential Medicines. In 2017, a nasal spray was made available by the European Commission (EMCDDA, 2016).

But naloxone is also promoted outside of Europe. In 2016, Canada lifted the prescription requirement for naloxone to increase public access. Instead of requiring a prescription for each individual, pharmacies are able to proactively give out naloxone to those who might experience or witness an opioid overdose (Government of Canada, 2017). In the United States, access to naloxone is controlled individually in each state, with all 50 states allowing individuals to obtain the medication – it is mostly freely dispensed at pharmacies (Safe Project, n.d.).

Naloxone programmes aim to increase the availability of the medication in emergency situations by administering the medicine to opioid-using peers, family members, and other trained laypeople. In the prison system, Naloxone is distributed upon release to prevent opioid overdose death in the period of increased vulnerability following release from prison. In take-home naloxone programmes, nasal spray kits are usually administered. Over the past fifteen years, so-called 'take-home naloxone' programmes have gained increasing attention with several pilot programmes being initiated in European cities (EMCDDA, 2016). In these programmes, naloxone is distributed to prisoners upon release to prevent overdoses in the crucial initial time period outside of prison.

This chapter studies naloxone programmes in the prison system and in the community. As naloxone programmes are implemented in many

countries, there are different challenges surrounding scaling up naloxone training and distribution. Therefore, we conducted a comparative case study of naloxone programmes in the prison systems of three countries: Germany, Kyrgyzstan, and China. The objective of our analysis is to compare the difficulties and strengths in the naloxone programmes in each of these countries and to identify barriers to implementation. The chapter is structured as follows: first, important background information about naloxone and naloxone programmes is provided. Second, the experiences of the pilot naloxone programme for ex-detainees in Germany, the so-called 'take-home naloxone' programme, are presented. The next section discusses the debate surrounding naloxone distribution and overdose prevention in Kyrgyzstan and China. The chapter concludes with a discussion on the prospects of naloxone in the prison system in the region of Central Asia and China.

1. Background: Naloxone and Overdose Prevention

Opioid overdose is a major public health issue. Globally, an estimated 500,000 deaths in 2017 were related to drug use. Of these, the majority of deaths were related to opioid use (approximately 70%), of which 115,000 people died from opioid overdose (WHO, 2021). During the Covid-19 pandemic, the number of deaths due to opioid overdose has increased (CDC, 2020). Opioid overdose results in respiratory depression, which can be fatal. Naloxone is an antidote and reverses the effects of opioids within minutes. It was patented in 1961 and continues to be widely used in medical contexts to this day (Strang et al., 2019).

In the 1990s, the first proposals for the take-home use of naloxone were published (Strang et al., 1996). Take-home naloxone seeks to prevent overdose deaths and takes advantage of the observation that for many, overdoses happen in the presence of others (Strang et al., 2019). The groups that have an increased likelihood of being present during such an overdose can be easily summarised. These are, on the one hand, the drug users themselves and, on the other hand, relatives, social workers, and police officers. Providing these groups of people with naloxone and training them in its use enables them to administer naloxone immediately in the event of an overdose, thereby reversing the potentially lethal effects of opioids and saving the life of the person affected (WHO, 2021).

Since naloxone itself carries hardly any risks, its use by medical laypersons is unproblematic, at least since naloxone has been available as a nasal spray (Schäffer, 2020). Globally, there are various large take-home nalox-

one programmes, particularly in the United States, Canada, and England, which have reached hundreds of thousands of people (Barnsdale et al., 2017; Moustaqim-Barrette et al., 2019; Strang et al., 2019). In this regard, the effectiveness of take-home naloxone as a lifesaver has been repeatedly demonstrated (McDonald and Strang, 2016; Olsen et al., 2018) and its implementation has been recommended by both WHO and EMCDDA (EMCDDA, 2016; WHO, 2021). Take-home naloxone thus aims to empower people with an increased likelihood of being present at an opioid overdose to properly use and be equipped with naloxone to prevent opioid overdose deaths.

2. *Take-Home Naloxone in Prison*

Upon release from prison, the likelihood of dying from an overdose is particularly high (Jamin et al., 2021; Liu et al., 2021). The same is true for other phases that follow a period of abstinence (e.g. cessation or discontinuation of treatment) (WHO, 2021). Since, after a few days without consumption, the tolerance to the consumed substance decreases rapidly, too high dosages are often consumed in these phases, which can lead to a fatal overdose. For this reason, take-home naloxone can be particularly effective during prison release (Bird et al., 2016). Additionally, the setting is appropriate for naloxone education. Contact with drug users is a given, and the ability to provide more detailed group education on drug emergencies and naloxone is available. It is also possible to provide naloxone upon release from prison.

At the same time, several barriers play a role in the implementation of take-home naloxone in prison. Just like when living in the community, not all drug users are amenable to take-home naloxone education in prison. Both the conviction that they are not at risk of overdosing and the fear of repression due to disclosed opioid use, even if only prior to incarceration, may be reasons for this. In addition, take-home naloxone seems to go against the conviction to live abstinently. Thus, addressing this is not a self-fulfilling process, and face-to-face approaches and peer involvement can be helpful. The indication that naloxone can not only ensure survival in the event of one's own overdose but also offers the possibility of saving the lives of others in the event of an overdose can motivate drug users to get involved. The institution of prison itself can also stand in the way of implementing take-home naloxone. It requires staff for its implementation, money to buy the naloxone itself, and a willingness

to acknowledge possible post-release use and implement harm reduction measures.

The attitudes of prison staff can also stand in the way of naloxone training in prison. In addition, different sectors sometimes need to collaborate to coordinate training, obtaining naloxone, and dispensing naloxone upon release from prison (Horsburgh and McAuley, 2018). Scotland has been particularly successful in this and is the first country in the world with government funding for a national take-home naloxone programme, offering take-home naloxone training with naloxone dispensing upon release from prison. All prisoners who test positive for opioids are offered training, which should be completed within the last six weeks of imprisonment but is generally available at any time. Individuals who are not initially interested will be approached again at a later date and attempts will be made to motivate them to participate.

The training is linked to other pre-release programmes. While group training sessions were predominantly offered at first, short individual training sessions (10–15 min) have become increasingly popular. One-on-one trainings require fewer organisational hurdles within prison processes and are mindful of the sometimes very personal nature of the issue of overdose, which can be more difficult to address in a group setting (Horsburgh and McAuley, 2018). In doing so, 2,273 individuals in prison were reached in the first three years of the programme (2011–2013) (Bird et al., 2016). By the end of 2017, nearly 5,000 naloxone kits had been dispensed to individuals upon release from prison (Barnsdale et al., 2017).

Obtaining data on how many naloxone kits were used and how many overdose deaths were prevented in the case of different programmes is difficult and cost-intensive because the target groups need to be reached with a follow-up survey. The UNODC and WHO project 'Stop Overdose Safely' reported that 34.5% of the trained drug users who took part in the project witnessed an overdose and that 89.1% used naloxone. In 98.3% of cases in which naloxone was used, the victim survived the overdose (WHO & UNODC, 2021: 18).

3. Case Studies

Naloxone is effective, and laypersons are able to use naloxone correctly. With the introduction of the nasal spray, the administration of naloxone has become even easier. To reach the target group (defined as drug users and their social environment), different approaches can be applied. In the following section, we describe the prison system as a suitable context

for training people who use drugs and for distributing naloxone upon release from prison. Since the implementation of new programmes is often challenging and accompanied by various difficulties, we conducted three descriptive case studies of naloxone programmes in the prison systems of three countries: Germany, Kyrgyzstan, and China. The three examples illustrate the differences between the systems simply by the different ways in which the implementation is presented.

3.1. Germany: Experiences of the Take-Home Naloxone Programme

In Germany, take-home naloxone is currently only available in a few prisons. Since prisons in Germany are responsible for providing medical care to people in prisons, they also have to bear the costs for naloxone. However, since naloxone is only intended for the period after release, the question of financing is often problematic. However, the immediate availability of naloxone upon release from incarceration is critical. In addition, the implementation of naloxone education is an additional burden for prisons and must be integrated into the daily prison routine. Likewise, social and medical services need to establish a functioning cooperation to coordinate training and procurement of naloxone nasal spray.

In Germany, three federal states have so far enabled and financed take-home naloxone in prisons. Bavaria conducted a pilot project on the use of naloxone as overdose prevention in the prison system (Wodarz-von Essen et al., 2021). It remains to be seen to what extent the state-wide rollout planned in these states from 2023 will succeed. While in Bavaria naloxone training is mostly provided in prison by social workers from independent addiction support facilities, in North Rhine-Westphalia and Baden-Württemberg training is more often provided by prison staff themselves. Both are equally suitable options. In any case, the decisive factor is the cooperation of planning, addressing, and implementing the training sessions and the subsequent supply of naloxone upon release from prison. Implementation is still in its early stages, and there are no reliable statistics. It is estimated that in total, 100 to 300 naloxone kits have been issued on release from prison in Germany to date.

Since July 2021, the Federal Ministry of Health has provided funding for the nationwide project NALtrain. The objective of this programme is to provide training to prison staff and people in prison on the use of naloxone in overdose emergencies. The project aims to train as many prison employees as possible and reach out to as many drug users as possible. Especially in the prison context, there are significant differences

between the 16 federal states of Germany. The three federal states that are taking part in NALtrain have showed that with political support, it is possible to implement take-home naloxone programmes in prison settings very quickly. Besides the question of how to fund naloxone programmes, another challenge for scaling-up take-home naloxone is posed by the laws that exist in Germany for prescribing and distributing naloxone.

3.2. Kyrgyzstan: Experiences with Naloxone in Prisons and the Community

In Kyrgyzstan, the strategies to reduce deaths from opioid overdoses were set out in Resolution No. 445 of the Cabinet of Ministers of the Kyrgyz Republic of 10 August 2022. The resolution describes the tasks of reducing overdose mortality as follows: (1) conducting research on reducing mortality from the entire spectrum of narcotic drugs and psychotropic substances as well as new psychoactive substances, including reducing mortality from so-called 'indirect causes'; (2) providing professional training for ambulance crews; (3) providing information for drug users and those around them about overdoses, their prevention, and their treatment; and (4) the continuation of the naloxone programme.

The implementation of this programme is carried out by the Republican Center for Psychiatry and Narcology in collaboration with non-governmental organisations (NGOs). This involves distributing naloxone to clients who are injecting opioids. It should be noted that the number of opioid users in Kyrgyzstan has been declining in recent years. Nevertheless, naloxone is distributed among the customers of the syringe exchange points, both in the community and in the penitentiary system.

In Kyrgyzstan, all harm reduction programmes that are implemented in the community are also carried out in the penitentiary system. For example, methadone maintenance therapy and syringe and needle exchange points are being implemented both in the penitentiary system and in the community.

The regulatory framework for the use of naloxone was developed between 2009 and 2014. First, methodological work was carried out to include naloxone in the List of Essential Medicines. Currently, the drug naloxone is included in group 4. Antidotes used in case of drug poisoning are included in subgroup 4.2. The specifics of the List of Essential Medicines are regulated by the Decree of the Government of the Kyrgyz Republic No. 274 of 6 June 2018. Naloxone is thus included in the List of Essential Medicines of the Kyrgyz Republic and considered a specific antagonist of opioids. To prevent overdose, people with substance use

disorder are given naloxone. Naloxone is issued only in the presence of identity documents. Naloxone can be handed out to the relatives of the patient if they are able to provide documents proving their identity.

Kyrgyzstan has standards for the provision of medical services for injecting drug users. These standards include guidelines for overdose prevention using naloxone, approved by Order No. 494 of the Ministry of Health from 8 October 2010. The Standard for the Prevention of Overdoses from Opioids using naloxone prescribes a mechanism for providing naloxone to active drug users.

In 2012, the Clinical Guidelines for the Diagnosis and Treatment of Mental and Behavioral Disorders Caused by Opioid Use were approved. These are guidelines for medical professionals of narcological services, medical teachers, and health care professionals. The guidelines include chapters on 'acute opioid intoxication'; the classification according to ICD 10; general concepts of acute intoxication with surfactants; the main diagnostic criteria, F11.0, 'acute opioid intoxication' (ICD 10); clinical treatment of acute opioid intoxication (drug intoxication); differential diagnosis of overdoses from various psychoactive substances; and the definition, signs, and treatment of opioid overdose. The standards also describe the rules for how to proceed in an overdose emergency.

In 2013, the clinical protocol 'Opioid Overdose Care' was prepared and approved. It describes the definition of 'overdose', which can cause negative short-term or long-term somatic and mental consequences. The factors contributing to opioid overdose are defined. THe signs of opioid overdose and the differences between the state of strong euphoria and overdose are described. The protocol has a set of step-by-step instructions for helping in an overdose emergency. The protocol includes information on providing first aid, such as artificial respiration, and on the administration of naloxone. The protocol is publicly available on the websites of the Republican Center of Psychiatry and Narcology and the Kyrgyz State Medical Institute of Personnel Training.[1]

In addition, the issues of opioid intoxication, overdose, and assistance procedures are included in educational courses for medical specialists. For a long time, active work was carried out in the form of seminars and training sessions held by medical workers providing emergency medical

1 Republican Centre of Narcology, Peredozirovka opiatami [Opiate overdose], available at http://www.rcn.kg/prevention-overdoses/protocol; Ministry of Health of the Kyrgyz Republic, Klinicheskie Protokoly [Clinical Protocols], available at https://www.med.kg/clinicalProtocols.

care and by outreach workers to reduce deaths from opioid overdoses. The Republican AIDS Center, the Republican Center for Psychiatry and Narcology, and NGOs (for example, AFEW, ICCUP) conduct training for prison medical staff involved in overdose prevention programmes. The Republican AIDS Center and the Republican Center of Psychiatry and Narcology distribute informational material, new guidelines, and clinical protocols.

Since 2008, the Programme for Reducing Overdose Mortality has been implemented by the Republican Centre for Narcology. In December 2021, the centre was renamed the 'Republican Center for Psychiatry and Narcology' following the unification of psychiatric and narcological services. Furthermore, NGOs are actively working in this field, e.g. by running a phone hotline 'What to do in case of opiate overdose' and by distributing informational material (brochures, posters, leaflets) on the prevention and management of overdose emergencies, designed for injecting drug users.

NGOs in Kyrgyzstan run programmes with peer-to-peer volunteers. As a rule, they provide information on safe drug-use behaviour and on medical and social services that provide assistance for drug users, including the syringe exchange programme and the methadone maintenance treatment. Moreover, NGOs organise information meetings in prisons with people with substance-use disorders to inform them about overdose prevention. They conduct short trainings for people who use drugs to raise awareness of the signs of overdose, methods of providing pre-medical care, and the correct use of naloxone.

The Kyrgyz Republic participated in a multicentre study Stop Overdose Safely (SOS), jointly implemented by UNODC and WHO. The project included the rapid distribution of take-home naloxone and the provision of trainings for people who use opioids and are likely to be in a position to witness an overdose emergency. 14,263 potential opioid overdose witnesses were trained within the eight-month implementation phase in four countries: Kazakhstan, Kyrgyzstan, Tajikistan, and Ukraine. The project was successful and showed that naloxone is considered acceptable by key stakeholders, ranging from people using drugs to health and law enforcement officers. However, the spread of naloxone programmes continues to reach its limits due to a scarcity of public funding.

3.3. China

In 2008, China initiated naloxone programmes in Yunnan and Guangdong. Considering the current situation in the country, the most effect-

ive method for social workers is to distribute naloxone to peer groups, methadone maintenance treatment clinics, and needle exchange personnel. When heroin users witness an overdose emergency, they call social workers for assistance, and social workers will administer naloxone as first aid at the scene. China does not have a special programme that addresses overdose emergencies in the prison system.

Several studies on the use of naloxone in overdose emergencies have been conducted in China. The study by Luo et al. (2013) showed that naloxone first aid administered by social workers is feasible and acceptable to heroin users. The investigation of the naloxone programme in the city of Gejiu by Huang et al. (2011) revealed that naloxone first aid administered by social workers can be appropriate for small and medium-sized cities like Gejiu. In China, it is generally accepted that the use of naloxone by social workers significantly reduces heroin overdose mortality among injecting drug users. If only the mortality rate were used as the criterion for evaluation, the mortality rate of injecting drug users when social workers administer naloxone first aid would be significantly lower than when the approach of self-first assistance is used.

Social workers are non-medical personnel, whereas naloxone is considered a prescription drug in China. Some individuals are concerned about social workers' ability to recognise a heroin overdose and administer naloxone correctly. In certain cases, artificial respiration and cardiopulmonary resuscitation are preferable to other options. However, there are no medical reasons against the use of naloxone. It is a harmless medication. Seven of the 59 recipients of naloxone that took part in the study experienced withdrawal symptoms, but no other adverse effects were reported. Before being allowed to administer naloxone as first aid, social workers must undergo training. The training includes identification and diagnosis of overdoses, cardiopulmonary resuscitation, artificial respiration, and training in first aid skills. According to the investigation, some social workers received first aid training from medical doctors and obtained a first aid certificate from the Yunnan Provincial Emergency Center.

Naloxone is an effective and safe treatment for a heroin overdose. After training, drug users can use naloxone correctly for first aid; timely injection of naloxone after an overdose is the key to successful first aid, highlighting the importance of social workers arriving promptly at the scene of an overdose.

Social workers are non-medical personnel. If a dispute arises, it is illegal for them to prescribe medicine, and criminal liability may ensue if they do. Although social workers sign a first aid agreement and photograph and videotape the first aid process to avoid legal and first aid risks, legal

risks still exist, and the effect of first aid has yet to occur. It is in a state of 'acquiescence' regarding significant conflicts.

To improve overdose prevention in China, we need to consider the following three policies: Medical doctors should prescribe naloxone to people at risk of a heroin overdose; naloxone distribution programmes should be expanded to cover more people using opioids; and naloxone should be classified as a prescription drug.

4. Discussion and Conclusion

The comparison of the three cases studies shows that the implementation of naloxone programmes in the prison system and in the community is not an easy process. In all three countries, it is generally accepted that naloxone is an effective treatment in opioid overdose emergencies. Despite this finding, we are a long way away from naloxone being used in all cases of overdose. The main reason for this is that the target groups do not have access to the drug. Naloxone programmes provide an opportunity to facilitate access to the medication and to educate people on the use of naloxone in emergencies. So-called take-home naloxone programmes address an individual's increased vulnerability following prison release. Distributing naloxone as a take-home kit upon release can prevent a potentially fatal overdose. Although the benefits of this intervention are evident, take-home naloxone programmes have not yet been implemented in all the contexts where this would theoretically be possible.

The countries examined are at different stages of programme implementation. In Germany, the pilot project NALtrain has started training programmes for prison staff and for people using drugs in opioids in three federal states. Since being launched in July 2021, the pilot programme has scaled training and information exchange on naloxone. Together with an earlier pilot project in Bavaria, NALtrain shows that take-home naloxone programmes can successfully be implemented in the prison context in Germany. This has an impact on political decision makers. However, to date, there are only a limited number of German prisons that have incorporated a take-home naloxone programme into their daily routine. The result is that naloxone cannot always be used when it is needed. For the effective prevention of fatal overdoses, Germany therefore needs to upscale the intervention.

In Kyrgyzstan, the benefits of naloxone programmes are equally acknowledged. The country has created the legal basis for conducting naloxone programmes and included the drug in the List of Essential Medicines.

Kyrgyzstan is committed to creating the same conditions for harm reduction programmes in the prison system as in the community. This commitment extends to needle and syringe exchange points, methadone maintenance programmes, and overdose prevention with the help of naloxone. The prison administration conducts trainings for prison staff and for people using drugs in prison that include information on overdose prevention and on naloxone. In contrast to Germany, however, Kyrgyzstan has not introduced take-home naloxone programmes. Upon release from prison, people using drugs, or their family members, can obtain naloxone in pharmacies. The question remains whether people have the necessary information and can take on the responsibility for overdose prevention.

In China, naloxone programmes have been initiated in two regions. Chinese researchers have demonstrated that naloxone programmes are an effective treatment for overdose prevention among the Chinese population. However, to date, China has not introduced any naloxone programmes in its penitentiary system. In addition, non-medical people are not allowed to use naloxone in an overdose emergency, which creates a situation of legal insecurity.

The comparison of the three country studies shows that successful examples of administering naloxone in prison settings do exist. Despite this, naloxone is not used at a general level in any of the three countries. This shows that various legal, financial, and organisational barriers stand in the way of a broader implementation of naloxone programmes. Legal barriers include the question of whether naloxone as a substance is legal and can be used in treating an overdose emergency. Germany and Kyrgyzstan have taken the first step in creating a stable legal basis for naloxone programmes. In China, the use of naloxone is reserved for doctors, thereby reducing the possible uses of naloxone in emergencies.

The second barrier to the broader implementation of naloxone concerns financial issues. In general, health care systems must cover the costs of these interventions. In practice, there might not be sufficient financial resources to introduce naloxone programmes in the prison context, where funding is generally scarce. In addition to these legal and financial barriers, the introduction of naloxone programmes often fails due to a lack of organisational preparation. For a general scale-up, prison administrations need to introduce internal procedures. Moreover, prison staff and people using opioids in prison need to undergo training. Most importantly, however, a general level of awareness needs to be created among decision makers regarding the fact that naloxone programmes constitute an important element of harm reduction. The case studies of Germany, Kyrgyzstan, and China show that there is still a long way to go.

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14 Medication-Assisted Treatment in Prisons

Heino Stöver, Ingo Ilja Michels

Introduction: Drug Use of People Living in Prisons

Drug use remains endemic among incarcerated populations (EMCDDA, 2022). In 2019, there were around 856,000 people, including pre-trial detainees, living in prisons[1] in Europe, out of which 18% received a final sentence for offences related to the use, possession, or supply of illicit drugs (Aebi & Tiago, 2020; Royuela et al., 2021 Kolind and Duke, 2016; Walmsley, 2018;). In Europe, the lifetime prevalence of drug dependence among people living in prisons varies from country to country; a systematic review of the literature found the prevalence to range from 10% to 48% for male prisoners and 30% to 60% for female prisoners at the point of incarceration (Fazel et al., 2006).

Women represent around 5% of the total prison population in Europe (around 43,000), varying from 3% in Bulgaria to 5% in Cyprus. In 2016, one sixth of people living in prison in Europe were incarcerated for drug offences (Aebi et al., 2016; UNODC, 2014; Erickson et al., 2019). Among people who use drugs, a high proportion of people who inject drugs (PWID) are imprisoned (Dolan et al., 2005; WHO, 2014; Altice et al., 2016).

In the United States, the number of people incarcerated annually for drug-related offenses has grown in the past 20 years from 40,000 to 450,000, leading to prison populations with high rates of drug use (Rich et al., 2005). Imprisonment of drug users for crimes they commit – often

1 In the publication, particular attention is paid to the terminology; in particular, the term 'people in prison' is always used instead of 'prisoners', in order to avoid stigma and to highlight that people can experience imprisonment at some point in their life, but they should enjoy the same rights and respect as every member of society (Tran et al., 2018). Between 2018 and 2019 the prison population in the 27 EU Member States, Norway, Turkey, and the United Kingdom increased by more than 56,000. This is attributable to an increase of more than 80,000 people detained in prison reported by Turkey, where the last available data before 2018 were from 2016. In most of the other countries, the prison population decreased. For more information, see Aebi and Tiago (2020).

to support their dependence – contributes to prisoners' high prevalence of drug dependence (Final Report EU, 2008). A lifetime history of incarceration is common among intravenous drug users (IDUs); 56% to 90% of IDUs have been imprisoned previously (Jürgens et al., 2009; Stöver and Förster, 2022).

Ehab Salah from UNODC reported that 2.5 million people living in prison are estimated to have been convicted of drug-related offences, 22% of them for drug possession for personal use. The proportion of women imprisoned for drug-related offences is 35%, which is higher than that of men at 19%. There are no or limited alternatives to imprisonment. There is a lack of evidence-based harm reduction interventions in prisons (only 59 countries reported that they provide medication-assisted treatment (MAT) for people who use opioids and nine countries reported NSPs (needle exchange programmes). The risk of a fatal overdose increases markedly in the first one to two weeks after release (40 times more likely than the general population in the first week) (Salah, 2022).

In Germany, the representative 'DRUCK Study' carried out by the Robert Koch Institute (RKI, 2016) describes the consequences of criminalisation: out of the more than 2,000 drug users surveyed who were living in freedom, 84% had been incarcerated (on average for 5.4 years and average 5.4 times), 30% of those who had been incarcerated had injected while in prison, and 11% of those started their drug habit of injecting in prisons (confirmed by Hößelbarth et al., 2011; Stone et al., 2018; Zimmermann et al., 2019; Gassowskia et al., 2019). An earlier British study (Boys et al., 2002) reported that one fourth of heroin users started their drug use in prisons; in another study, a fifth of heroin users reported having started to inject while in prison (Singleton, 2003).

Drug-using people living in prisons may be continuing a habit acquired before incarceration or they may acquire the habit in prison (Royuela, 2021; Moazen et al., 2018; Wood et al., 2006). Current data on the prevalence of prior illicit drug use among the prison population in Europe is scarce. The aim of a study by van de Baan et al. (2022) was to identify the prevalence of illicit drug use prior to incarceration, as reported by studies conducted in 30 European countries. A comprehensive literature review was conducted from 5–31 March 2018 in Europe. The review found that the lifetime prevalence of illicit drug use before imprisonment ranged from 30% to 93%; last year prevalence from 51% to 69%; last six months prevalence from 13% to 75%; and last month prevalence from 58% to 62%. The prevalence of illicit drug use was especially high among women (van den Baan et al., 2022). 16% to 60% of people living in prison who injected outside prison continued to inject while incarcerated, whereas 7%

to 24% of prisoners who injected said they started in prison (Final Report EU, 2008). Levels of IDU within prison were reported in 36 European countries plus Turkey, with rates ranging from 0.8% to 64% among men, from 1% to 62.5% among women, and from 0.2% to 82.7% for both sexes (Moazen et al., 2018).

In general, sedative substances are preferred because their effects are easy to hide and their consequences easier to manage in the confined setting of a prison. The need to increase the efficiency of the drugs they take, due to its scarcity in prison, may also encourage some people who use drugs to adopt more harmful patterns of drug use, such as injecting instead of smoking or snorting. However, new psychoactive substances became an emerging issue in prisons in a number of European countries. The initial undetectability of new psychoactive substances in routine urine testing is thought to be the main reason for their increased use in prison, particularly for synthetic cannabinoids (Royuela, 2021).

Imprisonment also favours high-risk behaviour regarding drug use because of the concentrated at-risk populations and risk-conducive conditions, such as overcrowding and violence. Prisons continue to be settings where HIV and HCV prevalence is much higher than in the surrounding communities (Moazen et al, 2018). Based on a systematic review, there is evidence of an association between recent incarceration and increased HIV and HCV acquisition among people who inject drugs (Stone et al., 2018; ECDC, 2022).

Overall, we found a high prevalence of HIV risk behaviours in prison settings internationally in the context of a high background prevalence of infections (Final Report EU, 2008; Moazen et al., 2018; Vroling et al., 2018; Ickowicz et al., 2019). The consequences of drug use in prisons include drug-related deaths, suicide attempts, and self-harm – psychiatric comorbidities are widespread (Royuela, 2021).

Drug use tends to be riskier inside than outside prisons because of the scarcity of drugs and sterile injecting equipment (Moazen et al., 2018; Dolan et al., 2005; Final Report EU, 2008; Haber et al., 1999). People living in prisons engage in a range of risk behaviours that can cause the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV). Additionally, hepatitis C virus (HCV) infection through the use of shared injecting equipment in prison has been reported in several studies (Haber et al, 1999; O'Sullivan, 2003; Keppler & Stöver, 1999; Moazen et al., 2018; Azbel et al., 2018; EMCDDA, 2022).

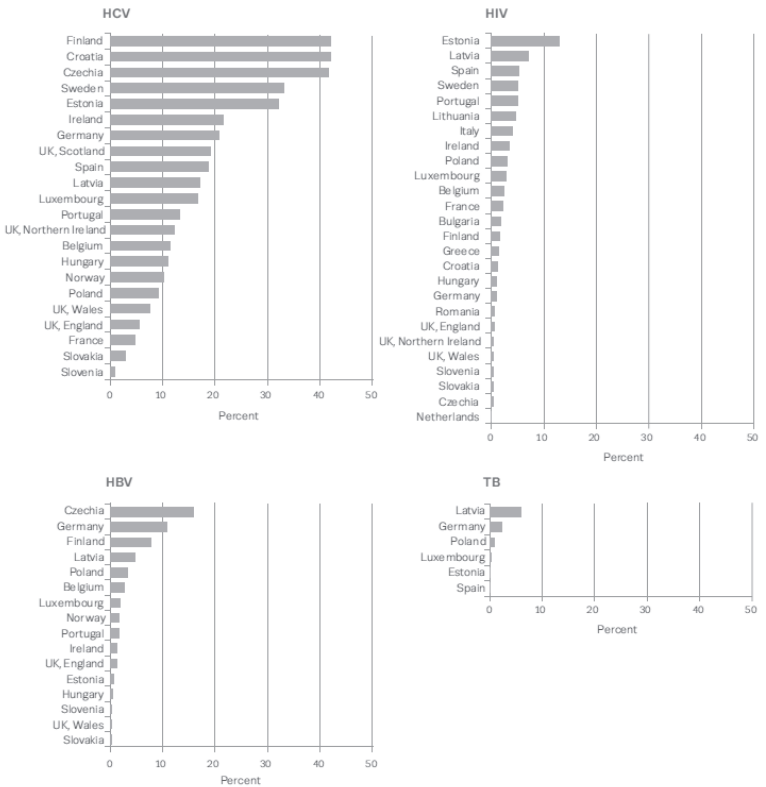

Figure 1. Prevalence of HIV, HCV, HBV, and TB Among the Overall Prison Population in the EU Member States, Norway, and the United Kingdom, 2009–2017

Source: Montanori et al. 2022

Drug use in prison is also associated with the risk of involvement in violence. People living in prisons who incur disciplinary action related to the possession or use of a controlled substance were 4.9 times more likely to display violent or disruptive behaviour than those who did not incur such disciplinary action (Friedman et al., 2008; Pont et al., 2015; van Hout et al., 2021). Prisoners using drugs are also at risk of engaging in further illicit activities because they are dependent on illicit psychoactive substances and using them will, by itself, lead to illegal behaviour and thus sooner or later to criminalisation and imprisonment (Stallwitz and

Stöver, 2007). If discovered using illegal drugs, people living in prisons risk prolonged incarceration for breaking security rules and eliciting hostility among prison staff.

Unless people living in prison receive adequate treatment, drug dependence and its associated risks persist after the prisoner's release into the community and are combined with a high rate of overdose and other forms of harm, especially in the first weeks after release (Binswanger et al., 2007 356/2; Merrall et al., 2010; Stöver et al., 2019; Stöver and Michels, 2022). Overall, the determining factor in drug-related mortality soon after release appears to be altered tolerance to opioids. In the first week after release, prisoners are approximately 40 times more likely to die due to an overdose than are members of the general population; in this immediate post-release period, more than 90% of deaths are drug related. Among women, the odds of a drug-related death in the first week after release were over ten times greater than at 52 weeks. Very high rates of drug-related mortality persist at least through the first two weeks after release from prison (Farell and Marsden, 2008; Binswanger et al., 2013).

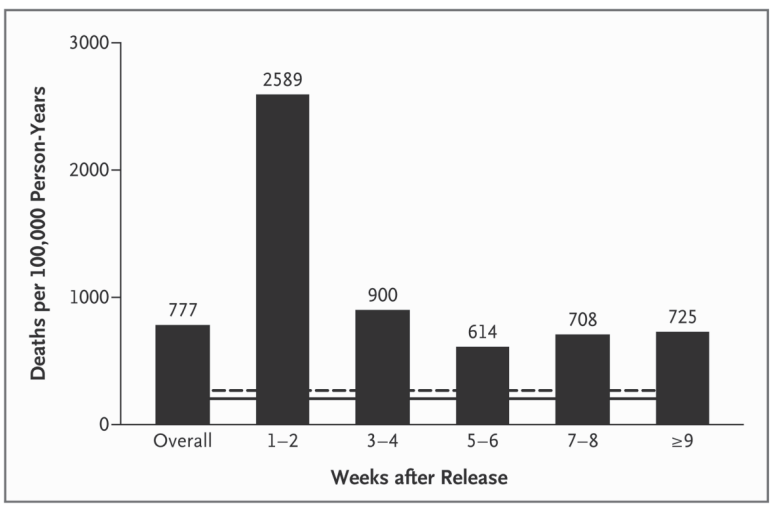

Figure 2. Mortality Rates Among Former Inmates of the Washington State Department of Correction During the Study Follow-Up (Overall) and According to Two-Week Periods After Release from Prison

Source: Binswanger et al., 2007; see also: Madzilli et al., 2022.

Among the costs to society for a prisoner's failure to fully reform while living in prison is the increased risk of recidivism. Within twelve months of release from prison, 58% of heroin users who did not receive MAT were re-incarcerated, compared with 41% of those who did receive MAT (Johnson, 2001).

1. *Current State of Drug Treatment for Drug-Using People Living in Prisons*

Many data attest to the low quality or even non-existence of drug treatment health care services for people living in prison, compared with offers made for drug users living in the community. Some interventions are of utmost importance for treating opioid users in prisons: namely MAT and needle and syringe programmes.

MAT is an intervention of proven effectiveness in the treatment of opioid use in community settings; in prison it is used in the different phases of drug treatment. The often-used terms 'methadone maintenance therapy' (MMT), 'opioid agonist treatment' (OAT), or 'opiate substitution therapy' (OST) have now been replaced by the term 'Medication-Assisted Treatment' (MAT): The reason for this is that the term 'substitution' is imprecise because treatment with opioid-containing drugs (such as methadone, buprenorphine, or morphine) is a medical – psycho-socially supported – treatment of an opioid dependence, and not a substitute for heroin. Since most of the drugs used for this treatment are not opioid derivatives but rather synthetically manufactured substances with the same effect (painkilling, calming, euphoric) (i.e. opioids), the term 'opioid' is used; since it is a treatment and not a mere replacement of the original substance, the term 'treatment' is used. In the initial health assessment of individuals who have a history of drug use, MAT can be used for managing withdrawal symptoms, and discontinuing medication for those who have been engaged in MAT programmes before incarceration may be risky.

A systematic review of 21 studies conducted in prison settings regarding the effectiveness of opioid maintenance treatment concluded that the benefits of this treatment when provided in prison are similar to those obtained in community settings. MAT was significantly associated with reduced heroin use, injecting, and syringe sharing in prison, if doses were adequate. Continuation of MAT for those who had been following this treatment before incarceration is essential to avoid relapse and the resurgence of high-risk behaviour while in prison (ECDC and EMCDDA, 2018a, 2018b, 2018c Prison and Drugs in Europe: Current and Future Challenges, Publications Office of the European Union, Luxembourg).

Pre-release MAT, meanwhile, was significantly associated with increased entry to treatment and retention after release, if arrangements existed to continue treatment (Hedrich et al., 2012; Alam et al., 2019; Grella et al., 2020). Boksán et al. (2022) have shown that MAT in prison settings reduces drug use, re-incarceration and leads to higher treatment engagement after release. More research is needed on the effects of incarceration-based MAT on secondary outcomes (e.g. health and social integration) and on factors that moderate these effects.

A recent study on the state of harm reduction in prisons in 30 European countries (Stöver et al., 2021) revealed that only one European country was not offering MAT in prisons: Slovakia. In prisons where MAT is available, those who have been receiving it in the community can continue to be treated in prison (Montanari et al., 2021, 59).

The substances most frequently used in MAT in prison are similar to those used in the community in each country. Most countries predominantly use methadone, but Croatia and France mostly use buprenorphine, and Belgium, Cyprus, Finland, and Norway prefer a buprenorphine-naloxone combination (Tarján et al., 2019). Continuity of care, when entering and leaving prison, is a critical issue for those undergoing MAT because there is a high risk of overdose and of transmission of HCV infection when treatment is disrupted (Stone, 2018). One in three countries has specific guidelines addressing continuity of care and cooperation between MAT services in prison and in the community. Most countries provide MAT to less than 10% of the prison population. Although this is only an indirect indicator of treatment coverage, data suggest a scarce implementation of MAT in prison. Only in the UK, Italy, Slovenia, and Croatia do more than 10% of the prison population receive MAT. MAT programmes include detoxification and maintenance programmes. In many countries, MAT can also be initiated in prison at different stages. Universally, the percentage of drug users offered MAT varied considerably from prison to prison (in European prisons from 0.001% in Hungary to 44.6% in Slovenia (Stöver et al., 2021).

In most European countries that offered MAT in prison, access to and varieties of available MAT programmes were heterogeneous and inconsistent (Stöver et al., 2006; Stöver, 2021). For example, although MAT is nominally available in German prisons, implementation is the responsibility of each of the 16 federal states and often varies from prison to prison within states and even from doctor to doctor (Stöver et al., 2019). In France, many physicians have been reluctant to initiate MAT in prison or even to renew existing buprenorphine or methadone prescriptions for prisoners (Larney et al., 2014). In some parts of Europe, pharmacological treatment

is often limited to drug detoxification. Furthermore, most efforts to scale up MAT in the community have not been carried through to the prison setting. However, there have been essential improvements in the last 10 years (Stöver and Hariga, 2016; Stöver et al., 2021).

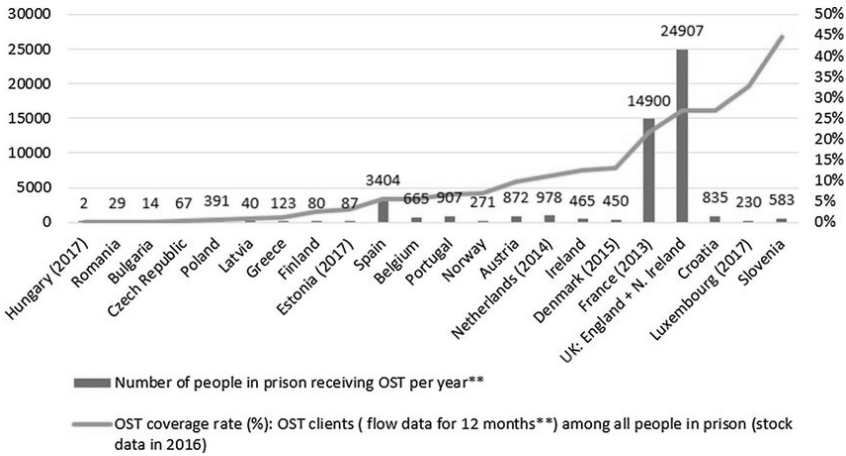

Figure 3. Number of People in Prison Receiving OST per Year

Source: Stöver et al., 2021

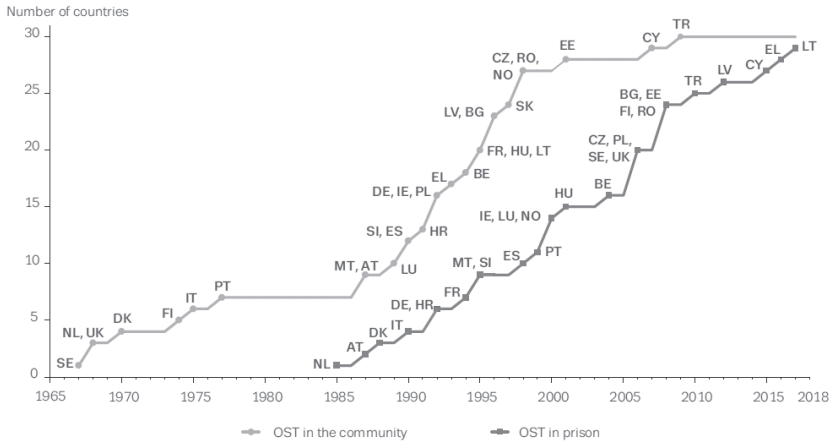

Figure 4. Cumulative Number Countries Introducing OST in the Community and in Prison in the European Union, Norway, Turkey and the United Kingdom, 1965-2019

Source: Montanori et al. 2022

2. *Why is Drug Treatment for People Living in Prisons not yet Comparable to that Available for Non-Incarcerated Drug Users?*

Several factors affect the extent to which prisons provide MAT, including the varied prison health policies of prisons and difficulties in employing adequate numbers of high-quality prison staff (Michel and Maguet, 2005). Some people living in prisons had been prevented from entering an MAT programme because of restrictive criteria. For example, in some countries MAT is limited to people living in prisons who are serving sentences of a particular length, were in treatment before imprisonment, or can confirm that they are enrolled in a post-release treatment programme (Larney et Dolan, 2009). Other limitations related to MAT in prisons include a deficiency of psychological and social support for drug-using prisoners (Final Report EU, 2008) and lack of or limited access to certain MAT programmes, such as buprenorphine-based regimens, that may be more suitable for use in prison.

Several theoretical and functional issues have resulted in drug treatment for prisoners not having parity with treatment for drugs users in the community. In particular, some societal misconceptions pervade the medical

management of drug dependence. There exists a poor understanding of opioid dependence as a chronic and recurring disease; some clinicians may feel that a hedonistic practice indicates a weakness of character (Lesting et al., 2021). Another widespread but mistaken belief involves the benefits of abstinence for drug users, which leads to the omission of maintenance therapy after detoxification, which in turn leads to reversion to opioid use (Keppler and Stöver, 2021). Also the full range of registered medications are not rolled out in prison settings – for instance, only methadone is prescribed, despite the registration of many other medications (like buprenorphine, slow-release morphine, etc.). Also different application modes do exist but are not used in a way that they could be used (for instance, depot solutions of buprenorphine (Keppler and Stöver, 2021).

There are also socio-economic reasons why drug-using people living in prisons, particularly IDUs, do not receive appropriate therapy for their drug problem: they are frequently poor and deprived and, therefore, marginalised and not considered worthy of treatment. The majority come from extremely disadvantaged backgrounds (Stöver, 2021). On the other hand, the false beliefs of prison staff regarding the common perception that prisons should be 'drug-free zones' lead to a delay in the implementation of MAT. Prison authorities may also be concerned that MAT undermines their efforts to reduce the drug supply in their institutions, i.e. the black market for drugs (Stöver, 2021).

3. Rationales for Drug Dependence Treatment in Prisons

3.1. Benefits for the Prisoner

There are many reasons drug-using prisoners should be afforded the same quality of health care regarding drug maintenance treatment – including MAT – as is available to non-prisoners. Primarily, it is appropriate to treat prisoners' drug use so that they will not leave prison in worse health than when they entered (Stöver, 2021). MAT is recognised as one of the most effective treatment options for opioid dependence (Stöver et Keppler, 2022). It can decrease the high cost of opioid dependence for users, their families, and society at large by reducing heroin use, associated deaths, HIV-risk behaviours, and criminal activity. MAT is established as a critical component of community-based approaches towards the management of opioid dependence. One cohort study (Larney et al., 2014) that enrolled N=16,715 opioid-dependent people who were in prison between 2000 and 2012 showed that:

- being in MAT was associated with a 74% lower risk of dying in prison (adjusted HR [Hazard Ratio], 0.26; 95% CI [Confidence Interval] 0.13 to 0.50), compared to time not in MAT;
- being in MAT was associated with an 87% lower risk of unnatural death (adjusted HR [AHR] 0.13; 95% CI 0.05 to 0.35), compared to time not in MAT;
- being in MAT was associated with a 94% lower all-cause mortality risk during the first four weeks of incarceration (adjusted HR [AHR] 0.06; 95% CI 0.01 to 0.48), compared to time not in MAT;
- being in MAT was associated with a 93% lower risk of unnatural death during the first four weeks of incarceration (adjusted HR [AHR] 0.07; 95% CI 0.01 to 0.59), compared to time not in MAT.

Many studies had already demonstrated the successful application of MAT in prison populations with regard to prisoner-centred and non-prisoner-centred outcomes. Positive prisoner-centred outcomes associated with MAT include reduced rates of drug use and infectious diseases. People living in prisons receiving MAT have shown less drug-injecting behaviour (Heimer, 2006) and less risk-taking behaviour (e.g. sharing of syringes) (Dolan et al., 1998; Stöver and Hariga, 2016). After four months in prison, the illicit use of morphine was at 27% for MMT-treated prisoners and 42% for controls ($P = 0.05$) (Dolan, 2003).

The use of buprenorphine maintenance therapy in prisons has been based chiefly on results obtained outside prisons (Michel, 2005; Michels et al., 2020); however, there is growing experience with buprenorphine in prisons (Keppler and Stöver, 2021a; Keppler and Stöver, 2021b). A group of people living in prisons receiving buprenorphine reported for their designated post-release treatment programme significantly more often than did a comparison group receiving methadone (48% vs. 14%, respectively; $P < 0.001$) (Magura, 2009).

An older two-year study in Puerto Rico examined the feasibility of initiating prisoners with histories of heroin addiction on buprenorphine/naloxone before their release to determine the effectiveness of such treatment with regard to post-release treatment entry, reduction in heroin use, and reduction in criminal activity at one month after release (Gordon, 2007).

MAT in prison has also been associated with reduced rates of infectious diseases. Adequate MAT has been associated with reduced risk of HCV infection (Dolan et al., 2005; UNODC/UNAIDS, 2006; Dolan et al., 2016; Azbel et al., 2018; Kamarulzaman et al., 2019), whereas inadequate MAT – periods of less than five months in one study, for example – was found to be significantly associated with increased risk of HCV seroconversion (*P*

= 0.01) (Kinlock et al., 2009). People living in prisons receiving MAT with a daily dose of more than 60 mg during their whole prison sentence were found to be the least likely to inject heroin, share needles, and engage in HIV risk-taking behaviour while in prison (Dolan et al., 2003).

MAT has also been associated with a reduced risk of prisoner death. In one study, no deaths were recorded while prisoners were enrolled in MAT, whereas 17 prisoners died while not enrolled in MAT, representing an untreated mortality rate of 2.0 per 100 person years (95% CI, 1.2–3.2) (Kinlock et al., 2009). Finally, people living in prisons receiving MAT have shown a decrease in serious violent drug charges over time, whereas those not receiving MAT showed an increase (Johnson, 2001).

Other positive prisoner-centred outcomes related to MAT in prison can be observed after the term of incarceration is completed. Reduced drug use after release was reported among people in prisons engaged in MAT. The mean number of days in community-based drug use treatment one year post release – as a function of in-prison treatment for drug abuse – was 23.1 days of counselling only in prison; 91.3 days of counselling plus passive transfer to treatment upon release; and 166.0 days of counselling plus methadone treatment in prison and continued post release (each pairwise comparison, $P < 0.01$). Participants in the counselling-plus-methadone group were significantly less likely than those in the other groups to have opioid-positive or cocaine-positive urine drug test results (Kinlock et al., 2009). MAT also lessens the likelihood of released prisoners committing crimes. The reported number of days of criminal activity in the past 365 days after release was 106.7 (standard deviation [SD] = 128.7) with counselling only; 65.2 (SD = 96.2) with counselling plus transfer to methadone; and 81.8 (SD = 109.5) days with counselling plus methadone (Kinlock et al., 2009). Reduced recidivism was reported among people living in prisons engaged in some type of MAT. People living in prisons on a twelve-month MAT while incarcerated had a lower level of re-incarceration than heroin-using prisoners with no treatment (Johnson, 2001). Reduced rates of re-incarceration during a 3.5-year period following a first incarceration were related to maintenance MAT in prison (Sibbald, 2002). A Correctional Service of Canada study found that, after one year, 41% of addicted inmates receiving MAT were readmitted to prison compared with 58% of addicted inmates who were not receiving the treatment (Sibbald, 2002). Compared with periods of no MAT in prison, the risk of re-incarceration was reduced by 70% during MMT periods greater than or equal to eight months ($P < 0.001$) (Dolan, 2005) (Gross et al., 2021).

3.2. Benefits for the Prison Staff and Community

A major rationale for the use of MAT in prison is the cost-effectiveness of such a strategy. For example, prison methadone is not costlier than community methadone and provides the benefit of reduced heroin use in prisons with the associated reductions in morbidity and mortality (Warren et al., 2006). The cost of an institutional MAT programme may be offset by the cost savings accruing from offenders successfully remaining in the community longer than equivalent offenders not receiving MAT (Warren et al., 2006). Expanded access to MAT has an incremental cost-effectiveness ratio of less than $11,000 per quality-adjusted life year, which is more cost-effective than many widely used medical therapies (Barnett et al., 2000). Implementing MAT in prisons is also associated with improvement in inmate manageability and prison safety; total institutional charges for prisoners enrolled in MAT are lower than for prisoners not enrolled in MAT. Reduced drug use and reduced recidivism were reported among prisoners engaged in methadone treatment.

4. Guidance on Overcoming Barriers to the Implementation of Substitution Programs in Prisons

4.1. Overcoming Barriers from the Prisoner

The resistance of people living in prisons to participate in a maintenance programme is often based on a lack of desire to be treated. Of the 140 eligible men approached to take part in a study of opioid detoxification, 36% declined to be recruited (Sheard et al., 2009). A similar lack of desire to be treated may be seen with regard to MAT. Some prisoners may resist participating in a programme because they do not want their partners or relatives to know they have been using drugs. Some may resist treatment with methadone because they consider methadone a street drug.

The refusal of people in prisons to participate in a MAT programme is best addressed by improving prisoner education. People living in prisons may be convinced to participate in a substitution maintenance programme through discussion that includes an explanation and demonstration – through the use of data – of the benefits accruing from in-prison MAT, including easier incarceration with less desire to inject an illicit drug (Stallwitz and Stöver, 2007) and the potential for less violence (Friedmann, 2008), less risk of prolonging incarceration or irritating prison staff, less risk of acquiring an infectious disease, and less risk of self-harm. Other

benefits that may be demonstrated are realised after release from prison, including less desire to commit crime and, consequently, a lower risk of re-incarceration, violence, potentially lethal overdoses (Drug-Related Mortality Among Newly Released Offenders, 2003), and infectious diseases (Kinlock et al., 2009).

4.2. Overcoming Barriers from the Prison Staff and Other Stakeholders

Stakeholders who lack understanding or misunderstand the value of maintenance treatment in prisons – and who may block the implementation of a treatment programme – include politicians, ministerial representatives, and prison staff and professionals. A necessary step in convincing stakeholders to support the development of an MAT programme is to educate them on the nature of the opioid drug problem among prisoners and on the evidence-based benefits of successful MAT, including health economics benefits.

It must be explained to stakeholders that opioid dependence is a chronically relapsing disease (Stöver et al., 2006; WHO/UNODC, 2019) and that coercive abstinence in prison may be followed by relapse immediately after release, often resulting in overdose, drug emergencies, and death (Farrell et al., 2008). This stakeholder education may include evidence of the beneficial results of MAT, including reduced rates of drug use, both in prison and after release from prison (Michel et al., 2005; Dolan, 2003; Stöver et al., 2021b), less risk-taking behaviour (Dolan et al., 1998), a reduced rate of infectious disease acquisition (Dolan et al., 2003; Dolan et al., 2005), a reduced risk of death, a decrease in serious violent drug charges (Johnson, 2001), reduced criminal activity after release (Kinlock et al., 2009), and a reduced re-incarceration rate (Dolan et al., 2005; Levasseur et al., 2002; Sibbald, 2002).

Outcomes and health economics data demonstrating the results of studies showing the cost-effectiveness of drug maintenance therapy in prisons (Warren et al., 2006) should be included. Techniques and resources to gain support for instituting an MAT programme and to disseminate information in support of such a programme include initiating and maintaining contact with decision-making politicians, the media, the professional public, and non-governmental organisations such as human rights agencies, UNODC, and the WHO Regional Office for European Health in Prison Project.

Other techniques for obtaining and building support for a programme include publishing and making available information on best MAT

practices; promoting the exchange of knowledge and experience among scientists, politicians, and practitioners through international and national conferences of experts from various fields; and organising local and regional discussions among interested physicians. Finally, identifying local 'champions' who can knowledgeably explain models of best practice to their peers and provide opportunities for personnel who are interested in starting an MAT programme to visit prisons where successful harm reduction programmes are in operation can be invaluable in the process.

Stakeholders should be informed that an MAT programme must provide for the supply of MAT medications. Lack of access to these medications is often a barrier to the successful implementation of an MAT programme. Prisons may have a limited list of medications available for dispensing, and MAT maintenance medications may not be among those available. In some cases, there may not be medication available to continue maintenance therapy that was started before imprisonment. Prisoners usually do not have health insurance while in prison and thus cannot afford the medication they could afford outside of prison; they are dependent for their medication on a prison's health care system.

Prison staff often express the concern that MAT programmes introduce the potential risk of internal diversion of the used medications (Stallwitz and Stöver, 2007). In some studies, such diversion was suspected (Magura et al., 2009), whereas in others it was found not to be a problem. When diversion was suspected, it was because of actions such as the movement of a prisoner's hand to their face when sublingual buprenorphine was administered (Magura et al., 2009). Because it takes five to ten minutes for a buprenorphine tablet applied sublingually to be absorbed completely, there is time for it to be removed from the mouth after insertion for subsequent potential black-market sale.

Prison personnel are often unwilling to spend the time necessary to observe each administered dose of buprenorphine in order to prevent its extraction from the mouth and diversion. Thus, instead of buprenorphine tablets, prisons are increasingly administering tablets combining buprenorphine and naloxone to reduce potential diversion and misuse: applied sublingually, the naloxone is poorly absorbed and has limited pharmacological effect, whereas the efficacy of the buprenorphine is not affected by the presence of naloxone. If a buprenorphine/naloxone tablet is crushed and used intravenously, the naloxone is bioavailable; it will counteract the potential euphoric effect of the buprenorphine and can precipitate severe opioid withdrawal, a strong deterrent to intravenous misuse of diverted buprenorphine/naloxone.

Finally, lack of adequate funding to cover the start-up costs of a prison MAT programme constitutes a barrier to implementing a programme. To remove this barrier, the following items must be covered in a programme's start-up budget: general administration and administration of the MAT programme; medical and nursing staff to execute maintenance therapy assessments, administration, and delivery; pharmacy and courier services for the stocking, preparation, and delivery of medications; disposable materials used in medicating prisoners; maintenance medication; and correction officers to supervise the administration of medication to prisoners (Warren et al., 2006).

5. *Prospects for Developing MAT in Prisons in China and Central Asia*

The development of MAT of opioid dependence in Central Asia and the People`s Republic of (PR) China has only been treated marginally in the international specialist literature in recent years, although it is precisely in these two regions that it can be exemplified which supporting and which obstructing factors play a role. The professional world is usually more interested in the development of MAT in the USA, Canada, Australia, or Europe. Why should the focus instead be on Central Asia and China? There are several reasons: Central Asia is marked to a considerable extent by increasing 'trade' (via smuggling, clandestine sale, and money laundering) and the consumption of opiates and opioids (especially heroin).

The positive international experiences that foreground public health through harm-reduction and human rights approaches encourage local service providers to implement MAT in order to reduce overdoses and infectious diseases rates. However, the most recent evidence shows that funding of MAT in low- and middle-income countries has been visibly decreasing, leaving Central Asia and Eastern Europe with less than 27% of international donorship (Serebryakova et al., 2021). In both Central Asia and PR China, the official numbers of registered people who use opioids and the estimated grey numbers differ vastly (Zabransky et al., 2014; Zhao, 2020). In Central Asia, approximately only 2,500 of around 400,000 opioid-dependent people are being treated with opioid medications (mostly methadone). In Kyrgyzstan this number is 1,450 and in Kazakhstan 353 (Michels, 2021). Although there is MAT in prisons in Kyrgyzstan, access to treatment is inconsistent (Azbel, 2017).

In both Central Asian countries and the PR China, modern methods of treatment of drug-use disorders, according to the UNODC/WHO International Standards of treatment of drug use disorders (UNODC/WHO 2020),

have been implemented, including Medication-Assisted Treatment (MAT), although the provision of treatment is limited and not affordable for all those in need and psycho-social assistance is still widely unavailable. Social work in particular is missing or still in its infancy.

Marienfelda et al. (2015) provided a comprehensive overview on the development of MMT in *China [In China MAT had been named as MMT, Methadone Maintenance Therapy, as used in USA earlier]*. Shui Shan Lee together with Robert Newman had been researching on the long-term experiences from Hong Kong (Lee and Newman, 2017) and earlier Yin et al. (2010). The early success of small pilot MMT programmes introduced in 2004 (Yin, 2010) has been followed by the rapid expansion of MMT programmes that follow standardised clinical protocols, and physicians providing MMT participate in a structured, centrally run, national training programme. By the end of 2019, more than 160,000 patients had been enrolled in more than 730 clinics established since 2005 (Sullivan et al. 2014). The latest overview was given by Tianzhen Chen and Min Zhao in 2019 (Chen, 2019) and showed a decrease of patients. But unfortunately, MAT in prisons is neither implemented nor planned.

The development and implementation of MAT in *Central Asia* has been stagnating in the past few years. The implementation is accompanied by strong media and other public campaigns against this type of drug treatment and harm-reduction measure, which had been claiming that MAT will lead to a 'new type of addiction', that people who use drugs are 'poisoned with a dangerous drug', referring to methadone, or that this treatment intervention is another form of 'Western imperialism', etc. Against this backdrop, local governments and the Ministries of Health and Internal Affairs have been very cautious in implementing MAT, reflecting the scepticism that is still dominating the Central Asian drug policy landscape. We believe that this opposition widely communicates the influence from Russia against MAT, too (Michels et al., 2021).

Despite the above-cited challenges, implementation of MAT has undergone several successful stages, even if small in scale. However, only in the Kyrgyz Republic and Tajikistan has MAT been implemented in the prison system on a small scale (Subata et al., 2016). In Uzbekistan MAT was not implemented following a pilot project (Khachatrian, 2009; Michels et al., 2021). In Kazakhstan, MAT has not been allowed to be implemented in prisons.

In fact, there is still considerable ignorance of the rationale for the implementation of medication-assisted treatment in the prison systems in Central Asia and China. However, the first positive experiences in the Kyrgyz Republic and Tajikistan gives us hope that this will lead to further

implementation of this treatment option more in the next few years. Time will tell whether this also applies to China. The wide implementation in the public health system with very positive results gives us hope.

Conclusion

Drug use is prevalent throughout prison populations, and, despite advances in drug-treatment programmes for people living in prisons, access to and the quality of these programmes often remain substantially poorer than those available for non-incarcerated drug users. Because prisoners may be at greater risk of some of the harms associated with drug use (infectious diseases, overdoses, etc.), they deserve therapeutic offers that are at least equal to those available for drug users in the community. The new EU drugs strategy 2021–2025 includes a strategic priority aimed at addressing the health and social needs of people who use drugs in prison settings and after release.

The principles of equivalence and continuity of health care provision in prison are central in these documents and underline the necessity to treat drug-using prisoners. The key role of drug-related services for people in prison with drug problems is also in line with UN Sustainable Developmental Goal (SDG) 10 to reduce inequality and with UN SDG 3 to ensure healthy lives and promote well-being for all at all ages (Goosdeel, 2021).

This chapter has discussed drug use – in particular opioid use – by prisoners and its associated harms. In addition, we have provided an overview of studies conducted in prisons related to MAT, a clinically effective and cost-effective drug treatment strategy.

The findings from this overview indicate that treatment efforts for opioid users in prison are often poorer than those available in the community and demonstrate how the implementation of MAT programmes benefits not only prisoners but also prison staff and the community at large. Finally, the chapter has outlined strategies that have been found to be effective for implementing MAT in prisons and offered suggestions for applying these strategies more broadly.

Imprisoned people using drugs have the basic right to receive treatment for their drug addiction comparable to treatment available to people using drugs in the community. This treatment should include MAT, a treatment modality with demonstrated broad benefits to prisoners – both while they are incarcerated and after their release from prison – as well as benefits to the community. Examples of successfully implemented MAT programmes

exist, and these point to effective strategies and tactics for establishing MAT programmes elsewhere.

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Glossary

AFEW	Aids Foundation East West
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CADAP	Central Asia Drug Action Programme
CESCR	Committee on Economic, Social, and Cultural Rights
CF	Correctional Facility
ECDC	European Centre for Disease Prevention and Control
EPLN	European Prison Litigation Network
GFATM	Global Fund to Fight AIDS TB and Malaria
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICPR	Institute for Crime & Justice Policy Research
IDU	Injection drug users
IFSW	International Federation of Social Workers
LEAHN	Law Enforcement and HIV Network
MAT	Medication-assisted treatment
MHKR	Ministry of Health of the Kyrgyz Republic (Kyrgyzstan)
MIS	Criminal-Executive System (Kyrgyzstan)
MMT	Methadone maintenance therapy
NEP	Needle exchange points
NGO	Non-Governmental Organisation
NSP	Needle and Syringe Exchange Program
OHCHR	Office of the High Commissioner for Human Rights, United Nations
OSCE	Organization for Security and Co-operation in Europe
OST	Opioid substitution therapy

PWID	People Who Inject Drugs
PRI	Penal Reform International
RAC	Republican AIDS Center (Kazakhstan)
RNC	Republican Narcology Center
SDG	Sustainable Development Goals
SEP	Syringe exchange points
S-O-S	Stopping Overdose Safely
SSEP/ GSIN	State Service for Execution of Punishment
STI	Sexually transmitted infection
SSSS	Self-Strengthening Service Society (China)
TB	Tuberculosis
UIC	Unique identification code
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USCIRF	United States Commission on International Religious Freedom
WHO	World Health Organization

Authors' Biographies

Zhyldyz Bakirova is deputy director of the Republican Center of Narcology in Bishkek and PhD student at the International School of Medicine of the International University of Kyrgyzstan. She is trained as a psychiatrist/narcologist, and participated in a number of international research projects, including the Central Asia Drug Action Programme (CADAP) and in the study "Needs and gaps in treatment and rehabilitation for people who use drugs in selected countries of EECA." Zhyldyz is an expert of the national group of developers of the UNODC quality assurance tools. She has published articles on opioid overdose and the drug rehabilitation in the Kyrgyz Republic. Her research interests include social work in the treatment continuum and organization of psychosocial assistance to persons with substance dependence in Kyrgyzstan.

Tynchtyk Estebes Uulu is a PhD student at the Department of Sociology of Bishkek State University. He holds a master's degree from the OSCE Academy in Bishkek, majoring in "Politics and Security" with a special focus on Central Asia. His current major research focuses on social work, NGOs, the probation system, drug addiction, drug trafficking and sustainable development.

Simon Fleißner is research assistant at the Institute for Addiction Research at the University of Applied Sciences in Frankfurt am Main. He holds a MA in Research in Social Work and is currently working as a project coordinator in the Germany-wide model project NALtrain on the implementation of take-home naloxone in addiction aid in Germany. At the same time, he is investigating the processes of implementation of take-home naloxone in Germany in his doctoral thesis. He is also focusing on the topic of women in prison from a human rights perspective in a global context.

Sandugash Ismagulova is a social work specialist in Kyzylorda city polyclinic №6. She is also a Branch Manager in National Alliance of Professional

Social Workers of Kazakhstan, for the city of Kyzylorda and Kyzylorda region.

Anna Konvissar is deputy head of the Department of Organization of Social Work in the Internal Affairs Bodies and police captain at Kostanay Academy of the Ministry of Internal Affairs of the Republic of Kazakhstan named after Sh. Kabylbayev.

Ulla-Britt Klankwarth is an MA student in "Criminology and Violence Research" at the University of Regensburg, Germany. She holds a B.A. in Social Work and is a research assistant at the Institute for Addiction Research at the University of Applied Sciences in Frankfurt am Main. Her main research interests include women in prison and alternatives to imprisonment.

Medet Kudabekov is a PhD student at the Department of Sociology and Social Work of the Eurasian National University named after L.N. Gumilyov in Astana, Kazakhstan. His main research interests include professionalization of social work in the framework of modernization of the social service system.

Ingo Ilja Michels, PhD, is sociologist and advisor for treatment of drug dependence. Since 2010, he was Project Leader of the EU Central Asia Drug Action Programme (CADAP), since 2020 he is the International Scientific Coordinator of the DAAD project "Social work and strengthening NGOs in development cooperation to treat drug addiction"(SOLID) of the Frankfurt University of Applied Sciences. He worked in psychiatric clinic with drug dependent heroin user, as Head of the Drugs and Prison projects department of the German AIDS-Hilfe in Berlin, as Drug Commissioner of the Federal State of Bremen in northern Germany, and as Head of the Office of the Federal Drug Commissioner within the Federal Ministry of Health in Berlin. He is freelance advisor for drug services in PR China in Beijing and Shanghai and Guest Professor at the Department of Sociology/Social Work of the East China University of Science and Technology (ECUST), Shanghai. He is author of several articles on prevention and

treatment of drug dependents and on drug policy in International Journals on Substance Use.

Dalida Mukasheva is PhD student at the Department of Sociology and Social work of the Eurasian National University, named after L. Gumilyov. Her main research topic include health and social welfare in prisons, the situation of women with HIV and the professional roles of social workers. Before joining the SOLID Project, Dalida worked for development agencies in Kazakhstan. She has experience in education, science and research, and is member of the National Alliance of Professional Social Workers of Kazakhstan.

Nurgul Musaeva, PhD, is Associate Professor of Psychology at the Bishkek State University (BSU) named after K. Karasayev. She holds a PhD in Social Philosophy. She is member of the Association of Social Workers of the Kyrgyz Republic and one of the developers of the State Educational Standards in the direction of "Social Work" and "Psychology" at Master's and Bachelor's level. Since 2020, she is National Scientific Coordinator of the SOLID Exceed SOLID project Kyrgyzstan, which is funded by the German Academic Exchange Service (DAAD). She is the author of more than 30 scientific articles, three books devoted to the philosophy of social work, the development of psychological thoughts among the Kyrgyz people and social psychology. Currently, she is studying the issues of training specialists to work with vulnerable population groups such as people living with HIV, prisoners and people using drugs.

Cholpon Omurkanova is director of the Public Foundation "Egl". From April 2011 to June 2021, she was chairwoman of the public Council of the state penitentiary Service of the Kyrgyz Republic. She is an independent expert on the reform of the penitentiary system. Moreover, she is a mediator and expert on conflict transformation. Mrs. Omurkanova participated in several monitoring studies of the penitentiary system of the Kyrgyz Republic.

Eric Orozaliev, PhD, is a professor of psychology at the K. Karasaev BSU and dean of the Faculty of Social Psychology. At the same time, he is a member of the council for the defense of candidate and doctoral disserta-

tions in sociology and political science at the J. Balasagyn KNU, president of the Association of Social Workers of the Kyrgyz Republic and chairman of the public supervisory board of the Ministry of Social Development of the Kyrgyz Republic. Professor Orozaliev has published more than 80 scientific articles and methodological works, including 6 monographs and textbooks for practicing social workers and psychologists. He was awarded as excellent employee of the education system of the Kyrgyz Republic and as honored scientist of the Kyrgyz Republic.

Ulla Pape, PhD, is a postdoc in the SOLID Project (Germany) and scientific staff member at the Institute of Addiction Research of the University of Applied Sciences in Frankfurt am Main. She holds a Ph.D. in International Relations and International Organization from the University of Groningen. Before joining the SOLID project in 2022, Ulla was research associate at Free University Berlin, University of Bremen, Radboud University Nijmegen, and Higher School of Economics in Moscow. Her research interests include international health and social policy, welfare state development and civil society in Eastern Europe and Central Asia. Ulla has published a book The Politics of HIV/Aids in Russia (2014) and several articles in international journals such as Europe-Asia Studies, the Journal of Civil Society, the International Journal for Sociology and Social Policy, and Voluntas. In the SOLID project, Ulla is responsible for the research on social work in the prisons and social work and infectious diseases (HIV, HCV and tuberculosis). Furthermore, she focuses on the participation with civil society actors in developing social work in Central Asia. In addition, Ulla is member of the editorial board of Voluntas and associate lecturer at the Free University Berlin.

Mariya Prilutskaya, PhD, is a postdoc at the SOLID Project (Kazakhstan) and a research assistant at Semey Medical University (Pavlodar, Kazakhstan). She graduated from Astana Medical University in 2008 and has worked as a psychiatrist for ten years. The sphere of her professional interests is drug addiction. In the last seven years, she has focused on the problems of novel psychoactive substances in clinical practice of Kazakhstani doctors. Mariya Prilutskaya studies the epidemiological and clinical aspects of drug addictions caused by synthetic cannabinoids and cathinones in Kazakhstan. She is a member of International Society for the Study of Emergent Drugs and International Society of Substance Use Professionals.

She participated in development of national clinical standards for management of addictions caused by novel psychoactive substances. Her research activities have been supported by CADAP and UNODC.

Jarkyn Shadymanova, PhD, is a postdoc in the SOLID Project (Kyrgyzstan) and an associate professor at the Bishkek State University and American University of Central Asia. She holds a PhD degree in Sociology. Her research interests include qualitative and quantitative research methods, social work, sociology of deviation and gender studies. She was a postdoctoral researcher at the Sociology Consumption and Household Group, Wageningen University, and at the Department of Anthropology, University of Amsterdam. Jarkyn is an author of numerous articles in peer-reviewed journals and book chapters on social issues.

Zhanar Shaidullina is head of the medical support department of the Criminal Executive System Committee of the Ministry of Internal Affairs of the Republic of Kazakhstan and colonel of justice.

Sergey Soshnikov, MD, PhD, is postdoc in the SOLID project (Uzbekistan) and researches social work in prisons and infectious diseases. He began his career in healthcare in Russia in 2000. Sergey Soshnikov obtained a PhD from the Russian Public Health Research Institute in 2008. He has experience as an assistant professor and researcher at various institutions, including the Russian Medical Academy of Postgraduate Education, Central Michigan University (as a Fulbright scholar), and the Federal Public Health Research Institute. Additionally, he has held leadership positions such as head of the department and a chief specialist at the Center for Healthcare Quality Assessment and Control of the Ministry of Health. He also worked as an expert consultant for the World Health Organization and as a Professor at Sechenov First Moscow State Medical University.

Heino Stöver, PhD, is social scientist and Professor of Social Scientific Addiction Research, Faculty of Health and Social Work at the University of Applied Sciences in Frankfurt, Germany. since 2020 he is the Project Director of the DAAD project "Social work and strengthening NGOs in development cooperation to treat drug addiction" (SOLID) of the Frankfurt University of Applied Sciences Since 1987, he is director of the Archive

and Documentation Centre for Drug Literature and Research at the Frankfurt University of Applied Sciences (http://www.archido.info/), and the "Institute of Addiction Research of the University of Applied Sciences in Frankfurt" (https://bit.ly/3GV0XFC). Main fields of his research and project development expertise are health promotion for vulnerable groups, drug services, prisons, and related health issues (especially HIV/AIDS, Hepatitis C, and drug dependence). Consultant for the European Commission, United Nations Office on Drugs and Crime (UNODC), WHO, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), International Committee of the Red Cross (ICRC), and Open Society Institute (OSI) in various contexts. He has published several articles in international journals and books on preventing and treating infectious diseases adequately (HIV/AIDS, hepatitis, STIs, and TB), opioid substitution programs, and drug treatment in general.

Hang Su, PhD, is a postdoc at the Shanghai Mental Health Center, majoring in psychiatry and mental health. Hang Su has been engaged in the basic and clinical research of drug dependence and substance addiction, and learn knowledge about addiction medicine, psychology, epidemiology and sociology since 2011. Hang Su has successively participated in a series of research projects including the key research and development plan of the Ministry of Science and Technology of the People's Republic of China, the key project of the National Natural Science Foundation, the regional joint fund of the National Natural Science Foundation, and the major special project of the Shanghai Municipal Commission of Science and Technology, focusing on the brain electrophysiological characteristics, brain imaging mechanism, and new physical intervention of the psychological craving for substance abuse. As the project leader, he has successively undertaken one youth project of the National Natural Science Foundation and one general project of China Postdoctoral Fund. Over 20 papers have been published in the past five years, including 13 SCI papers published by the first author/co-first author). At present, he is a member of the Addiction Medicine Branch of the China Association for the Prevention and Control of Drug Abuse and the Addiction and Brain Science Branch of the China Association for the Prevention and Control of Drug Abuse.

Nurlan Tulkinbayev, PhD, is acting head of the Professional Training Faculty at Kostanai Academy of the Ministry of Internal Affairs of the Republic

of Kazakhstan named after Sh. Kabylbayev. He earned the degree of Candidate of Pedagogical Sciences and serves both as an associate professor and police colonel.

Dinara Yessimova, PhD, is lecturer at the Department of Sociology of the Eurasian National University and executive director of the National Alliance of Kazakhstan's Professional Social Workers. To train competitive specialists, Yessimova Dinara pays much attention to replenishing educational and methodological materials. Dinara has played an important role in the development and promotion of social work in Kazakhstan. She advises UN agencies in Kazakhstan on projects related to maternal and infant mortality, children's rights, and the development of social work in the health and justice systems.