



**CIVIL SOCIETY
FORUM
ON DRUGS
IN THE EU** 

CIVIL SOCIETY SURVEY

**GOOD PRACTICES
IN PRISON SETTINGS**

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GOOD PRACTICES IN PRISON SETTINGS

In the context of the Cypriot Presidency of the EU Council, which has identified prisons as a priority within the work of the Horizontal Drugs Group (HDG), the Civil Society Forum on Drugs (CSFD) launched a survey among its members. The objective was to:

- identify concrete good practices addressing drug-related issues in prison settings;
- demonstrate that effective, evidence-informed responses already exist and can be adapted and disseminated across contexts.

The eighteen practices gathered span fourteen countries, including EU member states, candidate countries, and neighbourhood partners. They cover the full spectrum from targeted in-prison interventions to structural governance reforms, and they have been implemented by civil society organisations, public authorities, and partnerships between the two.

Four main thematic areas emerge:

HARM REDUCTION IN PRISON SETTINGS

Harm reduction is essential to uphold the right to health and the principle of equivalence of care, and to prevent infectious diseases, overdoses, and other harms in high-risk prison environments. However, implementation remains limited due to legal and political barriers (especially where prohibition-oriented approaches are prevalent), security concerns, and stigma. Services are often uneven or restricted to pilot initiatives.

The practices collected show that harm reduction can be effectively delivered in prison, including through peer-based approaches and integrated models. They also highlight that such interventions remain insufficiently scaled up and not yet systematically embedded in prison systems.

ACCESS TO TREATMENT IN DETENTION

Access to treatment and psychosocial support is a core component of healthcare, contributing to improved health and reduced reoffending. It reflects the principle that imprisonment should not worsen existing health inequalities. Yet access remains uneven, constrained by limited resources, institutional fragmentation, and prison-specific constraints such as short sentences or overcrowding.

The practices demonstrate the value of diverse treatment models, including therapeutic communities and structured programmes. At the same time, they reveal gaps in coverage, accessibility, and adaptation to different populations.

CONTINUITY OF CARE (INSIDE–OUTSIDE PRISON)

Ensuring continuity of care is critical to protect the right to health, particularly during release, a period of high risk for overdose and treatment interruption. It also ensures the effectiveness of interventions initiated in prison. However, continuity is often undermined by fragmentation between prison and community services, weak coordination, and administrative barriers.

Continuity of care is shaped not only by access to health services, but also by conditions that affect people upon release, in particular access to housing and economic resources.

The listed good practices highlight the importance of early release planning, referral mechanisms, and sustained follow-up, often involving community-based actors. They underline the need for strong coordination with health services but and community services, but they also show that continuity of care remains insufficiently structured and too dependent on local initiatives.

TRAINING FOR PRISON PERSONNEL

Training is essential to equip prison staff with the knowledge and skills needed to respond to drug-related issues, reduce stigma, and support a health-oriented approach in prison settings. In practice however, training remains limited and uneven, due to resource constraints, competing priorities, and the need for continuous updates.

The practices collected point to a notable gap in this area, with very few dedicated initiatives identified. Where implemented, training demonstrates clear benefits, suggesting significant potential for further development.

TREATMENT AND REHABILITATION PROGRAMME FOR MEN IN PRISON

Country : Ireland

What it does

The TARP Treatment and Rehabilitation Programme is an eight-week intervention for men in prison who use drugs. It supports participants in learning tools to maintain a drug-free life and in managing the emotions and practical difficulties they are likely to face on release. The programme uses a non-judgmental, person-centred and harm reduction-informed approach.

Why it is relevant

According to the respondent, the programme is a good practice because it helps participants feel valued and worthwhile. It creates a safe, non-judgmental space where men can discuss their views openly, work out what they need to do, and take the lead in the group process. The client-led nature of the groups is central: participants' views and ideas are actively valued rather than managed from above.

Replication: facilitating factors and barriers

The respondent noted one condition for replication above all: the programme needs to keep a client-led and non-judgmental approach. That ethos is the main facilitating factor because it shapes how participants engage. The barriers identified in the survey are widespread drug use in prison, overcrowding, an insufficient number of addiction counsellors, and the fact that returning participants to the main prison after the programme rather than to a safer prison environment can be counterproductive.

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PEER-TO-PEER HARM REDUCTION SERVICE IN PRISON

Country : Ukraine

What it does

In this model, prisoners are trained to provide harm reduction services to other prisoners, including the distribution of syringes. They are not simply volunteers: they are officially hired by an NGO and paid for the services they provide. The approach therefore embeds peer work inside the prison setting in a formalised and remunerated way.

Why it is relevant

The programme gives people in prison access to harm reduction services around the clock from trusted peers. This strengthens trust, helps fight prejudice within the prison population, improves access to services, supports earlier detection of health problems, reduces drug-related stigma, and contributes to continuity of care after release.

Replication: facilitating factors and barriers

The survey response states that this practice can be replicated anywhere there is sufficient political will to provide low-threshold, people-centred services in prison. Formal employment of peers, rather than informal peer volunteering alone, is a facilitating factor because it clarifies roles and legitimises the service. The barriers identified are lack of political will for people-oriented approaches, lack of funding because prison programmes are often financed on a residual basis, lack of trained staff, and prison healthcare being subordinated to law-enforcement ministries rather than ministries of health.

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PRISON-BASED THERAPEUTIC COMMUNITY FOR ADDICTION RECOVERY

Country : Spain

What it does

Proyecto Hombre runs five prison-based therapeutic communities in Spain. These are treatment and rehabilitation units within penitentiary centres for people with substance use disorders. They are located in wings that are completely separate from inmates who are not in treatment. The prison-based therapeutic community is designed not as an isolated intervention but as part of a longer rehabilitation and social reintegration pathway that continues in a facility outside the prison while the person is on probation.

Why it is relevant

Three core reasons: it helps reduce criminal recidivism, reduce drug use, and foster social reintegration. Its relevance comes from the fact that it combines treatment inside prison with preparation for rehabilitation beyond prison.

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“STAYING IN TOUCH” PRISON CONTACT SERVICE FOR CONTINUED HARM REDUCTION SUPPORT

Country : Poland

What it does

‘Staying in touch’ is an approach built around maintaining contact between people in prison and the harm reduction services they knew before incarceration, while also helping those who had no previous contact but reach out from prison. Contact can be maintained by post, by telephone, through family members or lawyers, or during scheduled prison visits. This makes it possible to monitor what is happening to the person and intervene where necessary. The organisation uses its cooperation with the Ombudsman, the Patient Rights Advocate and the media to strengthen its negotiating position when treatment is interrupted, medical care is denied, or a person is subjected to abuse. Support does not stop at healthcare: the service may also provide cash assistance, food packages and psychological support. After agreements with individual prison authorities, people leaving those facilities receive leaflets with information about harm reduction services, including contact details and details of available support.

Why it is relevant

Impact, evidence, sustainability and access to treatment: the programme protects continuity of treatment during incarceration, creates practical leverage when rights are not respected, and provides direct support around basic needs as well as medical or psychosocial care. It also allows the organisation to gain first-hand knowledge of prison rules and conditions, which in turn informs wider advocacy and service planning.

Replication: facilitating factors and barriers

Barriers identified are substantial: drug use in prison remains taboo, prison officials are reluctant to acknowledge it, and officers may fear the reaction of superiors in a culture of silence; stigma means some prisoners avoid discussing their use or refuse HIV and HCV testing and even therapeutic interventions; treatment units are too few and waiting lists delay proper care; shortages of staff and equipment slow diagnosis and treatment; the prison as a ‘total institution’ harms mental wellbeing; and in Poland treatment continuity is weakened because the Ministry of Health is responsible for OAT outside prison while the Ministry of Justice is responsible inside prison, with no guarantee of continuity either during custody or after release.

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A THERAPEUTIC COMMUNITY UNIT IN A PRISON

Country : France

What it does

The Drug User Rehabilitation Unit is a specialised programme inside Neuvic prison for people with substance use disorders. It is organised in a dedicated prison wing, separated from the general population, so that participants live together in a structured and safer environment focused on recovery. The unit follows a therapeutic community model: residents take part in daily group sessions, receive individual support, and join collective activities that encourage peer support, active participation, and shared responsibility. The model relies on close collaboration between healthcare professionals, social workers, and prison staff so that therapeutic support and prison security are managed together rather than in parallel.

Why it is relevant

This initiative was presented as a good practice because it is unique in France in offering a therapeutic community inside a prison, thereby filling a clear gap in addiction care in detention. It strengthens the principle of equivalence of care between prison and the community by making available, inside custody, a structured and intensive form of support that is more commonly found outside prison. Its relevance also lies in the way it has been adapted to prison constraints: prison officers are integrated into the programme to ensure both security and continuity of care, and this integration requires dedicated partnership work so that staff adopt appropriate professional postures when working with participants.

Replication: facilitating factors and barriers

The model is transferable where prison administrations are willing to dedicate a separate unit and support a therapeutic rather than exclusively custodial culture. Replication is helped by multidisciplinary cooperation, the existence of addiction professionals, and agreement that prison officers can be involved in a recovery-oriented framework. The main barriers are the need for a dedicated wing, sustained staffing, and careful inter-professional work to reconcile security roles with therapeutic practice.

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PRISON SUBSTANCE USE UNITS WITH COORDINATED THROUGH-CARE ON RELEASE

Country : Norway

What it does

These are special prison units for people with substance use problems. They provide treatment and rehabilitation inside prison while also strengthening coordination among the prison system, specialised health services, prison health services and municipal services after release.

Why it is relevant

The units ensure continuity of health services in prison and create an opportunity to start treatment during imprisonment. Their added value is improved coordination with health and municipal services after release.

Replication: facilitating factors and barriers

The main barrier identified is the prevalence of relatively short prison sentences, which makes it difficult to map needs and initiate treatment or other health services before release.

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ADDICTION CENTRES FOR CARE AND RELEASE PREPARATION

Country : France

What it does

This practice consists of designated CSAPA teams working inside prisons. In France, CSAPAs are specialised outpatient addiction services; in this model some CSAPAs are specifically mandated to intervene in custodial settings. They target people in prison with substance use issues, particularly those approaching release. Their role is to assess needs, provide addiction support, link with prison healthcare, coordinate with probation services and community providers, and prepare the person's care pathway beyond custody. The core function is to connect inside and outside systems before release rather than waiting until the person leaves prison.

Why it is relevant

It responds to a clear need to connect the actors working in prison with those outside. That coordination helps release take place with fewer risks. The continuity of addiction care at release is essential, since many people leave prison with major social vulnerabilities, including poor social integration and lack of housing, while the risk of overdose is particularly high in the days immediately after release. By assigning a specific actor responsibility for coordinating the care plan before release, creating time to establish contact with community services, and supporting people directly during the transition period, the model reduces breaks in care and helps prevent overdose after release.

Replication: facilitating factors and barriers

This is transferable to other countries because the principle is clear: involve specialised addiction services inside prison early enough to establish contact with people before release and organise continuity with community-based care. Replication is facilitated where the same professionals, or well-coordinated professionals, can work across prison and community settings. The main implementation barriers identified are structural: prison overcrowding without matching increases in prison and healthcare staffing; difficulty organising escorts or transfers for access to care; healthcare teams forced to prioritise emergencies; lack of offices, computers, phones and confidential spaces; uneven access to harm reduction tools, including sterile injecting or inhalation equipment and naloxone at release; and weak release preparation, with many people leaving without care plans or basic social rights such as housing, healthcare coverage, or identity papers.

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PRE-RELEASE OVERDOSE PREVENTION AND NALOXONE TRAINING

Country : Ireland

What it does

This initiative delivers overdose prevention sessions in prison through a group of professionals from different organisations. The training explains why the first two weeks after release carry especially high overdose risk, particularly after abstinence, reduced use, lower-quality drugs or changes in route of administration. Participants are shown how naloxone works, how to use it, and which addiction services are available after release. In Ireland, people in prison can obtain free nasal naloxone on release if they ask for it, although the respondent notes that it is not proactively offered and people need to know to request it.

Why it is relevant

The intervention can raise awareness of overdose risk, increase awareness that naloxone is available free of charge on release, lower the risk of overdose after release, and leave more peers trained in naloxone use.

Replication: facilitating factors and barriers

This is readily transferable wherever addiction services are able to provide naloxone training in prisons. The main facilitating factor is the straightforward link between pre-release training and overdose prevention after release. The principal barrier identified in the survey is operational rather than conceptual: in Irish prisons people cannot keep naloxone in their cells because the nasal naloxone device contains a small sharp element, so in an overdose they must alert prison guards, who then call a nurse to administer naloxone, creating potentially life-threatening delay.

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PENITENTIARY DRUG TREATMENT PROGRAMME WITH RELEASE PREPARATION AND FOLLOW-UP CARE

Country : Czechia

What it does

This penitentiary drug treatment programme provides preventive and treatment services for people in conflict with the law who have problems with drug use. It is implemented inside prisons and targets incarcerated people with a history of substance use. The intervention combines counselling, motivational work and therapeutic support. Its aims are to encourage clients to change their lifestyle, prevent further drug use and criminal recidivism, reduce the health risks associated with drug use, prepare clients for release, and connect them with social and health services for follow-up care after they leave prison.

Why it is relevant

The programme reaches a relatively hidden population of people with substance use problems who often had no previous contact with drug services before imprisonment. By providing early intervention, motivational support and professional counselling in prison, the programme can increase readiness for treatment and for wider lifestyle change. Continuity of care is a central strength: the model actively links clients with social and health services after release. In that sense it contributes both to the prevention of drug-related harm and criminal recidivism, and to more successful social reintegration.

Replication: facilitating factors and barriers

The model is transferable because it is built on established addiction-treatment and counselling approaches that can be adapted to different prison settings. Replication is facilitated by cooperation between prison services and community treatment providers, and by including release preparation as part of prison-based work rather than as an afterthought. The barriers identified in the survey are limited availability of comprehensive drug-treatment services in prisons, insufficient specialised staff, weak continuity between prison-based care and community treatment after release, the fact that many people with substance use problems remain a hidden population during imprisonment, and the need for more systematic evaluation and stronger cooperation between prison authorities, health services and community organisations.

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ACCESS TO TREATMENT IN DETENTION CONTINUITY OF CARE

CENTRES FOR PSYCHOSOCIAL VULNERABILITY

Country : Italy

What it does

In the Lombardy Region, 10 day care centres for vulnerability operate within major correctional institutions, supported by two external day care centres for people serving non-custodial sentences, one of which is dedicated to women. The centres serve people with significant psychosocial vulnerabilities, often including substance dependence. They operate on a multidisciplinary case-management model, bringing together healthcare professionals, custodial staff, and third-sector organisations to deliver integrated social, educational, and health-oriented support. Their aims include strengthening personal services networks across social, socio-health, and health sectors; preparing people for release through bridging services between custody and community; and activating semi-residential pathways through internal day care centre activities and external day care centres as community-based hubs for the prevention and treatment of marginalisation. The external centres can be accessed by detained people through one-day release permits.

Why it is relevant

The initiative brings together, within prison spaces, professionals from health, custodial, and civil society sectors to carry out structured activities for people with significant psychiatric or psychosocial vulnerabilities, often with substance dependence. In the Italian context, units dedicated to such vulnerabilities within correctional settings tend to be limited to healthcare provision, with little rehabilitative or social content. The experience of the external day care centres adds further value by enabling detained people to access community-based spaces through one-day release, supporting reintegration before formal release.

Replication: facilitating factors and barriers

The model is transferable where prison and health administrations are willing to allocate dedicated spaces — separate from residential wings — for educational and rehabilitative activities, and to engage third-sector partners in their delivery. For the external component, authorities must be willing to grant one-day release permits, and territorial health and social services must be engaged. A practical benefit noted is that the centres reduce pressure on custodial and healthcare staff, who often work in environments poorly suited to supporting people with complex psychosocial needs.

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OUTSIDE-REHABILITATION PLACEMENT PROJECT FOR DEFAULT AND SHORT-TERM PRISONERS

Country : Finland

What it does

Launched in 2021 by the Finnish Criminal Sanctions Agency, this project was created for inmates serving short custodial sentences, including default imprisonment in lieu of unpaid fines and other short sentences, who have substance use rehabilitation needs. The problem it addresses is specific: because sentences are so short, there is usually not enough time for meaningful rehabilitation if standard prison procedures are followed. Although Finnish law has allowed the use of outside rehabilitation institutions as part of prison sentences since the early 2000s, there had been no operational process to make that possibility work in practice. The project therefore put that process in place. Project coordinators were recruited into prisons, eligibility criteria for outside placement were developed, and a competitive bidding process was organised to identify outside rehabilitation institutes. People were informed about the possibility of outside placement before entering prison and consent was sought in advance; in some cases, detoxification was arranged before prison entry. Because work began before admission, some people could be placed in NGO or private rehabilitation institutions within days of entering prison. For unplanned admissions, placement took longer, but a coordination process still existed. Continuity after the sentence was coordinated with welfare districts, which are responsible for rehabilitation more generally.

Why it is relevant

The programme solves several problems linked to the rehabilitation of short-term prisoners, a group long recognised in Finland as being at particular risk of substance use disorders and yet difficult to treat within the usual prison timetable. Research evidence has not yet been published, but a three-year follow-up with a matched comparison group was completed on 31 December 2025 and publications are expected. Even before those publications appear, the operational value of the model lies in creating a route to rehabilitation for people who would otherwise serve their sentence without meaningful treatment input.

Replication: facilitating factors and barriers

The practice can be transferred, but not copied without adaptation to national legal and institutional features. Replication is helped by having a legal basis for placement outside prison, named coordinators, and established links with external rehabilitation providers and community services. The main barriers are legal restrictions in countries where drug-rehabilitation placement outside prison is not permitted; uncertainty over who should pay for rehabilitation, as shown in Finland by tensions between the Criminal Sanctions Agency and the welfare districts; and the risk that continuous coordination is overlooked and underfunded once the initial project phase is over. which makes the model readily transferable. Replication is facilitated where prison administrations can integrate drug-specific training into staff development. The barriers identified are wider contextual issues: limited access to care and treatment for inmates, stigma and shame among inmates regarding drug use, overcrowded cells, lack of prison-specific research on drug use, lack of staff, and a general prison approach that treats drug use mainly through sanctioning.

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LINKING HARM REDUCTION SERVICES WITH PRISON RELEASE

Country : Portugal

What it does

GAT IN Mouraria, run by the NGO Grupo de Ativistas em Tratamentos in Lisbon, is an integrated harm reduction and risk minimisation service that combines a fixed-site centre with outreach work in partnership with municipal actors. It mainly serves people who use drugs and experience severe vulnerabilities, especially homelessness, social exclusion and precarious legal status. Many users are at heightened risk of imprisonment because of minor offences or undocumented status. What distinguishes the initiative is its holistic, multidisciplinary model. Social workers, peer workers and health professionals provide standard harm reduction interventions such as needle and syringe programmes, testing and linkage to care, but they also maintain regular contact with service users when they are in prison. This includes in-person visits, phone contact and direct economic support for basic needs. The team stays in contact with prison social and health staff, shares relevant clinical information, and works to prevent treatment interruption during detention. After release, each person receives a comprehensive clinical and social assessment. Peer workers then accompany users in resolving administrative problems, obtaining identity documents or social benefits, and navigating the healthcare system, with the aim of rebuilding trust, strengthening autonomy and supporting reintegration.

Why it is relevant

The programme directly addresses one of the main weaknesses in prison-related care: interruption of health and social support across the prison–community boundary. The sharing of clinical information, regular contact during incarceration and intensive peer-supported transition after release can significantly improve continuity of treatment. According to the response, such interventions can also lower overdose rates and infectious-disease transmission after release, reduce recidivism, and improve adherence to addiction and infectious-disease treatment. The involvement of peers, close coordination with prison health and social teams, and tailored support during re-entry were highlighted as central to sustainability and positive outcomes. The model is also presented as cost-effective and transferable where prison, health and social services collaborate and adapt it to local needs.

Replication: facilitating factors and barriers

Replication is facilitated by a multidisciplinary service model, active peer workers, regular communication with prisons, and the ability to combine harm reduction, healthcare navigation and practical social support. The barriers identified are the same ones the initiative was created to address: weak data collection and monitoring on health, drug use and harm reduction in prisons at EU level; poorer availability and quality of harm reduction inside prisons than in the community; repeated interruptions in treatment for substance use disorders and chronic infections such as HIV and hepatitis C; and the compounded effects of stigma, social exclusion and precarious legal status on access to care. In Portugal specifically, the respondent notes that people leaving prison are not automatically registered with a primary healthcare centre, and many leave without personal documents or a fixed address, making continuity of treatment particularly difficult unless a specialised service helps them navigate these barriers.

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SAFE HOUSE AND SUPPORTED HOUSING PROGRAMME FOR WOMEN WHO USE DRUGS AFTER PRISON

Country : Slovenia

What it does

Safe House Stigma was established in 2010 for women who actively use drugs and have nowhere to return after a prison sentence. It functions as a gender-specific, harm reduction-based residential option. Some women stay there while waiting to begin serving their sentence; others come after completing it. The programme also includes three supported apartments for women who are more stable. In addition, staff visit the women's prison every week to facilitate group discussions, provide counselling and offer support. Because prison staffing is insufficient, the service also accompanies women to institutions and medical appointments.

Why it is relevant

The respondent presented the programme as the only gender-based harm reduction settlement programme in Slovenia. Its relevance lies in the fact that it combines housing, harm reduction, prison outreach and gender-responsive support for a group facing multiple forms of stigma. It supports women not only after release but also, in some cases, before imprisonment, and extends continuity through supported apartments for those who have stabilised further.

Replication: facilitating factors and barriers

Women in prison who actively use drugs and are multiply stigmatised need dedicated programmes that are both harm-reduction based and gender based, and that there is a lack of such programmes across Europe. Replication is therefore supported by a clear unmet need and by the possibility of combining residential support, prison outreach and accompaniment. The main barriers identified come from the broader prison context in Slovenia: prisons, as total institutions, do not respond adequately to drug use through harm reduction; past attempts to introduce syringe vending machines were blocked by prison administration; and harm reduction is often misrepresented as enabling or encouraging drug use, even though the absence of sterile equipment contributes to infections through shared drug-use materials.

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PRISON STAFF TRAINING PROGRAMME ON NEW DRUGS AND NPS

Country : Netherlands

What it does

This is a four-year project focused on training prison staff about new drugs, with a particular emphasis on synthetic cannabinoids and synthetic opioids. It responds to the growing presence of these substances in prison settings and aims to improve staff knowledge and preparedness.

Why it is relevant

Drug training in prisons is scarce. Prison staff generally have little information about drugs and especially about NPS, while the training provided through this project is well appreciated. Its relevance therefore lies in filling a practical knowledge gap in the day-to-day management of prisons.

Replication: facilitating factors and barriers

The NPS 'know no borders' and are now present in prisons in many countries while staff still lack proper information, which makes the model readily transferable. Replication is facilitated where prison administrations can integrate drug-specific training into staff development. The barriers identified are wider contextual issues: limited access to care and treatment for inmates, stigma and shame among inmates regarding drug use, overcrowded cells, lack of prison-specific research on drug use, lack of staff, and a general prison approach that treats drug use mainly through sanctioning.

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COMMUNITY-LED MONITORING TO REMOVE BARRIERS TO HEPATITIS C TREATMENT IN PRISON

Country : Kazakhstan

What it does

This practice uses community-led monitoring (CLM) to remove practical barriers to hepatitis C treatment in prison. After prison healthcare in Kazakhstan was transferred from the Ministry of Interior to the Ministry of Health, HCV treatment became technically available to people in prison. During regular visits to prison facilities, community representatives discovered that medical units were still refusing to start treatment because there were no guards available to transport patients to civilian medical facilities for the mandatory diagnostics required under the national HCV clinical guidelines, notably ultrasound and fibroscan. Community representatives collected written requests from 15 prisoners needing HCV treatment and submitted them to the healthcare department of Almaty region. Following an investigation, prison administrations organised transport to civilian facilities for diagnostics, and the prisoners who had submitted requests received treatment. The respondent adds that HCV treatment is now usually initiated in prison facilities across Almaty region without the same level of additional advocacy, although the situation still needs close monitoring in other regions.

Why it is relevant

This demonstrates in a concrete way how community-based monitoring data can trigger systemic change and make previously unavailable services accessible to people in prison. Rather than only documenting a problem, the monitoring process generated action by the health authorities and changed how treatment access was organised in practice.

Replication: facilitating factors and barriers

Replication is possible wherever communities are able to participate in monitoring services in prisons. Replication is made easier by access for community representatives, channels for submitting evidence to health authorities, and a legal framework that allows prison healthcare decisions to be challenged or reviewed. The main barriers identified were lack of political will, lack of funding, and stigma and discrimination.

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MINISTRY OF HEALTH OVERSIGHT OF PRISON HEALTH SERVICES

Country : Kosovo

What it does

In Kosovo, healthcare services in correctional facilities are organised and supervised by the Prison Health Department within the Ministry of Health rather than by the prison administration or justice authorities. This arrangement follows a formal transfer of responsibility from the Ministry of Justice to the Ministry of Health in 2013, with the aim of aligning prison healthcare with public health standards and ensuring professional independence and equivalence of care in line with the European Prison Rules and WHO recommendations. Drug-related health services currently available include basic addiction counselling and referral, psychological and mental health support, general medical care within prison health units, antiretroviral therapy for HIV-positive prisoners, and some HIV voluntary counselling and testing capacity. Rehabilitative and occupational programmes are an increasing focus of ongoing prison healthcare reform.

Why it is relevant

The structural separation of medical authority from prison security administration is a meaningful institutional step towards equivalence of care and clinical independence. By locating accountability for prison health within the public health system, the model reduces the risk of health needs being subordinated to custodial priorities, and creates a professional accountability framework consistent with international standards. The practice illustrates how governance reform, even without full implementation of all recommended interventions, can establish the structural conditions for improved care.

Replication: facilitating factors and barriers

The model is transferable to other jurisdictions willing to formally delegate prison healthcare responsibility to health ministries, and represents a feasible structural reform even where broader harm reduction services are not yet in place. The main implementation challenge illustrated by the Kosovo experience is the gap between structural reform and full service delivery: opioid substitution therapy is not yet consistently available inside prisons, meaning that people entering custody who were previously on community-based treatment may face interruption. Continuity of addiction treatment between prison and community remains a system weakness. Replication is therefore most effective when structural transfer of responsibility is accompanied by investment in specific services and clear protocols for continuity of care, particularly for opioid agonist therapy.

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COMPREHENSIVE HARM REDUCTION PROGRAMME IN MOLDOVAN PRISONS

Country : Moldova

What it does

Implemented by the National Administration of Penitentiaries (ANP), this programme creates a public-health and judicial framework for harm reduction across the prison system in Moldova. It reaches around 1,300 active beneficiaries each year out of an annual population flow of roughly 9,000 inmates, specifically targeting people who use opioids or synthetic substances such as alpha-PVP. The programme operates in 13 of the country's 17 penitentiary facilities. Its components are extensive: a Needle and Syringe Programme using both inmate volunteers and automated vending machines; Opioid Agonist Therapy with methadone and buprenorphine, currently reaching more than 205 people; routine six-monthly screening for HIV, hepatitis B and hepatitis C; access to treatment for viral hepatitis C; 93.8% antiretroviral therapy coverage; hepatitis B and COVID-19 vaccination for all inmates; emergency overdose management with injectable naloxone; and a therapeutic community component, the 'Catharsis' sector in Penitentiary No. 9, which provides a segregated drug-free space centred on intensive psychosocial rehabilitation and peer mentoring. After a successful pilot in Penitentiary No. 4 in Cricova, the ANP has expanded the vending-machine element, with nine units planned across eight prisons.

Why it is relevant

Since early 2022, Moldovan prisons have recorded zero documented cases of HIV transmission, attributed to the combined effect of needle and syringe provision, opioid agonist therapy, and high ART coverage. The programme also shows financial sustainability: since 2020, OAT medicines and their administration have been fully financed by the prison budget, and the prison budget already covers NSP consumables for the first 300 beneficiaries, with a roadmap to full domestic financing by 2027. It is also innovative in operational terms, because anonymous-card vending machines provide discreet 24/7 access and reduce stigma. The ANP is further planning to introduce long-acting buprenorphine and intranasal naloxone. Finally, the respondent notes institutional benefits: managed withdrawal and psychosocial support have reportedly reduced physical attacks on prison staff.

Replication: facilitating factors and barriers

The Moldovan programme shows that harm reduction can be institutionalised in complex prison environments if three conditions are met: judicial realism (meaning sterile equipment, OAT, HCV treatment and vaccination are treated as medical necessities); phased absorption of costs into the national budget; and hybrid delivery that combines automated technology, peer involvement and structured therapeutic-community work. The main barrier is achieving alignment among all actors involved: prison staff, healthcare professionals, policy-makers, civil society inside and outside prison, and people with lived experience of incarceration. The respondent stresses that equivalent standards of care require dialogue, recognition of different forms of expertise, and meaningful inclusion of lived experience in decision-making.

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SCALE-UP OF HARM REDUCTION AND SUBSTITUTION TREATMENT IN UKRAINIAN DETENTION FACILITIES

Country : Ukraine

What it does

FREE ZONE began harm reduction activities in prisons and pre-trial detention institutions in 2018. Its service package includes needle exchange; counselling on safer use, drug-related harms and overdose prevention; and support linked to substitution treatment. As part of substitution-treatment work, the organisation offers psychological support to clients, follows substitution-treatment clients in detention institutions, and works to ensure treatment continuity after release. The defining feature of the model is the peer principle: prisoners are recruited as outreach and social workers, trained, and formally contracted as official workers. In pre-trial detention institutions, where hiring peers is not feasible because of the specific penitentiary regime, healthcare staff are recruited as social workers instead. At the time of the survey, needle exchange and counselling were operating in five detention institutions. A critical operational element is 24/7 access to sterile injecting equipment through a combination of peer outreach workers, needle-delivery machines and posters with syringe-delivery attachments placed in safe locations. Substitution treatment had become accessible in detention institutions, and the organisation was providing counselling and support as part of its broader social-management and social-integration work in 24 detention institutions for more than 807 clients as of 28 February 2026.

Why it is relevant

First, the peer principle is the cornerstone of the model: peer outreach workers and healthcare workers receive certified training and are officially contracted as social workers. Second, the service is accessible 24/7 through agreements with penitentiary authorities and through a mix of person-to-person and machine-based delivery. Third, continuity of care is built into the model, because harm reduction and substitution-treatment follow-up are treated as part of a comprehensive pathway from pre-trial detention through prison and into release. Fourth, the programme has created a documented implementation algorithm for sustainability. Through work with the Public Health Center of the Ministry of Health, the organisation piloted a social-contracting model in the Stryzhavska detention institution in Vinnytsia, securing state funding for NGO-delivered harm reduction inside detention and creating a model for wider scale-up.

Replication: facilitating factors and barriers

All activities are well documented, evidence based, and built on international good practice with support from leading global experts, which strongly supports transferability. Replication is helped by documented procedures, formal agreements with prison authorities, social-contracting mechanisms and the integration of harm reduction with substitution treatment and wider social support. The main barriers identified were the war in Ukraine, including prison evacuations near the frontline and the resulting bureaucratic and operational strain; instability in staffing, funding and access to medicines and harm reduction commodities; and reduced international and national funding due to war and economic crisis.

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The eighteen practices presented in this report span fourteen countries and every stage of care: from targeted in-prison interventions to structural governance reforms, from peer-based harm reduction to release preparation and supported housing.

No single model fits every context, but taken together, they demonstrate three things that the Council of the European Union should take into account in its deliberations:

First, effective, evidence-informed responses already exist. For example: zero HIV transmissions recorded in Moldovan prisons since 2022; over 800 people receiving harm reduction and substitution treatment support across 24 Ukrainian detention facilities; therapeutic communities operating inside prisons in France and Spain with documented reductions in recidivism and drug use; peer-based services delivering round-the-clock harm reduction in settings where staff capacity is severely limited. The question is not whether these interventions work, it is why they remain the exception rather than the rule.

Second, the barriers are consistently structural and political, not technical. Across every thematic area and every country represented in this collection, the obstacles to good practice are the same: prison healthcare subordinated to justice ministries rather than health ministries; absence of political will to implement harm reduction inside custodial settings; fragmentation between prison and community services with no named actor responsible for continuity; chronic underfunding of prison health; and stigma, both institutional and social, that treats drug use in prison as a disciplinary matter rather than a health one. These are policy failures, and they require policy responses.

Third, the EU has a concrete role to play. The practices collected here are transferable. Their contributors have identified the conditions that enable replication and the barriers that prevent it. What is needed is a framework that incentivises Member States to adopt minimum standards for prison health, supports civil society organisations working in custodial settings, and creates mechanisms for the systematic exchange and scale-up of what already works.

ABOUT THE CIVIL SOCIETY FORUM ON DRUGS

The Civil Society Forum on Drugs (CSFD) is the official advisory body to the European Commission on drug policy, composed of 43 expert organisations from across Europe.

Representing a broad range of experiences including prevention, harm reduction, treatment, recovery, and the voices of people who use drugs, the CSFD brings grounded, evidence-informed, and community-based perspectives to the policy table. Its recommendations are rooted in both practice and lived realities, making it a legitimate and essential partner in shaping an EU Drugs Strategy that is effective, inclusive, and responsive to current and future challenges.

